Waterloo Wellington Local Health Integration Network

Annual Business Plan: 2018-2019 (REVISED)

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1) Context

A. Transmittal Letter from the LHIN Board Chair

Attached

B. Mandate (confirmation of the LHIN's mandate) and Strategic Directions

Over the past decade, the Waterloo Wellington Local Health Integration Network (WWLHIN) has worked significantly to improve the quality and availability of local health care. In 2017-18, we shifted to focus on making it easier for you to be healthy. Easier for you to get the care and support you need. Easier for you and your family to live the healthiest lives possible.

To make this possible, last year we launched five bold new strategic directions to enable this next phase of transformation in the local health system:

- Starting with the Patient Experience
- Driving Through Community Leadership
- Igniting Innovation and Creativity
- Empowering Clinical Leadership
- Creating A Great Place to Work

Building on the progress achieved over the past year, and guided by these strategic directions, our 2016-2019 IHSP and the Patients' First Action Plan, in 2018-19 we continue to drive our mission forward to improve the health of every single person who lives in Waterloo Wellington. The strategic directions noted above, and the initiatives contained within the Annual Business Plan, are based on local need and reflect the priorities outlined in the Minister's Mandate Letter (see alignment table below).

C. Alignment with the Priorities of the Minister's Mandate Letter

The WWLHIN 2018-19 Annual Business Plan is a high-level strategy that sets direction for WWLHIN staff and health service providers. The table below summarizes the wording from the ABP document. For a full version of the plan including operational actions, see Appendix A.

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP

Transparency and Public Accountability
• *E.g., working with Health Shared Services Ontario (HSSOntario) on an enterprise-wide review of the LHINs, managing risks effectively, and meeting reporting and accountability obligations*
	Actions Identified:
	• Free up capacity through reducing red tape and executing big impact ideas through the WWLHIN's Continuous Improvement Taskforce (Innovation Strategic Direction Initiative)
	• Achieve Accreditation (Innovation Strategic Direction)
	• Increase efficiency to ensure resources are optimized to support staff and delivery of care for our patients and residents (Innovation Strategic Direction) actions include:
	  ○ Optimize WWLHIN organization processes to simplify, improve efficiency, and achieve savings either in time or dollars that can be directed to providing care for patients
	  ○ The LHIN will work with Health Shared Services Ontario to complete an enterprise-wide review of the LHINs that identifies opportunities for improving efficiency and effectiveness and opportunities for savings that can be reinvested into patient care

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	○ The LHIN, while continuing to transform the health system, will remain fiscally responsible and manage its budget in a prudent manner to ensure that staff have the resources they need, and programs and services are effective, efficient, and sustainable into the future
Improve the Patient Experience • *E.g., initiatives to reduce caregiver stress and improve transitions between care settings; Patient and Family Advisory Committee(s) engagement*	Two Overarching Objectives with Subsequent Actions Identified Under the Strategic Direction of Starting with the Patient Experience: • Embed the patient voice across the health system (examples of actions identified include: engaging the PFAC in specific projects to improve the patient experience and building a patient experience program to engage patients and caregivers in the design and delivery of health services) • Continue to build the Care Community Model. Actions Include: ○ Improve access and meaningful attachment to primary care ○ Improve access to quality, coordinated mental health and addictions services in each sub-region ○ Increase LTC capacity and improve quality of care and facilities: ▪ Support the redevelopment of older long-term care homes to meet quality standards ▪ Implement LTC regulation amendments and standards to improve access, quality and transparency ▪ Increased capacity to support patients with responsive behaviours in LTC ○ Improve consistency and coordination of Home and Community Care (align care coordinators to primary care, increase PSW capacity, improve the patient experience) ○ Bring more specialty care closer to home (i.e. Cardiac, vision care) ○ Implement the Ontario Palliative Care Network plan to increase access to a palliative approach to care for all residents ○ Facilitate planning and integration at the sub-region level by implementing effective sub-region governance ○ All strategic directions link with the patient experience; the operational plan highlights other areas such as a caregiver strategy etc.
Build Healthy Communities Informed by Population Health Planning • *E.g., assessing local population health needs, identifying how providers in sub-regions will collaborate to address health gaps, working with public health and others to*	Under the Strategic Direction of Driving Through Community Leadership, two actions identified under the improve the health and wellbeing of our community objective read: • Work with public health and other partners on health promotion, prevention, and health equity. Examples include: ○ Promote health equity through consideration of high-risk populations in the planning, design, delivery and evaluation of services in each sub-region/care community ○ Address root causes of health inequities and the social determinants of health, by investing in health promotion, and reducing the burden of disease and chronic illness ○ Expand access to health interpretation services, based on

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
incorporate health promotion strategies	evaluation of pilot project • Lead and support collective impact initiatives to improve the health and wellbeing of our community (all based on collaboration and assessing local needs). Examples include: o Preventing Opioid Overuse and Overdose o Increasing access to supportive housing o Implementing and leading adoption of the compassionate communities approach o Supporting Seniors and Older Adults including dementia capacity planning o Improving access to child and youth mental health services through the children's planning table o Improving women's health and wellness in collaboration with the sexual assault taskforce o Wellbeing Waterloo Region o Advancing applied research through partnerships with local universities, colleges and research institutions Under the Strategic Direction of Starting with the Patient Experience, the action of facilitate planning and integration at the sub-region level by implementing effective sub-region governance was included.
Equity, Quality Improvement, Consistency, and Outcomes-based Delivery • *E.g., enhancing performance and quality measurement frameworks, working with Health Quality Ontario to support implementation of quality standards, ensuring engagement with Indigenous and Francophone leaders, providers, and patients to guide initiatives*	Under the Empowering Clinical Leadership Strategic Direction, the objective of improve quality across the health system, both at the regional and Sub-region levels: • Provide input to and implement HQO Quality Standards • Advance regional integration and quality improvement by expanding and empowering physician leadership of integrated clinical programs Under the objective of Driving Through Community Leadership, actions identified under the improve the health and wellbeing of our community objective read: • Work with public health and other partners on health promotion, prevention, and health equity. Examples include: o Promote health equity through consideration of high-risk populations in the planning, design, delivery and evaluation of services in each sub-region/care community o Address root causes of health inequities and the social determinants of health, by investing in health promotion, and reducing the burden of disease and chronic illness o Expand access to health interpretation services, based on evaluation of pilot project • Improve Indigenous health and wellbeing through collaboration with Indigenous leaders, providers and patients. Examples of operational actions include: o Expand access to culturally safe care o Enhance access to appropriate primary care locally o Improve Indigenous community's ability to self-determine its

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP

	own needs including the allocation of available resources
	• Improve the health and wellbeing of French-speaking residents. Operational actions include:
	  ○ Assess and strengthen health services in French including active offer
	  ○ Expand use of digital health for access to French services

Primary Care
• *E.g., working with providers to implement sub-region plans to integrate Health Links, enhance care coordination, and improve access and care transitions*
	The following actions are included in the Starting With the Patient Experience Strategic Direction:
	• Improve access and meaningful attachment to primary care (especially for the vulnerable complex). Operations include:
	  ○ Bring primary health care to places where our most vulnerable congregate to create care that is meaningful and responsive to their unique needs.
	  ○ Make it easier for residents to have a primary care provider (family doctor or nurse practitioner) and see them in a timely manner.
	  ○ Improve access to team-based care to provide comprehensive care for those who have complex social and/or medical needs.
	  ○ Support continued integration of Health Links into sub-regional planning with input from primary care providers.
	• Improve access to quality, coordinated mental health and addictions services in each sub-region
	• Improve consistency and coordination of Home and Community Care: Align care coordinators to primary care
	• Implement the Ontario Palliative Care Network plan to increase access to a palliative approach to care for all residents:
	  ○ Enhance primary care capacity to effectively support palliative patients and bring a palliative approach to care to those living in vulnerable conditions.
	
	In the Strategic Direction of Igniting Innovation and Creativity, the following action is incorporated:
	• Implement the digital health plan to make more information available to patients and improve referrals
	  ○ Support care plan collaboration and information sharing across multiple providers so that all care providers are aware of a patient's goals and patients do not have to repeat their story
	  ○ Support the exchange of immunization records between primary care, public health and patients to decrease unnecessary visits, support appropriate immunization and facilitate effective medical records management
	
	The Empowering Clinical Leadership Strategic Direction also includes primary care, as clinicians from this sector will be involved in collaboratively working to improve the care experience and quality of care. Initiatives identified in this section include:
	• Increase clinician engagement and input into decision-making across the health system

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	• Make it easier for clinicians to help their patients by increasing access to services, and supporting clinician wellbeing • Advance regional integration and quality improvement by expanding and empowering physician leadership of integrated clinical programs
Hospitals and Partners • *E.g., working with system partners to improve the patient journey through hospitals, and supporting hospitals to adopt innovations like bundled care*	Under the Strategic Direction of Empowering Clinical Leadership, the following actions are included: • Implement a one-team approach to improve how people move through the health system: o Improve how people move through the health system to avoid unnecessary hospital stays, reduce the length of time people must spend in hospital including the emergency room, and reduce the number of people who are waiting in a hospital bed for the right level of care • Reduce hospital wait times, focusing first on hip and knee surgery, cataract, MRI, and CT: o Support hospitals to enable the adoption of innovations in patient care, like bundled care o Implement a new model of care for people suffering from musculoskeletal (MSK) pain, including low-back pain Under the Strategic Direction of Igniting Innovation the following action is included under the digital health objective: o Implement and support adoption of more efficient referral processes through System Coordinated Access (SCA) for hip and knee replacement surgery, diagnostic imaging, mental health and addiction services, and other specialty care streams, as appropriate, to reduce wait lists.
Specialist Care • *E.g., working with providers to enable communications; improve appropriate care for people suffering from musculoskeletal (MSK) pain and mood disorders*	Under the Strategic Direction of Empowering Clinical Leadership, the following action is included: • Reduce hospital wait times, focusing first on hip and knee surgery, cataract, MRI, and CT o Implement a new model of care for people suffering from musculoskeletal (MSK) pain, including low back pain Additional operational actions include: o Expand WWLHIN clinical leadership in Mental Health and Addictions, Cardiology, Diagnostic Imaging and Oncology Under the Strategic Direction of Starting with the Patient Experience the initiative of Bring more specialty care, closer to home (i.e. cardiac, vision care) o Establish a robust regional cardiac program for the entire WWLHIN integrated with acute care, primary care and community partners o Establish a retinal surgery program for the WWLHIN Under the Strategic Direction of Innovation and Creativity, implement the digital health plan includes: implement and support adoption of more efficient referral processes through System Coordinated Access (SCA)

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	for hip and knee replacement surgery, diagnostic imaging, mental health and addiction services, and other specialty care streams, as appropriate, to reduce wait lists
Home and Community Care • *E.g., reducing home and community care wait times; improving coordination and consistency with input from patients, caregivers, and partners* • *E.g., working with the Ministry and Ontario Palliative Care Network to expand timely access to coordinated and high-quality palliative and end-of-life care*	The Strategic Direction of Starting with the Patient Experience includes the Objective of Continue to Build the Care Community Model actions specific to home and community care include: o Improve consistency and coordination of Home and community care : ▪ Align care coordinators to primary care ▪ Increase PSW capacity ▪ Improve the patient experience o Implement the Ontario Palliative Care Network plan to increase access to a palliative approach to care for all residents The operational plan includes: • Align care coordinators with primary care practitioners so they can support the coordination of care of complex patients in collaboration with primary care • Improve care coordination and communication among care teams for those with complex health and social needs in each sub-region • Implement improved models of home and community-based care with a focus on optimization of roles, capacity-building, furthering an integrated and inter-professional approach to patient care, and improving the patient experience • Partner with community health service providers and others to implement new ways of delivering care to residents, and optimizing the total home and community care budget • Implement patient safety improvements based on leading practices for medication safety, falls prevention, and timeliness of discharge notes from hospitals, with a particular emphasis on cross-continuum collaborative improvement opportunities • Drive excellence in quality of practice for wound care throughout the health system resulting in improved patient and system level outcomes • Implement a multi-year plan for caregiver respite services • Provide clear and easy-to-understand care plans, and identify how everyone has an accountability in providing the best possible care and outcome for the person receiving care • Improve the patient experience in nursing clinics • Develop a healthcare human resources strategy to meet current and future demands starting with personal support workers and primary care
Long-Term Care *Work with the Ministry to strengthen long-term care, including the redevelopment of homes*	The Strategic Direction of Starting with the Patient Experience includes the objective of Continue to Build the Care Community Model, and specific actions to strengthen long-term care include: • Increasing Long-Term Care capacity and improve quality of care and facilities. The operational plan for this includes: • Supporting the redevelopment of older long-term care homes to

