Waterloo Wellington **LHIN**

BRIEFING NOTE

January 31, 2018

For Information

Board of Directors Item 12.5 – Annual Business Plan 2018/19

PURPOSE

To provide an update to the WWLHIN Board of Directors on the development of the 2