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	meet quality standards • Implement LTC regulation amendments and standards to improve access, quality and transparency, • Increased capacity to support patients with responsive behaviours in LTC
Dementia Care *Implement regional dementia capacity plans, with support from the Ministry, to enable persons living with dementia and their care partners to live well at home and in their communities for as long as possible.*	The Strategic Direction of Driving Through Community Leadership includes the objective of leading and supporting collective impact initiatives to improve the health and wellbeing of our community. The operational plan for this includes: • Supporting Seniors and Older Adults including dementia capacity planning, and; • The achievement of collective impact objectives set for the regional dementia capacity plan
Mental Health and Addictions • *E.g., working with partners to expand access to services including structured psychotherapy and supportive housing; supporting the provincial opioid strategy; and connecting patients with high-quality addictions treatment*	Under Starting with the Patient Experience, the following action related to mental health and addictions reads: Improve access to quality, coordinated mental health and addictions services in each sub-region The actions identified in the operation plan are: • Improve access to timely, flexible community treatment for people with complex mental health and addictions needs • Implement Rapid Access Addictions Clinics to assist residents in getting timely local addictions treatment • Expand access to structured psychotherapy (counselling) and e-Mental health options for self-care • Improve the care experience and access to care for children and youth with mental health needs In addition, under the strategic direction of driving through community leadership, the following actions are identified: • Lead and support collective impact initiatives to improve the health and wellbeing of our community: o Preventing Opioid Overuse and Overdose o Increasing access to supportive housing o Improving access to child and youth mental health services through the children's planning table
Innovation, Health Technologies, and Digital Health • *E.g., support the Ministry's Digital Health Strategy including HIS, virtual, and digital models of care, and referral processes*	Under the Strategic Direction of Igniting Innovation and Creativity, the following objectives and subsequent actions are included in the plan: • Make WWLHIN a recognized hub for social and tech innovation: o Lead development of health and social innovation hub for Waterloo Wellington o Further the WWLHIN innovation ecosystem through engagement and helping to serve as an innovation catalyst and broker • Make more health information available digitally to patients and clinicians, and improve quality and efficiency through digital health

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	tools ○ Implement the digital health plan to make more information available to patients and improve referrals: ▪ Increase patients' access to their health information through tools such as a Patient Portal ▪ Support care plan collaboration and information sharing across multiple providers so that all care providers are aware of a patient's goals and patients do not have to repeat their story ▪ Support the exchange of immunization records between primary care, public health and patients to decrease unnecessary visits, support appropriate immunization and facilitate effective medical records management ▪ Implement Ontario's Digital Health strategy including alignment of Hospital Information System improvements with provincial requirements ▪ Implement and support adoption of more efficient referral processes through System Coordinated Access for hip and knee replacement surgery, diagnostic imaging, mental health and addiction services, and other specialty care streams, as appropriate, to reduce wait lists. Also included in the Strategic Direction of Driving Through Community Leadership, the following was included: action an influencer strategy (with traditional and non-traditional partners) to advance delivery on the Annual Business Plan. The influencer strategy refers to driving outcomes through the planning, research and nurturing of relationships specifically with influential non-health care partners in the community to improve the health of the community.

D. Overview of the LHIN's current and forthcoming programs/activities

Over the last number of years, access to local health care has increased significantly. In partnership with health service providers and our broader community, the WWLHIN has led the creation of a higher-quality, more integrated health system. We invest $1.1 billion annually into local health services which includes hospital care, long-term care, mental health and addictions, home and community care, community support services, and primary care.

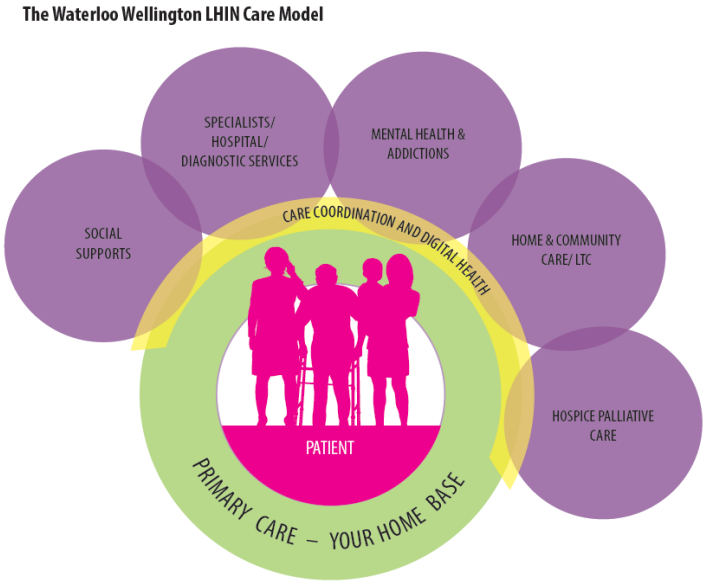
We also work closely with public health to prevent illness and improve the health of all residents, helping more people to have equitable care experiences regardless of gender, location, socioeconomic status, and more. This specifically includes our local Francophone, Indigenous, and newcomer residents. We will continue to build these relationships and expand upon our efforts to improve the health and wellbeing of our community. We will continue to be a community leader working together with police services, municipalities, school boards, businesses, associations, and others to improve the overall health and wellbeing of residents across Waterloo Wellington.

Despite actions to date and transformations that have occurred, residents and health care professionals tell us that navigating and accessing the local health care system can be difficult. We need to make it easier. Residents and many health care professionals also tell us we need to take a stronger leadership role to shift the system towards a focus on making health more equitable; to better support those who are disadvantaged because of their background, income, and education.

Population health varies across the WWLHIN. Sub-regions help us to better understand that variation and take specific actions to address inequities in health outcomes. To do that, we have introduced a care community concept which will help us with both the healthcare and some of the non-healthcare components that impact the determinants of one's health.

Under this approach:

- There is a better understanding of the population and inequities in health outcomes at the neighbourhood and population level within each sub-region.
- Everyone has access to a primary care home that meets them where they are at and specific focus is on those who will have poorer health outcomes
- Primary care providers and the most complex patients and those who are destined to have poorer health outcomes are supported by system-wide care coordination
- Digital health tools make access and navigation easy
- Patients and primary care benefit from better access to higher-quality specialty care
- Primary care and residents have simple access to mental health and addictions
- Patients and residents are seamlessly supported by Home and community care, LTC, and palliative care



The Annual Business Plan uses the care community as its strategic underpinning, and the five strategic directions and objectives and actions incorporated help to build and improve the care community for each resident.

A number of actions have been identified for 2018-19 in the Annual Business Plan and subsequent operational plan that will advance the strategic plan and work towards achieving the following corporate objectives that fall under the five strategic directions:

- Embed the patient voice across the health system
- Continue to build the Care Community Model
- Make it easier for staff, clinicians, and patients by empowering staff to do things differently in the best interest of our residents
- Make WWLHIN a recognized hub for social and tech innovation
- Make more health information available digitally for patients and clinicians, and improve quality and efficiency through digital health tools
- Improve the health and wellbeing of our community
- Empower clinical leadership to improve quality across the health system, both at the regional and sub-region levels
- Address the quadruple aim in improving the work life of staff and clinicians across the health system (Approaching health system planning and delivery from a quadruple aim approach means that you seek to enhance the patient experience, improve population health, reduce costs, and improve provider work-life for the best possible outcome. Improving provider work-life has been a recent addition to this model.)

D. Environmental Scan

Our Community

The population in Waterloo Wellington LHIN is an estimated 783,000 with 15% of the population over age 65 and 23% under the age of 20. We are also growing. Our population is projected to reach over 1 million residents by 2041; Guelph was the fastest growing community in Ontario between 2011 and 2016.

Waterloo Wellington is an increasingly diverse community from all around the world, speaking

different languages at home. Those born outside of Canada make up 22.3% of our community, and 22.5% of our residents do not speak English as their first language. Part of our population growth is the result of an increased number of government-assisted refugees: 1,780 settled in the Kitchener-Waterloo-Cambridge region from January 2015 to June 2017.

It is a community where residents expect care to be accessible and responsive to their needs, whenever they need it. However, not all people have the same starting point when it comes to health. We know that those who are most vulnerable, marginalized, and who experience barriers within the system do not have the same health outcomes because of a variety of factors including social determinants of health (e.g., income, employment, housing, and food security). The barriers, needs, and health outcomes for our residents may be different depending on what sub-region they live in.

Our geography includes four sub-regions which give us an opportunity to better plan, integrate, and improve the performance of local health services: Wellington, Guelph-Puslinch, Cambridge-North Dumfries, and KW4 (Kitchener-Waterloo-Wellesley-Wilmot-Woolwich). These sub-regions represent diverse population needs (e.g., linguistic, cultural, urban/rural). Our health care system is responding better to the diverse needs of the communities we serve. Through looking at care patterns through a local lens, we are able to identify and respond to each community's needs and ensure that patients across the entire WWLHIN have access to the care they need, when and where they need it.

Wellington

Approximately 95,000 of our residents live in the Wellington sub-region which covers the most northern geography of Waterloo Wellington. This region has the oldest population in the WWLHIN, with 17.6% of residents 65 years of age and older. It is uniquely diverse with almost 5,000 Mennonites. Approximately 1,500 residents in this region identify as Indigenous, while over 1,000 have French as their mother tongue. There are almost 800 residents in Wellington who have indicated that they have no knowledge of English or French.

Over 55% of the population has completed post-secondary education. The Wellington sub-region has the lowest unemployment rate in Waterloo Wellington (4.1%). Less than 10% of the population live in the low income cut-off; however, this varies by municipality- Southgate (18%) and Guelph/Eramosa (5.6%).

Guelph-Puslinch

The Guelph-Puslinch sub-region has approximately 140,000 residents with 95% of residents living in the City of Guelph. Over 20,000 residents are 65 years of age or older representing 15% of the population. Puslinch has an older population with about 1 in 5 residents aged 65 years or older. Almost 2,000 residents in Guelph-Puslinch self-identify as Indigenous. There are over 2,100 residents who use French as their mother tongue and more than 1,700 who have no knowledge of English or French. Within the sub-region, it is estimated that there are roughly 3,600 new immigrants with the majority living in the City of Guelph.

Approximately 66% of the population has a post-secondary education. The unemployment rate in Guelph is 6.1% and 4.7% in Puslinch. Almost 15,000 people in the region live in low-income with the majority of these residents residing in the City of Guelph (98%).

Cambridge-North Dumfries

Cambridge-North Dumfries has a population of roughly 147,000 residents with 93% of its

residents living in the City of Cambridge. Seniors, 65 years of age and older, make up 18% of the population (approximately 20,000 residents). Almost 2,700 residents self-identify as Indigenous There are over 2,000 people who have no knowledge of English or French, while approximately 2,100 have French as their mother tongue. Approximately 1,900 new immigrants reside in this sub-region, with the majority settling in the City of Cambridge.

Roughly 56% of the population has a post-secondary education, which is lower than the WWLHIN average of 62%.The unemployment rate in Cambridge-North Dumfries is higher than the Waterloo Wellington average (8.1% compared to 6.7%) with an estimated 6,100 residents unemployed. There are over 15,600 residents in this sub-region who live below the low-income cutoff. There is also significant variation in household income within the region: City of Cambridge: $81,000; North Dumfries: $108,000.

KW4

There are approximately 402,000 residents who live in the KW4 sub-region, with 86% of the population living in the Cities of Kitchener and Waterloo. Over 57,000 residents are 65 years of age and older, representing 14% of the population; the townships of Wilmot and Woolwich have older populations where 17% of their residents are seniors. This sub-region is diverse with both a large urban centre (Kitchener and Waterloo) and the surrounding rural townships (Wellesley, Wilmot, and Woolwich). Approximately 10,300 Mennonites reside in the rural townships, with the majority living in Wellesley and Wilmot.

Half of the Indigenous population in Waterloo Wellington resides in KW4 (approximately 6,270 residents). Within the KW4 sub-region there are almost 6,000 residents who have no knowledge of French or English, while roughly 5,500 have French as their mother tongue. In KW4, 3.4% of the population (12,130 people) are recent immigrants.

Almost 65% of the population has a post-secondary education. KW4 residents have an unemployment rate of 6.3%, representing almost 14,000 residents. About 1 in 8 people in the region live in low-income, many of which are seniors.

2/3) Health System Oversight and Management and LHIN-delivered Home and Community Care

Priority 1
Starting With the Patient Experience – We will listen, learn, and be relentless in making improvements to the patient experience.
Priority Description and Current Status
It starts with the patient experience – these are the stories you hear and tell your friends and family about when you interact with the health system. Only by listening and acting on the patient experience can we truly make it easy for people to be healthy and to get the care and support they need. Most residents are able to get not just good care, but great care when they need it. But it's not true for all. Residents tell us that getting the care and support they need to be healthy isn't always easy. In 2016-17, local residents needing hip or knee replacement surgery waited longer here than anywhere else in Ontario (CCO, Access to Care), although this is improving in the current year. While 97% of residents have a primary care provider, more than 50% aren't able to get in to see them when they need to (Health Care Experience Survey, 2016). In addition, many of our most vulnerable residents are challenged in receiving care. Also, our most vulnerable residents have different primary care needs that we are seeking to address. Residents are waiting far too long for mental health supports, especially housing supports. And the home and community care experience isn't always as great as it could be – while more and more residents are relying on this needed care. These are just some of the examples of areas within the health system that need to be improved. **What does success look like?** Every program and service in the health system is designed and delivered based on patient input. You have your own care community designed to support your individual needs. This means that regardless of who you are or where you live, if you want a primary care provider, you have one. When you need to see them, you can easily get an appointment. Depending on your needs, having an "appointment" could look different than having to travel to a primary care provider. You and your provider work together to keep you healthy through prevention. When you need a diagnostic test or specialty care, you are able to get the care you need quickly, as close to home as possible. Your care reflects and respects your cultural and spiritual needs. Your provider has all of your health information at their fingertips, digitally. If you need mental health and addictions supports, they are easy to access and are well-coordinated. When you need home and community care, your care is consistent and meets your individual needs, allowing you to live independently, as long as possible. When you need long-term care, the home is modern, delivers high-quality care, and makes you feel as at-home as possible. At the end of your life, you and your family are well supported and you are able to die in the place of your choice, whether at home, hospice, or in hospital.
Goal (s)
Embed the Patient Voice across the health system: • Engage the Patient and Family Advisory Committee PFAC in specific projects to improve the

patient experience (i.e. patient declaration of values)
- Continue to build a patient experience program to engage patients in the design and delivery of health services

Continue to build the Care Community Model:

- Improve access and meaningful attachment to primary care (especially for the vulnerable/complex)
- Improve access to quality, coordinated mental health and addictions services in each sub-region
- Increase LTC capacity and improve quality of care and facilities
- Improve consistency and coordination of Home and Community Care:
  - Align care coordinators to primary care
  - Increase PSW capacity
  - Improve the Patient Experience
- Bring more specialty care closer to home (i.e. cardiac, vision care)
- Implement the Ontario Palliative Care Network plan to increase access to a palliative approach to care for all residents
- Facilitate planning and integration at the sub-region level by implementing effective sub-region governance

Government Priorities:

See table in section 1C above: Improve the Patient Experience, Build Health Communities Informed by Population Health Planning, Equity, Quality Improvement, Consistency, and Outcomes-Based Delivery, Primary Care, Home and Community Care, and Mental Health and Addictions

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	**Expected Completion Date**
• Leading through the Patient and Family Advisory Committee, update the Patient Declaration of Values and ensure adoption by all health service providers	Completed	September 30, 2018
• In collaboration with the PFAC, develop new patient-focused communications materials	Completed	March 31, 2019
• In collaboration with PFAC, develop and execute engagement plan to develop IHSP 2019-22	Completed	December 31, 2018
• Work with PFAC to develop patient experience program that expands patient engagement opportunities beyond the committee with clear actions and results	In Progress	March 31, 2020
• Improve our ability to capture and effectively act	Completed	March 31, 2019

	on patient feedback, including streamlining process, enhanced tools, and engagement		
	• Bring primary health care to places where our most vulnerable congregate to create care that is meaningful and responsive to their unique needs	In Progress	March 31, 2021
	• Make it easier for residents to get a primary care provider (family doctor or nurse practitioner) and see them in a timely manner	In Progress	March 31, 2021
	• Improve access to team-based care to provide comprehensive care for those who have complex social and/or medical needs	In Progress	March 31, 2021
	• Support continued integration of Health Links into sub-regional planning with input from primary care providers	In Progress	March 31, 2020
	• Improve access to timely, flexible community treatment for people with complex mental health and addictions needs	Completed	September 30, 2018
	• Implement Rapid Access Addictions Clinics to assist residents in getting timely local addictions treatment	Completed	December 31, 2018
	• Expand access to structured psychotherapy (counselling) and e-Mental health options for self-care	Completed	March 31, 2019
	• Improve the care experience and access to care for children and youth with mental health needs	In Progress	March 31, 2020
	• Support the redevelopment older long-term care homes to meet quality standards	In Progress	March 31, 2021
	• Implement LTC regulation amendments and standards to improve access, quality, and transparency	In Progress	March 31, 2019
	• Increased capacity to support patients with responsive behaviours in LTC	Completed	March 31, 2019
	• Align care coordinators with primary care practitioners so they can support the coordination of care for complex patients in collaboration with primary care	Completed	March 31, 2019
	• Improve care coordination and communication among care teams for those with complex health and social needs in each sub-region	In Progress	December 31, 2019
	• Implement improved models of home and community-based care with a focus on optimization of roles, capacity-building, furthering an integrated and inter-professional approach to patient care, and improving the patient	In Progress	March 31, 2021

	experience		
	• Partner with community health service providers and others to implement new ways of delivering care to residents and optimizing the total home and community care budget	In Progress	March 31, 2020
	• Implement patient safety improvements based on leading practices for medication safety, falls prevention, and timeliness of discharge notes from hospitals, with a particular emphasis on cross-continuum collaborative improvement opportunities	Completed	March 31, 2019
	• Drive excellence in quality of practice for wound care throughout the health system resulting in improved patient and system level outcomes	Completed	December 31, 2018
	• Implement a multi-year plan for caregiver respite services	In Progress	March 31, 2020
	• Provide clear and easy-to-understand care plans and identify how everyone has an accountability in providing the best possible care and outcome for the person receiving care	Completed	December 31, 2018
	• Improve the patient experience in nursing clinics	Completed	March 31, 2019
	• Develop a health care human resources strategy to meet current and future demands starting with personal support workers and primary care	Completed	December 31, 2018
	•		
	• Establish a robust regional cardiac program for the entire WWLHIN integrated with acute care, primary care, and community providers	Completed	September 30, 2018
	• Establish a retinal surgery program for the WWLHIN	Completed	March 31, 2019
	• Implement the Health Quality Ontario Palliative Quality Standard including Advance Care Planning, Caregiver Support, and access to hospice palliative care support in the community	In Progress	March 31, 2020
	• Enhance primary care capacity to effectively support palliative patients and bring a palliative approach to care to those living in vulnerable conditions	Completed	March 31, 2019
	• Sub-region Clinical Leads, in partnership with their Director dyad to pivot high-functioning	Completed	March 31, 2019

	governance tables (C-QiP, Health Links, rural WHA) into sub-region planning tables • Expand sub-region planning tables to include broad, cross-sector engagement, and patients with lived experience • Align WWLHIN staff supports to facilitate quality improvement and strengthen clinical leadership at the sub-region level	In Progress Completed	March 31, 2020 September 30, 2018

Priority 2
Igniting Innovation and Creativity – We will ignite innovation and creativity to exponentially impact the patient experience
Priority Description and Current Status
There is nothing more frustrating than hearing things are the way they are because they always have been that way or there is no easy solution. Waterloo Wellington communities are known for their social and technology innovations. We need to apply more of that innovation and creativity in our health system to tackle the issues that remain. The problems that remain in health care are too complex for traditional approaches. Instead, we need to tap into the collective wisdom of patients, clinicians, and staff to find solutions. We will continue to ignite innovation and creativity in the system and spark new ways of doing things that lead to better outcomes. Innovation and creativity are not strategies that work well with a "templated" approach. Too often, opportunities arise that are not specific projects, or they are out of sequence with planned activities. We will be open, flexible, and nimble with an entrepreneurial spirit that will allow patients to benefit from a culture that supports continuous improvement. **What will success look like?** Staff and clinicians working at the WWLHIN, and across the health system, automatically default to trying new things and innovating to deliver a better patient experience. Everyone is solution-focused and phrases like "We can't do that because…" are replaced with "We could do that if…." Waterloo Wellington has one of the most recognized and robust health and social innovation ecosystems in Ontario and is a major supporter of economic growth. We eliminate barriers start-ups face when trialing new technologies to improve care for patients. Digital Health in Ontario is modelled after the work in with electronic solutions that improve patient safety, reduce wait times, and empower patients with access to their own health information.
Goal(s)
Make it easier for staff, clinicians, and patients by empowering staff to do things differently in the best interest of our residents: • Free up capacity through reducing red tape and executing big impact ideas through the WWLHIN's Continuous Improvement Taskforce • Achieve Accreditation

- Increase efficiency to ensure resources are optimized to support staff and delivery of care for our patients and residents

Make WWLHIN a recognized hub for social and tech innovation:
- Lead development of an innovation hub for Waterloo Wellington
- Further the WWLHIN innovation ecosystem through engagement and helping to serve as an innovation catalyst and broker

Make more health information available digitally for patients and clinicians, and improve quality and efficiency through digital health tools:
- Implement the digital health plan to make more information available to patients and improve referrals

Government Priorities:

See table in section 1C above: Innovation, Health Technologies and Digital Health, Primary Care, Specialist Care, Hospital and Partners, Transparency, and Public Accountability.

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	**Expected Completion Date**
• Through the Continuous Improvement Task Force, implement process improvement ideas focusing on patient experience and care coordination team optimization	In Progress	March 31, 2021 (ongoing)
• Spread a culture of problem-solving within the organization by sharing the Task Force activities with staff (through regular meetings and some focused event)	In Progress	March 31, 2021 (ongoing)
• Execute big impact ideas by promoting and recognizing innovative and creative thinking through "What if there are no rules?" campaign	Completed	March 31, 2019
• Develop the first wave of "problem-solver" champions by CQI and on the job training for seconded front line staff	Completed	December 31, 2018
• Establish Accreditation Committee/work plan • Implement plan to achieve accreditation	Completed Completed	June 30, 2018 March 31, 2019
• Optimize WWLHIN organization processes to simplify, improve efficiency, and achieve savings either in time or dollars that can be directed to providing care for patients	In Progress	March 31, 2020
• The LHIN will work with Health Shared Services Ontario (HSSOntario) to complete an enterprise-wide review of the LHINs that identifies opportunities for improving efficiency and effectiveness, and	In Progress	March 31, 2020

opportunities for savings that can be reinvested into patient care • The LHIN, while continuing to transform the health system, will remain fiscally responsible and manage its budget in a prudent manner to ensure that staff have the resources they need, and programs and services are effective, efficient, and sustainable in the future	In Progress	March 31, 2021 (ongoing)
• Establish a virtual and physical space to connect innovators and health services providers	In Progress	March 31, 2020
• Build on the WWLHIN system-wide Innovation Program to curate ideas, encourage innovation, and share knowledge and experience	In Progress	March 31, 2020
• Scale and spread the innovation strategy beyond the health care system to influence health and social innovation across the province as an imperative enabler to achieving better results for patients	Completed	March 31, 2019
• Increase patients' access to their health information through tools such as a Patient Portal	Completed	March 31, 2019
• Support care plan collaboration and information sharing across multiple providers so that all care providers are aware of a patient's goals and patients do not have to repeat their story	Completed	March 31, 2019
• Support the exchange of immunization records between primary care, public health, and patients to decrease unnecessary visits, support appropriate immunization, and facilitate effective medical records management	Completed	March 31, 2019
• Implement Ontario's Digital Health strategy including alignment of Hospital Information System (HIS) improvements with provincial requirements	In Progress	March 31, 2021
• Implement and support adoption of more efficient referral processes through System Coordinated Access (SCA) for hip and knee replacement surgery, diagnostic imaging, mental health and addiction services, and other specialty care streams, as appropriate, to reduce wait lists	Completed	March 31, 2019

Priority 3

Driving Through Community Leadership – We will be recognized as a trusted, credible, and influential system leader in the community

Priority Description and Current Status

The largest issues facing the health and wellbeing of our communities today cannot be solved solely by one organization, system, or sector alone; nor will they be solved through passive leadership.

The WWLHIN will continue to increase its leadership role advocating for and supporting an agenda that is community-focused, innovative, and results-oriented. The WWLHIN will continue to be a catalyst for improvement, breaking down institutional silos, and challenging self-serving agendas and the status quo.

The WWLHIN will lead in its communities, giving voice to those unable to speak for themselves, and supporting and strengthening those ready to focus on prevention to create healthy people, thriving communities, and bright futures for all. We will lead by example – paving the way for others – by innovating, reducing red tape, taking risks, and always focusing on what's in the best interests of our residents.

What will success look like?
When someone mentions the Waterloo Wellington LHIN, residents know who they are talking about. Residents think of the WWLHIN as a champion of community health and wellbeing, a strong community leader that brings partners together, and they understand the WWLHIN's role in leadership of the local health system. Institutionalized silos are eliminated in order to achieve the best results possible for patients.

The major health issues facing our communities are tackled together with partners in health and social services, policing, education, business, and more. Those who don't yet see the value of a collective impact approach are influenced to understand and join together to ensure the brightest futures possible for local residents. Our community benefits from a collective advocacy for decisions that are made in the best interest of advancing the health and lives of those living across Waterloo Wellington.

Goal(s)

Improve the health and wellbeing of our community:

- Action an influencer strategy (with traditional and non-traditional partners) to advance delivery on the Annual Business Plan
- Lead and support collective impact initiatives to improve the health and wellbeing of our community
- Work with public health and other partners on health promotion, prevention, and health equity
- Improve Indigenous health and wellbeing through collaboration with Indigenous leaders, providers and patients
- Improve the health and wellbeing of French-speaking residents

Government Priorities:

See table in section 1C above: Hospitals and Partners, Specialist Care, Build Healthy Communities Informed by Population Health Planning, Equity, Quality Improvement, Consistency, and Outcomes-Based Delivery, Innovation, Health Technologies, and Digital Health.

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	**Expected Completion Date**
• Identify the top barriers to achieving the vision in each sub-region and action an influencer strategy to remove them	Completed	March 31, 2019
• Develop a network of champions who work together to lead change in care communities	In Progress	March 31, 2021 (ongoing)
• Significantly reduce hospital wait times through governance leadership and engagement	In Progress	March 31, 2020
• Collective Impact Initiatives:: o Preventing Opioid Overuse and Overdose o Increasing access to supportive housing o Implementing and leading adoption of the compassionate communities approach o Supporting Seniors and Older Adults o Improving access to child and youth mental health services through the children's planning table o Improving women's Health and Wellness in collaboration with the sexual assault taskforce o Wellbeing Waterloo Region o Advancing applied research through partnerships with local universities, colleges, and research institutions	In Progress	March 31, 2021 (some will be completed and others are ongoing)

	• Promote health equity through consideration of high-risk populations in the planning, design, delivery, and evaluation of services in each sub-region/care community • Address the root causes of health inequities and the social determinants of health by investing in health promotion, and reducing the burden of disease and chronic illness • Expand access to interpretation services, based on evaluation of pilot project	In Progress In Progress Completed	March 31, 2021 (ongoing) March 31, 2021 (ongoing) September 30, 2018
	• Expand access to culturally safe care • Enhance access to appropriate primary care locally • Improve Indigenous community's ability to self-determine its own needs including the allocation of available resources	In Progress	March 31, 2021 (ongoing)
	• Assess and strengthen health services in French including active offer • Expand use of digital health for access to French services	In Progress	March 31, 2020

Priority 4
Empowering Clinical Leadership – We will work hand in hand with clinicians to improve the care experience and quality of care
Priority Description and Current Status
In recent years, the greatest progress in improving local health care has been through the Waterloo Wellington LHIN working closely with clinicians and empowering clinical leadership to help drive meaningful improvements. Clinicians understand their patients' needs best. They also know where there are opportunities for improvement and how to make change at the clinical level. Listening to, and supporting clinicians to make it easier for them and their patients, has resulted in significant improvements to care – being the first LHIN in Ontario to make mental health care records available electronically is but one example. With the vast majority of WWLHIN staff now having clinical backgrounds and with the majority now providing direct patient care, we will intentionally shift to empowering clinical leaders to have more influence in decision-making. There is also a correlation between low clinical engagement and clinician burnout, and lowered patient satisfaction, poor outcomes, and higher costs. Care of the patient requires care of the provider. This is why many, including the WWLHIN are shifting from the triple aim of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care to include the fourth aim of care of clinicians. In fact, the Institute for Healthcare Improvement (IHI) recognizes that this aim must extend to all providers of care, regardless of role or profession.

What will success look like?
Every decision made in the local health system reflects the input of clinicians and their patients, and their patients' formal and informal caregivers. Clinicians, and individuals in other roles who provide support to patients and their families, feel engaged and able to influence the priorities of the local health system. Clinicians can name barriers that have been removed for them, and ways that the health system has become easier for them and their patients. Clinicians and all providers of care are empowered to provide programs and services that are evidence-based, grounded in the principles of experience-based design, and offer equitable access and consistency across communities, with the flexibility to tailor to the needs of a specific community or individual.

Goal(s)

Empower clinical leadership to improve quality across the Health System, both at the regional and sub-region levels:

- Advance regional integration and quality improvement by expanding and empowering physician leadership of integrated clinical programs
- Increase clinician engagement and input into decision-making across the health system
- Make it easier for clinicians to help their patients by increasing access to services, and supporting clinician wellbeing
- Provide input to and implement HQO Quality Standards
- Implement a one-team approach to improve how people move through the health system
- Reduce hospital wait times, focusing first on hip and knee surgery, cataract, MRI, and CT

Government Priorities:

See table in section 1C above: Improve the Patient Experience, Equity, Quality Improvement, Consistency and Outcomes-Based Delivery, Primary Care, Hospitals and Partners, Specialist Care, Innovation, Health Technologies, and Digital Health

Action Plans/Interventions

Action Plans		
	Expected Status (as of March 31, 2019)	**Expected Completion Date**
• Expand WWLHIN clinical leadership in mental health and addictions, cardiology, diagnostic imaging, and oncology	Completed	March 31, 2019
• Ensure clinical leadership at all ICP Councils	Completed	December 31, 2018
• Work with system leaders to pivot ICP Councils into sub-committees of the Regional Quality Table, where feasible	Completed	December 31, 2018

	• Work with expanded WWLHIN clinical leadership to expand the mandate of these sub-committees as recommendation-making bodies	Completed	September 30, 2018
	• Host 2 critical conversations events	Completed	December 31, 2018
	• Include clinicians in performance meetings with HSPs	Completed	March 31, 2019
	• Engage care providers and patients together to help achieve specific outcomes in the Annual Business Plan	Completed	March 31, 2019
	• Work hand in hand with informal clinical leaders to advise and guide system design changes, with particular focus on those with expertise in the areas of care for complex-vulnerable, refugees, mental health, and palliative patients	In Progress	March 31, 2020
	• Engage clinicians in solutions to mitigate high rates of burnout	In Progress	March 31, 2020
	• Make it easier to access urgent and emergent clinical services throughout the region, regardless of sub-region services available	In Progress	March 31, 2020
	• Maintain a relentless focus on system access and flow	In Progress	March 31, 2021 (ongoing)
	• Contribute and help inform new HQO Quality Standards through active participation at the HQO Provincial Clinical Leads table	Completed	March 31, 2019
	• Work with local clinicians to formulate gap analysis in HQO Quality Standards	Completed	December 31, 2019
	• Leverage partnerships developed through the C-QiP process to collaborate on bridging gaps in HQO Quality Standards	In Progress	March 31, 2020
	Improve how people move through the health system to avoid unnecessary hospital stays, reduce the length of time people must spend in hospital including the emergency room, and reduce the number of people who are waiting in a hospital bed for the right level of care	In Progress	March 31, 2021
	• Support hospitals to enable the adoption of innovations in patient care, like bundled care	In Progress	March 31, 2020
	• Implement a new model of care for people suffering from musculoskeletal (MSK) pain, including low-back pain	Completed	March 31, 2019

Priority 5
Creating a Great Place to Work – Great staff experience = Great patient experience
Priority Description and Current Status
Our people are our greatest asset. The Waterloo Wellington LHIN is made up of a diverse and dedicated workforce passionate about the patient experience. Most of our staff are clinicians directly supporting patient care; others are respected experts with health care experience in planning, finance, decision support, engagement, and other professions to support care delivery and the improvements needed to transform local health care. A direct correlation can be drawn between the experience of staff in an organization and achieving outcomes for patients. The better the staff experience is, the more innovative we are, the more we partner and the better the patient experience is. Creating a great staff experience requires creating a great place to work. This means fostering a supportive, innovative, and patient-focused culture that empowers staff to do what's right for patients while finding joy in their work and work environment. This also means ensuring there is a safe, inclusive and transparent work environment regardless of gender, sexual orientation, ethnicity or faith. Continuing to support a culture where the values of the organization are lived every day, particularly acting in the best interests of residents' health and wellbeing, innovation, teamwork, community leadership, and strong partnerships is fundamental to success. **What will success look like?** Every person who works in the Waterloo Wellington LHIN, spreading to the entire health system, shares a common set of values that supports the delivery of an exceptional patient and staff experience. Patients and stakeholders report positive experiences when interacting with WWLHIN staff, describing our people as caring, compassionate, responsive, respectful, and passionate. Staff are empowered to think outside of the box and use their skills and judgment to deliver an exceptional experience for patients. Our people love what they do, understand their value individually and collectively to improve the health of our community and our organization, and are known for their collaboration, determination, and dedication to those we serve.
Goal(s)
Address the quadruple aim in improving the work life of staff and clinicians across the health system: • Make the WWLHIN most physically and psychologically safe place to work • Implement strategies to improve employee health and wellness • Increase efficiency and ensure value for money to redirect more resources to frontline caBuild a culture within the WWLHIN that enables staff to act in the best interest of residents' health and wellbeing
Government Priorities:
See table in section 1C above: Transparency and Public Accountability and Innovation, Health Technologies and Digital Health, Improve the Patient Experience

Action Plans/Interventions		
Action Plans		
	Expected Status (as of March 31, 2019)	**Expected Completion Date**
• Demonstrate zero tolerance for workplace violence and harassment	In Progress	March 31, 2021 (ongoing)
• Revise the “Incident Report Form” to include workplace violence	Completed	June 30, 2018
• Provide education to and encourage reporting by staff	Completed	March 31, 2019
• Take a public stand against workplace violence-both physical and psychological	In Progress	March 31, 2021 (ongoing)
• Assess risks and develop action plans	Completed	March 31, 2019
• Prompt investigation of incidents and root cause analysis and prevention action plan implementation	In Progress	March 31, 2021 (ongoing)
• Reduce paperwork and empower staff to do only the things that add value to the patient and employee experience	In Progress	March 31, 2020
• Identify best practices locally, nationally, and internationally that will contribute to a great place to work	Completed	December 31, 2018
• Reduce hierarchy and encourage collaboration as a means to demonstrate good leadership	In Progress	March 31, 2020
• Continue WWLHIN FACES campaign to demonstrate and celebrate the value of our people	Completed	March 31, 2019
• Create a recognition program that celebrates staff for living the values and achieving results to improve the patient experience and outcomes	Completed	December 31, 2018
• Develop and maintain a culture of service across the organization (i.e. responsiveness)	In Progress	March 31, 2021 (ongoing)

4) French Language Services (FLS)

The French Language Services Act (FLSA) *Ontario*, 1986 guarantees the right to communicate and receive services in French from the Government and Crown Agencies within designated areas. The *Local Health System Integration Act* (LHSIA) 2007 established the mandate and powers of LHINs to plan, fund, integrate, and respect the requirements of the FLSA in serving Ontario's French-speaking community. The *Patients First Act* (PFA), 2016 reinforced the expectation to respect the requirements of the FLSA in the planning, design, delivery, and evaluation of services. The Minister's Mandate Letter requires the LHIN to assess capacity of FLS and planning to enhance services in French.

The following key directions are foundational to improving access to FLS across the WWLHIN:

- Engagement and planning with the French Language Planning Entity and Francophone communities: As per the funding and accountability agreement, the WWLHIN in collaboration with the local French Language Planning Entité (FLPE), developed a Joint Annual Action Plan herein referred to as the Joint Plan that sets out the key deliverables and the associated work plan including the community engagement plan.
- Addressing the needs and concerns of the local Francophone community: The 2016 Census identified less than 13,000 French-speaking people within the WWLHIN (down from the previous Census). Sub-region planning will reflect the variation in the density of the French-speaking population. The priorities will focus on populations in which the impact of the language barrier is more severe; for example, seniors living in isolation, new immigrants, and patients with mental health issues. The new provincial tool will be used to assess current capacity of Health Service Providers (HSPs). This tool will also support designated, identified agencies, and Service Provider Organizations (SPOs) in their planning process for FLS. Provincial FLS provider indicators, categorized in different measurement domains such as demand, capacity, access, and active offer will streamline the role and activities of the WWLHIN regarding services in French.
- Compliance with the FLSA: The WWLHIN has developed and is implementing a multi-year comprehensive plan to address its obligation to be compliant with the FLSA, including services directly provided to the public by Home and Community Care. A FLS compliance committee is in place with representation from all divisions of the LHIN to implement all provisions for FLS services as outlined in the designation process. The work plan includes an HR plan and gap analysis, review and update of HR policies and procedures, testing for fluency for designated positions, implementation of interpretation services guidelines and modification of the intake process.
- Active offer implementation: The active offer is the clear and proactive offer of services in French to individuals, from the first point of contact, without placing the responsibility of requesting services in French on the individual. The FLS plan for the WWLHIN incorporates elements of active offer and is being implemented in the following domains:
    - Communication
    - Information and referral
    - Third-party service providers

Currently, services from Home and Community Care are in place and a French website operational for the services. In addition, brochures explaining all services are available in French. In 2017, the WWLHIN held French services forums in Kitchener, Cambridge and Guelph for the French community and the information is available through the Association Francophone Kitchener Waterloo, the Centre Francophone de Cambridge and the Réseau Franco in Guelph.

Currently, consultation is taking place with French-speaking senior residents of Waterloo

Wellington to better understand the needs for this population. A day program for French-speaking seniors will be implemented in 2018-2019 and the LHIN is working in partnership with LTC service providers to include the needs of French-speaking residents in the planning for new beds in LTC.

5) Indigenous Peoples

As we do not have any Indigenous Health Service Providers, the WWLHIN is evaluating any project or program on the ability of the service providers to have Indigenous services that are safe and culturally appropriate. Some HSPs have been able to establish partnerships with Indigenous HSPs serving other LHIN areas. For example, Guelph CHC has signed a MOU to have the Indigenous Health Centre in Hamilton support the Indigenous health workers at the Guelph CHC on an on-going basis. At this time, the WWLHIN funds an Indigenous Health and Wellness program for the Waterloo Region area and one for Wellington County area (hosted by Guelph CHC). The Indigenous health and wellness workers assist Indigenous residents to navigate the health care system. They also coordinate traditional healing services for the community. While the programs are hosted by HSPs, the Indigenous community oversees the programs by hiring the workers who are then accountable to the community. The programs' advisory councils also determine the priorities for the community and the allocation of funds. One of the identified priorities by the community was a day program for senior indigenous residents and a program is now in place at The Healing of Seven Generations in Kitchener. Another priority was the availability of traditional healing with the palliative care program and the Indigenous health worker oversees the allocation of funding for these services throughout the palliative care program of Waterloo and Wellington. A supportive housing project that will address the specific needs of the Indigenous community is in early stages and the WWLHIN will continue to support this process with both the Waterloo Region Housing and the Wellington Housing authorities.

To support HSPs, the WWLHIN has sponsored local Indigenous Cultural Safety training in each sector of the health care system over the last four years, and the plan is to offer this training to the hospital sector in 2018. In addition, the WWLHIN offers the Ministry's sponsored ICS training to service providers on a yearly basis.

The Indigenous community in Waterloo Wellington has been consulted in many ways including meetings at Indigenous Community Services agencies, the Indigenous Advisory Circle of the Indigenous Health and Wellness Program and direct e-mail surveys to identify their specific needs in regards to primary care, mental health and addictions and palliative care. In addition, a specific consultation took place to identify cultural needs when it comes to home care. The WWLHIN partnered with an Indigenous consultant to identify the specific culturally safe services that were a priority for the Indigenous community and this report serves as the base for planning for the WWLHIN over the next few years.

With over 20,000 Indigenous residents in Waterloo Wellington, the WWLHIN recognizes that having access to an Indigenous HSP would be in the best interests of this community. The LHIN and indigenous communities are advocating for increased culturally safe services, led by Indigenous organizations, for Indigenous residents in Waterloo Wellington.

6) Performance Measures

How will the LHIN measure success?

The performance metrics tied to the ABP are outlined in the Annual Business Plan Operation Plan attached. Each strategic direction includes specific metrics connected to initiatives outlined. For example, the strategic direction of Starting with the Patient Experience includes metrics such as:

- 100% of Health Service Providers endorsed and adopted a patient declaration of values
- Increase in patients who can access their primary care provider when they need to by 20%

In addition, performance will be measured through the quality dashboard also attached.

In 2018, a new Incident Management System will be launched with reports on patient feedback that will be circulated and analyzed regularly. The patient experience team will continue to work to enhance the patient experience through timely response to patient concerns and follow-up, including response within 24-48 hours for all concerns

7) Risks and Mitigation Plans

A comprehensive analysis of strategic organizational risk was undertaken in Fall of 2017. Risk events were evaluated against the ABP to identify strategic risks that may create barriers to meeting ABP objectives. The following key strategic risks were presented to our Finance and Audit Committee as high and moderately high barriers to ABP achievement.

Risk/Barrier	Mitigation Plan
Capacity Challenges – Service Provider Organizations (SPOs): • The Waterloo Wellington region is currently experiencing a personal support worker (PSW) capacity challenge, and our Service Provider Organizations (SPOs) are having difficulty recruiting and retaining sufficient numbers of PSWs to meet the current demand. This has impacted a small number of patients whose discharge from hospital is being delayed. It is also impacting both the WWLHIN H&CC Division and SPOs, given the extra work required to match patients to providers during a shortage of PSWs. Finally, it is impacting patient flow across the system, as patients wait in hospital for placement in long-term care rather than being discharged to home to wait for placement.	• New collaboration models have been initiated with respect to Community Support Services that allow CSS to fill some gaps in service using their Senior Support Workers where applicable. LHIN/SPO Collaborative meets monthly with SPO senior leadership to translate strategy into operational plans. PSW, Therapy and Nursing Working groups meet monthly to design and implement quality improvements: o Performance monitoring and quality improvement plans with PSW agencies o RFS for PSW volume awarded to CBI/PACE o PSW interval care strategy to maximize the utilization of PSW in retirement homes • The WWLHIN has issued an RFP to retain a third-party consultant to do a regional review of the causes for the PSW capacity challenges, and to provide concrete recommendations to address them.
Not Meeting Provincial Targets/Obligations Outlined in the MLAA • Wait times – CT, MRI, Cataracts, Hip & Knee • ALC Days	• The WWLHIN and its hospitals have initiated a third party review to address long-standing wait times in the LHIN. • MRI – Hospitals have a local obligation in the

	H-SAA for 2017-18 to participate in System Coordinated Access Model for diagnostic imagining. Clinical teams will be part of the design and development of the system which is expected to operationalize in 2017-18. Best practice pathways, diagnostic guidelines, and referral forms are being integrated into primary care electronic medical records to reduce unnecessary MRIs • CT – P4 scans are included in hospital performance indicators in their H-SAAs for 2017-18. Hospitals have submitted performance improvement plans and are conducting root cause analysis to better understand system pressures • Cataracts – Hospitals have submitted Board Chair approved performance improvement plans for mitigating noncompliance. Hospitals have a local obligation in the H-SAA for 2017-18 in System Coordinated Access (SCA) model for ophthalmology. Clinical teams will be part of the design and development of the system which is expected to be operational in 2017-18. WWLHIN is planning to develop a full-suite ophthalmology service in Waterloo Wellington. Presently there is a gap in the local provision of retina surgery. The creation of a provincially recognized online referral system for implementation by the WWLHIN (and 7 other LHINs) will help reduce wait times by connecting patients and primary care faster to other healthcare services in their community. The WWLHIN has proactively reallocated QBP volumes both within and across hospitals in 2017-18 or improve equity of access for our residents and optimize QBP resources. • Hip and Knee Replacements – All hospitals have self-declared performance factors and performance improvement plans approved by their Boards with the WWLHIN. The WWLHIN has proactively reallocated QBP volumes, both within and across hospitals in 2017-18 to improve equity of access for our residents and to optimize QBP resources. Additional volumes were also committed by GGH and GRH from additional non-HSFR base funding in order to meet targets as directed by the WWLHIN. Hospitals will have a local obligation in the H-SAA for 2017-18 to participate in System Coordinated Access (SCA) model for orthopedic specialists in

	2017-18. WWLHIN staff are working with surgeon champions directly; as well as senior administrative staff, to influence positively surgeon-level coding behaviour.
External Relations (Partner/Community Relations): • The degree of system change required locally and provincially requires the development and maintenance of strong relationships with HSPs, with particular attention paid to building adaptability and resiliency to ensure sustainability of business operations	• The LHIN/SPO Collaborative meets monthly with SPO senior leadership to translate strategy into operational plans. An integrated communications strategy is underway to increase an understanding of the WWLHIN's role, the value of our people, successes in the local health system, and the challenges ahead (e.g., state of the health system event, community report, media relations) • A government relations strategy is underway to influence process changes in communication with the Ministry. We are also working with H&CC on communication related to patient expectations and messaging to support (i.e., helping primary care better understand resources that are available to patients)

8) LHIN Operations and Staffing Tables

	2017/18 Budget	2017/18 Estimated Actuals	2018/19 Allocation	2019/20 Planned Expenses	2020/21 Planned Expenses
Allocation: Home Care/LHIN Delivered Services[1]					
Salaries (Worked hours + Benefit hours cost)	$23,662,894	$24,113,893	$24,122,271	$24,122,271	$24,122,271
Benefit Contributions	$6,016,889	$6,013,320	$6,451,052	$6,451,052	$6,451,052
Med/Surgical Supplies & Drugs	$4,595,320	$4,496,020	$4,620,520	$4,620,520	$4,620,520
Supplies & Sundry Expenses	$6,874,510	$6,721,510	$6,329,558	$6,329,558	$6,329,558
Equipment Expenses	$1,705,400	$1,705,400	$1,705,400	$1,705,400	$1,705,400
Amortization on Major Equip, Software License & Fees					
Contracted Out Expense	$101,454,260	$102,338,845	$97,213,560	$97,213,560	$97,213,560
Buildings & Grounds Expenses					
Building Amortization					
TOTAL: Home Care/LHIN Delivered Services	**$144,309,273**	**$145,388,987**	**$140,442,361**	**$140,442,361**	**$140,442,361**
Allocation: Aggregated Operation of the LHIN[2]					
Salaries (Worked hours + Benefit hours cost)	$2,472,379	$2,544,005	$2,443,555	$2,443,555	$2,443,555
Benefit Contributions	$527,621	$540,252	$556,445	$556,445	$556,445
Med/Surgical Supplies & Drugs					
Supplies & Sundry Expenses					

Equipment Expenses					
Amortization on Major Equip, Software License & Fees					
Contracted Out Expense					
Buildings & Grounds Expenses					
Building Amortization					
Sub-total: LHIN Operations	**$3,000,000**	**$3,084,257**	**$3,000,000**	**$3,000,000**	**$3,000,000**
Sub-total: LHIN Operations Initiatives	**$5,747,883**	**$5,747,883**	**$7,181,083**	**$7,181,083**	**$7,181,083**
Sub-total: LHIN Operations Digital Health					
TOTAL: Aggregated Operation of the LHIN[2]	**$8,747,883**	**$8,832,140**	**$10,181,083**	**$10,181,083**	**$10,181,083**
Allocation: Integrated LHIN Administration/ Governance[3]					
Salaries (Worked hours + Benefit hours cost)	$6,875,286	$6,157,137	$6,250,203	$6,250,203	$6,250,203
Benefit Contributions	$1,747,305	$1,651,982	$1,803,561	$1,803,561	$1,803,561
Med/Surgical Supplies & Drugs					
Supplies & Sundry Expenses	$1,733,659	$1,483,659	$2,259,353	$2,259,353	$2,259,353
Equipment Expenses	$691,200	$641,200	$708,383	$708,383	$708,383
Amortization on Major Equip, Software License & Fees	$32,100	$32,100	$32,100	$32,100	$32,100
Contracted Out Expense					
Buildings & Grounds Expenses	$1,958,010	$1,907,510	$1,983,960	$1,983,960	$1,983,960
Building Amortization	$40,000	$40,000	$40,000	$40,000	$40,000
TOTAL: Integrated LHIN Administration/ Governance	**$13,077,560**	**$11,913,589**	**$13,077,560**	**$13,077,560**	**$13,077,560**
TOTAL: LHIN SPENDING PLAN	**$166,134,716**	**$166,134,716**	**$163,701,004**	**$163,701,004**	**$163,701,004**

Notes:

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

Table B:LHIN Staffing Plan (Full-Time Equivalents or FTE[1])

	2017/18 Budget	2017/18 Actuals as of February 28/2018	2018/19 Forecast	2019/20 Forecast	2020/21 Forecast
Home Care/LHIN-Delivered Home and Community Services					
Management and Operational Support (MOS) FTE	**103.4**	**103.4**	**106.7**	**106.7**	**106.7**
Unit Producing Personnel (UPP) FTE	**201**	**205.6**	**205.6**	**205.6**	**205.6**
Nurse Practitioner (NP) FTE	**5.6**	**5.6**	**5.6**	**5.6**	**5.6**
Physician FTE					
Salaries (Worked hours + Benefit hours cost)	**$23,662,894**	**$24,113,893**	**$24,122,271**	**$24,122,271**	**$24,122,271**
Benefit Contributions	**$6,016,889**	**$6,013,320**	**$6,451,052**	**$6,451,052**	**$6,451,052**
Total FTE	**310.0**	**314.6**	**317.9**	**317.9**	**317.9**
LHIN Operations					
MOS FTE	**24**	**21**	**21**	**21**	**21**
UPP FTE					
NP FTE					
Physician FTE					
Salaries (Worked hours + Benefit hours cost)	**$2,472,379**	**$2,544,005**	**$2,443,555**	**$2,443,555**	**$2,443,555**
Benefit Contributions	**$527,621**	**$540,252**	**$556,445**	**$556,445**	**$556,445**
Total FTE	**24**	**21**	**21**	**21**	**21**
Integrated Administration and Governance					
MOS FTE	**49.9**	**48.9**	**44**	**44**	**44**
UPP FTE	**26**	**26**	**26**	**26**	**26**
NP FTE					
Physician FTE					
Salaries (Worked hours + Benefit hours cost)	**$6,875,286**	**$6,157,137**	**$6,250,203**	**$6,250,203**	**$6,250,203**
Benefit Contributions	**$1,747,305**	**$1,651,982**	**$1,803,561**	**$1,803,561**	**$1,803,561**
Total FTE	**75.9**	**74.9**	**70**	**70**	**70**
Initiatives					
MOS FTE	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**
UPP FTE					
NP FTE					
Physician FTE					
Salaries (Worked hours + Benefit hours cost)	**$961,729**	**$802,729**	**$961,729**	**$961,729**	**$961,729**
Benefit Contributions	**$167,410**	**$139,732.57**	**$167,410**	**$167,410**	**$167,410**
Total FTE	**2.8**	**2.8**	**2.8**	**2.8**	**2.8**
Digital Health					
MOS FTE					

UPP FTE					
NP FTE					
Physician FTE					
Salaries (Worked hours + Benefit hours cost)					
Benefit Contributions					
Total FTE					
TOTAL FTE SUMMARY	**412.7**	**413.3**	**411.7**	**411.7**	**411.7**

Notes:

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

9) Integrated Communications & Community Engagement Strategy

Communication Objectives

In support of our new mission, vision and values in conjunction with putting patients at the centre of our health care system, we will leverage existing communications tools and look for new opportunities to focus on increasing access to health care resources for all residents, connecting services to better serve patients, informing and engaging patients and working to protect and enhance our health care system. A particular focus this year will be on developing the WWLHIN's next three-year strategic plan through a robust engagement plan.

Target Audiences

The creation of a truly patient- centered health system cannot occur without clear communication and frequent engagement with patients, health professionals, service providers and key community stakeholders. Our efforts in 2018-19 will be intentionally focused on patients to improve the patient experience. We will also put special focus on engagement with primary care providers as we work to better understand how we can help them help their patients and with health system governors as we work to develop system level partnerships at a Sub-region level. This work will be aligned with the Ministry of Health's *Patients First: Action Plan for Health Care* is Ontario's plan.

Residents/Patients/Families/Caregivers

Our residents are at the center of everything that we do. As we work to drive forward initiatives that improve the patient experience, increase access, connect services, inform patients and protect our health care system, we will actively engage our residents through a variety of communications methods. Our aim is to better understand what health services are important to patients, to identify where patients see gaps in the system and to strengthen the voices of patients and families in their own health care planning.

We will also work with our health service providers, community leaders and other key stakeholders to ensure residents will have the information they need to make informed choices about their care and decisions about available health resources.

We will use the following methods to communicate and engage with our residents.

- Surveys
- Focus groups
- Community events
- Website – refresh to make more resident friendly
- Social media
- Blog
- Traditional media – news releases/stories
- Newsletter
- Resolving and tracking resident concerns
- Patient-focused communications materials – brochures, patient welcome package, fact sheets, hand-outs, messaging for staff, and more.

Primary Care Providers

As the hub of our health system, we will engage with primary care to better understand what they need to increase access to same and next day appointments and to better connect them with additional health services, inter-professional health care teams, hospitals, public health and home and

community care to improve their patients' experience.

- Engagement Events
- Newsletter
- Website – specific pages for primary care
- Social media
- Blog
- Network and Council meetings
- Facilitating connections between physicians and other providers

In addition to these, below is a list of stakeholders and partners with whom we will engage through a variety of methods to build partnerships, share information and feedback and assess our success to support our strategic objectives. We will further refine our engagement plan on continual basis to ensure the right stakeholders are engaged and to maximize the plan's impact.

- Local Health System Provider Leadership
- Front-line Staff
- Local Health Professionals Advisory Council
- Primary Care Advisory Committee
- Various Networks/Councils (Addictions and Mental Health, Community Support Services, Geriatric Services, Emergency Services, etc.)
- Internal Staff
- Waterloo Wellington LHIN Board of Directors
- Elected Officials
- Media
- Municipalities
- Public Health
- School Board
- Private Sector
- Ministry of Health and Long-Term Care
- Police/Community Safety
- Social Services Sector
- Post-secondary education
- Others

Key Messages

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

- The *Patients First: Action Plan for Health Care* sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre by improving the health care experience: increasing access, connecting services, informing patients and protecting our health care system.
- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come.

- Changes underway supported by the Patients First Act have expanded the LHIN mandate and will give LHINs the tools, oversight and accountability they need to better integrate local health care services and coordinate care across the care continuum in a way that better serves patients.
    - In May and June 2017, home care services and staff transferred from CCACs to LHINs. This was a structural system change that will help patients and their families get better access to a more local and integrated health care system. The process happened in carefully planned stages and was seamless for patients and home care clients. There was no disruption to care and providers remained the same.

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

Engaging our diverse residents

Diversity is part of what makes Waterloo Wellington unique. As we move forward with our plan for system improvement with a patient focused approach, we will be especially focused on the overall health of our population and inequities in our system.

Specific effort will also be taken to engage with and focus on cultural sensitivity and the delivery of health care services to Indigenous and Francophone communities. We work with the Entity[2] to identify the specific health care needs and priorities of aboriginal and francophone residents. We will also place special focus on engaging with marginalized and frequently underserved populations who experience statistically poorer health outcomes to identify ways to address their unique health needs.

Measuring our success

The true success of our communication and community engagement initiatives is measured by our ability to understand the needs of our residents and patients and translate that understanding into actionable items. We are committed to measuring our success against the expectations of our local residents, identified through engagement activities and through common communications metrics. By measuring our performance, we can continuously find ways to improve our work and achieve the best health outcomes to improve the patient experience. The following is a list of the performance measure indicators we utilize to do this:

- Consistent use of the Community Engagement Tracker with increased number of engagements each quarter.
- Increased social media following and level of social media engagement, including blog traffic and social media impressions.
- Feedback from patients and clinicians

Appendix: WWLHIN 2018-19 Annual Business Plan (including performance metrics/dashboard)

STARTING WITH THE PATIENT EXPERIENCE

We will listen, learn and be relentless in making improvements to the patient experience

What Does Success Look Like In 2018-19?

- *A patient-created declaration of values will be adopted by all health service providers*
- *More patients have a primary care provider and can see them when they need to*
- *Mental health services are connected to primary care and are easier to access*
- *Patients have easier access to long-term care*
- *Patients receive better coordinated and more consistent Home and Community Care*
- *More patients have access to a palliative-approach to care*
- *Patients can access more emergency specialty care in Waterloo Wellington*

Metrics

- 100% of Health Service Providers endorsed and adopted a patient declaration of values
- Increase in patients who can access their primary care provider when they need to by 20%
- 75% of LHIN-funded health service providers have a process to identify complex patients who would benefit from a coordinated care planning approach, and initiative and/or contribute to a Coordinated Care Plan by March 31, 2019.
- Meet target for % ALC days
- Missed care rate for PSW services is <.05%
  Provincial Indicators for Palliative Care.
- Wait times for patients with the most complex mental health and addictions care needs reduced by 30%
- Improvement in localization index for all emergency services by 10%

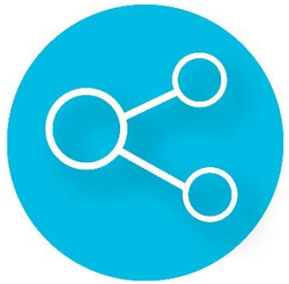
CORPORATE OBJECTIVE	INITIATIVES FOR 2018-19	MRP	Proposed actions to achieve outcomes	Year-end outcome
Embed the Patient Voice across the health system	Engage the Patient and Family advisory Council (PFAC) in specific projects to improve the patient experience (i.e. patient declaration of values)	To Be Confirmed (TBC)	• Leading through the PFAC, update the Patient Declaration of Values and ensure adoption by all health service providers.	• New Patient Declaration of Values launched • New Patient welcome book and information materials created and distributed

			• In collaboration with the PFAC, develop new patient-focused communications materials • In collaboration with PFAC, develop and execute patient and caregiver engagement plan to develop IHSP 2019-2022	• New IHSP developed, with patient and caregiver engagement led by PFAC.
	Continue to build a patient experience program to engage patients in the design and delivery of health services	TBC	• Work with PFAC to develop patient experience program that expands patient engagement opportunities beyond the committee with clear actions and results • Improve our ability to capture and effectively act on patient feedback, including streamlining process, enhanced tools and engagement	• New online engagement platform launched • PEP developed with PFAC • 50 PFAs recruited and trained • New IMS launched and reports on patient feedback circulated regularly • Review of processes for patient feedback and engagement and implementation of key areas of improvement
Continue to build the Care Community Model	Improve access and meaningful attachment to primary care (especially for the vulnerable/complex)	TBC	• Bring primary health care to places where our most vulnerable congregate to create care that is meaningful and responsive to their unique needs. • Make it easier for residents to get a primary care provider (family doctor or nurse practitioner) and see them in a timely manner. • Improve access to team-based care to provide comprehensive care for those who have complex social and/or medical needs. • Support continued integration of Health Links into sub-regional planning with input from primary care providers.	• Minimum of three primary care providers practicing in social service settings or on a mobile van (Working Centre, shelters, food banks) in KW4 and CND, anchored in a team-based care site • Intake and referral revamp to include primary care attachment workflow; attachment and access analysis and solutions supported by recruiters, clinical leads and primary care partners at sub-region level • eCE change teams, care coordinators and MHA support coordinators act as one virtual team to improve access and wrap care around non-team affiliated primary care providers • CFFM in KW4 developed and completed processes and workflow to facilitate non-team based primary care providers accessing FHT resources for their complex-vulnerable patients • Health Links steering tables evolved to align with new LHIN-directed sub-regional infrastructure (membership bifurcated to realize sub-regional planning and integration table; and operational workgroup)

	Improve access to quality, coordinated mental health and addictions services in each sub-region	TBC	• Improve access to timely, flexible community treatment for people with complex mental health and addictions needs. • Implement Rapid Access Addictions Clinics to assist residents in getting timely local addictions treatment. • Expand access to structured psychotherapy (counselling) and eMental health options for self-care.* • Improve the care experience and access to care for children and youth with mental health needs.	• Reduce Wait Times for Assertive Community Treatment Teams by 30% • 3 Rapid Access Addictions Clinics operating in WWLHIN • People with mild to moderate anxiety and depression have easy access to appropriate, evidence-based counselling options, including online supports, group and individuals therapies. • Families seeking help for children and youth mental health experience fewer repeat assessments and better communication on plan for care
	Increase LTC capacity and improve quality of care and facilities	TBC	• Support the redevelopment of older long-term care homes to meet quality standards. • Implement LTC regulation amendments and standards to improve access, quality and transparency. • Increased capacity to support patients with responsive behaviours in LTC	• 100% of WWLHIN LTC homes meet or exceed quality standards • Reduction in ALC to LTC for patients with responsive behaviours
	Improve consistency and coordination of Home and Community Care: ○ Align care coordinators to primary care ○ Increase PSW capacity ○ Improve the Patient Experience	TBC	• Align care coordinators with primary care practitioners so they can support the coordination of care of complex patients in collaboration with primary care. • Improve care coordination and communication amongst care teams for those with complex health and social needs in each sub-region. • Implement improved models of home and community based care with a focus on optimization of roles, capacity-building, furthering an integrated and inter-professional approach to patient care and improving the patient experience. • Partner with community health service providers and others to implement new ways of delivering care to residents and optimizing the total home and community care budget.	• 100% of care coordinators aligned to primary care • >80% of complex patients have a coordinated care plan in place using the coordinated care tool • <0.05% missed care • Enhanced integration of care coordination services across the system • Wound care pathways fully implemented with > 90% compliance • Formalized approach to care debriefs and adverse event reviews implemented • Medication management best practices in place across the continuum of care • Multi-year plan for caregiver respite services developed • 100% of HSPs with roles carrying out care coordination functions are engaged in system-building integration opportunities

			• Implement patient safety improvements based on leading practices for medication safety, falls prevention, and timeliness of discharge notes from hospitals, with a particular emphasis on cross continuum collaborative improvement opportunities. • Drive excellence in quality of practice for wound care throughout the health system resulting in improved patient and system level outcomes. • Implement a multi-year plan for caregiver respite services. • Provide clear and easy to understand care plans and identify how everyone has an accountability in providing the best possible care and outcome for the person receiving care. • Improve the patient experience in nursing clinics • Develop a healthcare human resources strategy to meet current and future demands starting with personal support workers and primary care.	• Health Human Resources Strategy developed • IALP model of care evolved to support value for money and potential for spread • Self-directed care model of care delivery in place • Levels of Care Framework in place
	Bring more specialty care, closer to home (i.e. cardiac, vision care)	TBC	• Establish a robust regional cardiac program for the entire WWLHIN integrated with acute care, primary care and community providers • Establish a retinal surgery program for the WWLHIN	• Regional cardiac rehab program is operational • Cardiac program offers comprehensive arrhythmia services • Cardiac program offers TAVI services • Integrated ophthalmology specialty service offers retinal surgery • All specialists use system coordinated access for referral management (cardiology, orthopaedics, ophthalmology, plastics…)
	Implement the Ontario Palliative Care Network plan to increase access to a palliative approach to care for all residents.	TBC	• Implement the Health Quality Ontario Palliative Quality Standard including Advance Care Planning, Caregiver Support, and access to hospice palliative care support in the community. • Enhance primary care capacity to effectively support palliative patients and bring a palliative approach to care to those living in vulnerable conditions.	• HQO Palliative Quality Standard implemented • More Primary Care providers have access to palliative approach to care

	Facilitate planning and integration at the sub-region level by implementing effective sub-region governance	TBC	• Sub-region Clinical Leads in partnership with their Director dyad to pivot high functioning governance tables (c-QiP, Health Links, rural WHA) into sub-region planning tables. • Expand sub-region planning tables to include broad, cross-sector engagement and patients-with-lived-experience. • Align WWLHIN staff supports to facilitate quality improvement and strengthen clinical leadership at the sub-Region level.	• Sub-region tables formed and functioning • Sub-region priorities identified and plans implemented to align with the ABP



IGNITING INNOVATION AND CREATIVITY

We will ignite innovation and creativity to exponentially impact the patient experience.

What Does Success Look Like In 2018-19?	**Metrics**
• *The WWLHIN will be a recognized centre for social and health technology innovation and adoption* • *Patients will have more health information digitally and referrals will be easier and faster* • *Staff will have more time to spend with patients by freeing up administrative capacity.*	• A plan for a Waterloo Wellington Health and Social Innovation Hub is endorsed by WWLHIN Board and community stakeholders and partners • System Coordinated Access will be live for hip and knee replacement surgery, diagnostic imaging, mental health and addiction services • 15% of patients able to access referral information for hip/knee digitally. • 100% of hip/knee referrals go through central intake. • 100% of parents able to view child's immunization record digitally • Successful accreditation survey • Increase in staff capacity

CORPORATE OBJECTIVE	**PLAN FOR 2018-19**	**MRP**	**PROPOSED ACTIONS TO ACHIEVE OUTCOMES**	**YEAR END OUTCOME**
Make it easier for staff, clinicians, and patients by empowering staff to do things differently in the best interest of our residents.	Free-up capacity through reducing red-tape and executing big impact ideas through the WWLHIN's Continuous Improvement Taskforce	TBC	• Through the Continuous Improvement Task Force, implement process improvement ideas focusing on patient experience and care coordination team optimization. • Spread a culture of problem-solving within the organization by sharing the Task Force activities with staff (through regular meetings and some focused event) • Execute big impact ideas by promoting and recognizing innovative and creative thinking through "What if there are no rules?" campaign	• Increase in HCC Front Line capacity • Two Open House events to share the Task Force activities • Complete minimum of 2 secondment rotations with CQI and practical training through the Task Force

			• Develop the first wave of "problem-solver" champions by CQI and on-the-job training for seconded front-line staff	
	Achieve Accreditation	TBC	• Establish Accreditation Committee/work plan • Implement plan to achieve Accreditation	• Successful accreditation survey
	Increase efficiency to ensure resources are optimized to support staff and delivery of care for our patients and residents	TBC	• Optimize WWLHIN organization processes to simplify, improve efficiency, and achieve savings either in time or dollars that can be directed to providing care for patients. • The LHIN will work with Health Shared Services Ontario (HSSOntario) to complete an enterprise-wide review of the LHINs that identifies opportunities for improving efficiency and effectiveness, and opportunities for savings that can be reinvested into patient care. • The LHIN, while continuing to transform the health system, will remain fiscally responsible and manage its budget in a prudent manner to ensure that staff have the resources they need, and programs and services are effective, efficient, and sustainable into the future.	• Organizational processes and models of care review complete • Implementation of three syndication and partnership funding approaches • Achieving a balanced budget • Full system resource utilization (i.e. no surplus returned to MOHLTC from our $1B in funding)
Make WWLHIN a recognized hub for social and tech innovation	Lead development of an innovation hub for Waterloo Wellington	TBC	• Establish a virtual and physical space to connect innovators and health services providers.	• Plan for a WW Health & Social Innovation Campus endorsed by WWLHIN Board and community stakeholders and partners • Virtual clinical crowdsourcing platform launched for Primary Care
	Further the WWLHIN Innovation ecosystem through engagement and helping to serve as an innovation catalyst and broker	TBC	• Build on the WWLHIN system-wide Innovation Program to curate ideas, encourage innovation and share knowledge and experience. • Scale and spread the innovation strategy beyond the health care system to influence health and social innovation across the province as an imperative enabler to achieving better results for patients.	• WWLHIN named as an Office of the Chief Health Innovation Strategist Innovation Broker for Home and Community Care • Connect 15 local health and social innovation companies with innovative health system partners
Make more health information	Implement the digital health plan to make more information available to patients and improve	TBC	• Increase patients' access to their health information through tools such as a Patient Portal.	• Patients will have access to referral information • Two sub-regions will leverage the CHRIS solution to support care plan collaboration

available digitally for patients and clinicians and improve quality and efficiency through digital health tools.	referrals		• Support care plan collaboration and information sharing across multiple providers so that all care providers are aware of a patient's goals and patients do not have to repeat their story. • Support the exchange of immunization records between primary care, public health and patients to decrease unnecessary visits, support appropriate immunization and facilitate effective medical records management. • Implement Ontario's Digital Health strategy including alignment of Hospital Information System (HIS) improvements with provincial requirements • Implement and support adoption of more efficient referral processes through System Coordinated Access (SCA) for hip and knee replacement surgery, diagnostic imaging, mental health and addiction services, and other specialty care streams, as appropriate, to reduce wait lists.	• Parents will be able to view their child's immunization record online • System Coordinated Access will be live for hip and knee replacement surgery, diagnostic imaging, and mental health and addiction services

DRIVING THROUGH COMMUNITY LEADERSHIP

We will be recognized as a trusted, credible and influential system leader in the community.

What Does Success Look Like In 2018-19?	**METRICS**
• *Residents will experience impactful change due to the collective impact of community based initiatives which include: sexual assault and harassment, women's health and wellness, Opioid Strategy, Wellbeing Waterloo Region, Child and Youth Mental Health, Supportive Housing Strategy, and the Compassionate Communities Approach.* • *Improved health and wellbeing of the most vulnerable residents across Waterloo Wellington.* • *Meaningful French language and culturally appropriate services available for francophone and indigenous residents*	• Canadian Index of Wellbeing • Compassionate communities designation achieved • PC alignment for complex/vulnerable (in QIP) • Objectives identified by collective impact tables • Active offer available for LHIN programs and services

CORPORATE OBJECTIVE	**INITIATIVES FOR 2018-19**	**MRP**	**PROPOSED ACTIONS TO ACHIEVE OUTCOMES**	**YEAR END OUTCOME**
Improve the health and wellbeing of our community	Action an Influencer strategy (with traditional and non-traditional partners) to advance delivery on the Annual Business Plan	TBC	• Identify the top barriers to achieving the vision in each sub-region and action an influencer strategy to remove them. • Develop a network of champions who work together to lead change in care communities. • Significantly reduce hospital wait times through governance leadership and engagement.	• Successfully use the influencer strategy to remove at least one barrier in each sub-region as identified by sub region planning tables.

	Lead and support collective impact initiatives to improve the health and wellbeing of our community.	TBC	<u>Collective Impact Initiatives:</u> • Preventing Opioid Overuse and Overdose (RW) • Increasing access to supportive housing (BP) • Implementing and leading adoption of the compassionate communities approach (EP) • Supporting Seniors and Older Adults including dementia capacity planning (SEC) • Improving access to child and youth mental health services through the children's planning table (KB) • Improving women's health and wellness in collaboration with the sexual assault taskforce (VP) • Wellbeing Waterloo Region (JFG) • Advancing applied research through partnerships with local universities, colleges, and research institutions. (JFG)	• Achievement of collective objectives set for: o Opioid Strategy o Supportive Housing Strategy o Compassionate Communities Approach o Child and Youth Mental Health o Sexual Assault Taskforce o Wellbeing Waterloo Region • Five academic lead initiatives underway to improve health outcomes for patients.
	Work with public health and other partners on health promotion, prevention, and health equity.	TBC	• Promote health equity through consideration of high-risk populations in the planning, design, delivery and evaluation of services in each sub-region/care community. (SEC) • Address the root causes of health inequities and the social determinants of health, by investing in health promotion, and reducing the burden of disease and chronic illness. (new VP, PH) • Expand access to interpretation services, based on evaluation of pilot project. (JFG/SF)	• Sub-region planning tables utilizing data to identify opportunities to improve health equity. • IHSP 2019-2022 developed grounded in evidence to support improvements in health equity in each sub-region. • Increase in utilization of interpretation services
	Improve Indigenous health and wellbeing through collaboration with Indigenous leaders, providers, and patients.	TBC	• Expand access to culturally safe care. • Enhance access to appropriate primary care locally.	• Qualitative updates from indigenous leaders on progress in collaborating to improve indigenous health.

			• Improve Indigenous community's ability to self-determine its own needs including the allocation of available resources	
	Improve the health and wellbeing of French-speaking residents	TBC	• Assess and strengthen health services in French, including active offer. • Expand use of digital health for access to French services.	• Assessment of health services active French offer complete • Increase in availability of WWLHIN information available in French.

EMPOWERING CLINICAL LEADERSHIP

We will work hand in hand with clinicians to improve the care experience and quality of care.

What Does Success Look Like In 2018-19?	**Metrics**
System-wide quality improvement, led and influenced by clinicians and patients, that improves equity, access, and outcomes for patients.	• Two Integrated Clinical Program Councils led by physicians, reporting to Regional Quality Table • Improvement in Quality Dashboard metrics (ED, MSK, Geriatrics, Mental Health, LTC, etc.)

CORPORATE OBJECTIVE	PLAN FOR 2018-19	MRP	OPERATIONAL PLAN FOR MRP	YEAR END OUTCOME
Empower Clinical Leadership to Improve Quality Across the Health System, both at the Regional and Sub-region levels	Advance regional integration and quality improvement by expanding and empowering physician leadership of integrated clinical programs.	TBC	• Expand WWLHIN clinical leadership in Mental Health and Addictions, Cardiology, Diagnostic Imaging and Oncology. • Ensure clinical leadership at all ICP Councils. • Work with system leaders to pivot ICP Councils into sub-committees of the Regional Quality Table, where feasible. • Work with expanded WWLHIN clinical leadership to expand the mandate of these sub-committees as recommendation-making bodies	• Regional Quality Table led by clinicians to directly inform the Quality Committee of the Board • Two ICP Councils will have dedicated clinical leadership and will make recommendations to the Regional Quality Table.
	Increase clinician engagement and input into decision-making across the health system	TBC	• Host 2 critical conversations events • Include clinicians in performance meetings with HSP's	• Two critical conversations held to provide specialists/primary care to learn and share expertise

			• Engage care providers and patients together to help achieve specific outcomes in the annual business plan • Work hand in hand with informal clinical leaders to advise and guide system design changes, with particular focus on those with expertise in the areas of care for complex-vulnerable, refugees, mental health and palliative patients	• 4 sub-region clinical leads and other clinical champions regularly supporting system design conversations around access, attachment and care community transition • Bring together PCAC and PFAC twice per year for focused discussions on system improvements
	Make it easier for clinicians to help their patients by increasing access to services, and supporting clinician wellbeing.	TBC	• Engage clinicians in solutions to mitigate high-rates of burnout • Make it easier to access urgent and emergent clinical services throughout the Region, regardless of sub-Region services available. • Maintain a relentless focus on system access and flow.	• WWLHIN resiliency toolkit for clinicians is developed and launched • ALC/wait times
	Provide input to and implement HQO Quality standards.	TBC	• Contribute and help inform new HQO Quality Standards through active participation at the HQO Provincial Clinical Leads table. • Work with local clinicians to formulate gap analysis in HQO Quality Standards • Leverage partnerships developed through the c-QiP process to collaborate on bridging gaps in HQO Quality Standards	• Gap analysis completed in all HQO Quality Standards • Two HQO Quality Standards translated into system dashboards • One HQO Quality Standard for WWLHIN prioritized across all sub-Regions
	Implement a one-team approach to improve how people move through the health system	TBC	• Improve how people move through the health system to avoid unnecessary hospital stays, reduce the length of time people must spend in hospital, including the emergency room, and reduce the number of people who are waiting in a hospital bed for the right level of care	• Alternate Level of Care (ALC) Regional Escalation Policy and Balanced Scorecard launched and operational. • Reduced ED LOS • ALC days reduced
	Reduce hospital wait times, focusing first on hip and knee surgery, cataract, MRI, and CT.	TBC	• Support hospitals to enable the adoption of innovations in patient care, like bundled care. • Implement a new model of care for people suffering from musculoskeletal (MSK) pain, including low back pain.	• Alternate Level of Care (ALC) Regional Escalation Policy and Balanced Scorecard launched and operational. • Wait times for hip and knee replacement and cataract surgery achieve minimum quality standard.

				• Two hospital pilots launched for bundled funding: Hip and Knees and one of CHF/ COPD. • Central Intake and Assessment Centres launched for hips, knees and spine care.

CREATING A GREAT PLACE TO WORK

Great staff experience=Great patient experience.

What Does Success Look Like in 2018-19?	**Metrics**
• *Being known as the most physically and psychologically safe place to work.*	• increase in Plasticity participation by 30% • Maintain best practice turnover rate • Number of reported incidents of physical and psychological safety in the workplace investigated and addressed (incidents)

CORPORATE OBJECTIVE	**INITIATIVES FOR 2018-19**		**OPERATIONAL PLAN FOR MRPS**	**YEAR END OUTCOME**
Address the quadruple aim in improving the work-life of staff and clinicians across the health system	Make the WWLHIN the most physically and psychologically safe place to work.	TBC	• Demonstrate zero tolerance for workplace violence and harassment. • Revise the "Incident Report Form" to include workplace violence • Provide education to and encourage reporting by staff • Take a public stand against workplace violence – both physical and psychological • Assess risks and develop action plans • Prompt investigation of incidents and root cause analysis and prevention action plan implementation	• Increase in reported incidents of workplace violence and harassment • Increase in staff and public awareness of the WWLHIN's zero tolerance policy for workplace violence and harassment.

	Implement strategies to improve employee health and wellness.	TBC	• Reduce paperwork and empower staff to only do the things that add value to the patient and employee experience • Look for best practices locally, nationally and internationally that will contribute to a great place to work • Reduce hierarchy and encourage collaboration as a means to demonstrate good leadership • Continue WWLHIN FACES campaign to demonstrate and celebrate the value of our people	• Positive increase in employee engagement scores • Increased utilization of plasticity by 50% • Maintain best practice turnover rate • Reach 1 million impressions/year • Profile 100 staff/clinicians
	Build a culture within the LHIN that enables staff to act in the best interest of residents' health and wellbeing.	TBC	• Create an employee recognition program that celebrates staff for living the values and achieving results to improve the patient experience and outcomes. • Develop and maintain a culture of service across the organization (i.e. responsiveness)	• Recognition program launched • Service standard launched • % of patient complaints related to customer service resolved.

Waterloo Wellington Quality Dashboard	Metric Type	Minimum Quality Standard	Cambridge-North Dumfries	Kitchener-Waterloo-Wellesley-Wilmot-Woolwich		Guelph-Puslinch	Wellington		Aggregate WW System Performance	LHIN Rank	Most Recent Reporting Period	Trend
			Cambridge Memorial Hospital	Grand River Hospital	St. Mary's General Hospital	Guelph General Hospital	Groves Memorial Community Hospital	North Wellington Health Care				
Primary Care												
Fewer residents will visit the emergency department for conditions best managed elsewhere *	Monitoring	TBD	1.8	1.5		2.1	10.7		2.7	5	Q1 2017-18	
Fewer residents will be hospitalized for conditions best managed elsewhere *	Monitoring	TBD	68.7	68.7		90.1	84.7		74.4	1	Q2 2017-18	
Residents will experience a decreased rate of hospital readmissions for chronic conditions	Performance	15.5%	13.3%	15.7%	14.1%	13.1%	12.6%	-	14.1%	1	Q4 2016-17	
Residents with a chronic condition will have a follow-up with a physician within 7 days of hospital discharge *	Monitoring	TBD	-	-	-	-	-	-	48.8%	5	Q4 2016-17	
Care Coordination and Digital Health												
Primary Care Providers have the support of dedicated Care Coordinator *	Quality	100.0%	32.0%	11.0%		25.0%	92.0%		26.0%	-	Q3 2017-18	
Specialists/Hospital/Diagnostic Services												
The percentage of days residents spend in acute care hospital beds when they should be receiving their care in a more appropriate location (ALC) will be lower	Performance	9.5%	9.2%	11.6%	11.2%	12.2%	16.4%	24.6%	11.9%	5	Q1 2017-18	
The percentage of hospital beds (acute and post-acute) occupied by patients who could be receiving care in a more appropriate location (ALC) will be lower	Performance	12.7%	-	-	-	-	-	-	12.2%	4	Q2 2017-18	
Patients arriving at the emergency department with complex needs will be seen and sent home or transferred to a hospital bed in 8 hours or less	Performance	8.0	7.6	10.2	7.9	7.1	9.1	-	8.4	2	Q3 2017-18	
Patients with minor uncomplicated needs requiring care in an emergency department will be seen and sent home in 4 hours or less	Performance	4.0	4.6	6.6	4.7	4.3	4.3	-	5.0	13	Q3 2017-18	
Residents will receive timely access to non-emergency hip-replacements	Performance	90.0%	93.0%	19.1%	-	98.6%	-	-	57.3%	12	Q3 2017-18	
Residents will receive timely access to non-emergency knee replacements	Performance	90.0%	98.8%	20.7%	-	92.5%	-	-	59.0%	11	Q3 2017-18	
Residents will receive timely access to non-emergency cataract surgery	Monitoring	90.0%	53.2%	-	70.3%	70.9%	-	-	67.2%	11	Q3 2017-18	
Residents will receive timely access to non-emergency MRIs	Monitoring	90.0%	20.7%	31.2%	-	33.2%	-	-	29.7%	11	Q3 2017-18	
Residents will receive timely access to non-emergency CTs	Monitoring	90.0%	93.9%	99.0%	61.6%	92.7%	91.6%	-	84.9%	5	Q3 2017-18	
Mental Health & Addictions												
Fewer residents will have repeat visits to the emergency department for Mental Health Conditions	Performance	16.3%	20.5%	20.3%	20.2%	19.5%	10.4%	15.0%	19.2%	8	Q1 2017-18	

Waterloo Wellington Quality Dashboard	Metric Type	Minimum Quality Standard	Cambridge-North Dumfries	Kitchener-Waterloo-Wellesley-Wilmot-Woolwich		Guelph-Puslinch	Wellington		Aggregate WW System Performance	LHIN Rank	Most Recent Reporting Period	Trend
			Cambridge Memorial Hospital	Grand River Hospital	St. Mary's General Hospital	Guelph General Hospital	Groves Memorial Community Hospital	North Wellington Health Care				
Fewer residents will have repeat visits to the emergency department for Substance Abuse	Performance	22.4%	25.1%	30.9%	28.8%	35.6%	17.9%	-	30.4%	8	Q1 2017-18	
Home & Community Care/Long-Term Care												
Residents will receive timely access to home care services from time of application to first service *	Performance	21.0	-	-		-	-		14.0	1	Q1 2017-18	
Following service authorization, residents with complex needs will wait no more than 5 days for in-home personal support worker services *	Performance	95.0%	-	-		-	-		94.4%	3	Q1 2017-18	
Following service authorization, residents will wait no more than 5 days for in-home nursing services *	Performance	95.0%	-	-		-	-		97.3%	3	Q1 2017-18	
Home care clients will be satisfied with the care they receive	Quality	93.0%	-	-		-	-		87.8%	-	Q3 2017-18	
Residents receiving Home Care will have their care plans shared with their primary care provider *	Quality	75.0%	75.6%	80.4%		74.1%	66.4%		76.3%	-	Q3 2017-18	
Residents will receive timely access to home care services from time of hospital discharge to service initiation *	Performance	TBD	-	-	-	-	-	-	5.0	1	Q1 2017-18	
Eligibility for LTC placement will be determined in a timely manner (Community) *	Monitoring	TBD	-	-	-	-	-	-	10.0	5	Q4 2016-17	
Eligibility for LTC placement will be determined in a timely manner (Acute) *	Monitoring	TBD	-	-	-	-	-	-	5.0	3	Q4 2016-17	
Hospice and Palliative Care												
Residents that received Home Care will have died in their preferred place of death *	Quality	80.0%	-	-		-	-		86.0%	1	Q3 2017-18	
Palliative patients discharged home will be sent home with support	Monitoring	TBD	75.0%	83.9%	92.3%	93.8%	-	-	88.9%	4	Q1 2017-18	

Waterloo Wellington **LHIN**

PERFORMANCE
Meets standard
Does not meet standard

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

* (asterisk) Results for these indicators are aggregated by patient residence

Note: Performance values are not shown when: (1) the data are not available, (2) the indicator is not applicable, or (3) the result is suppressed because it is based on less than five patients.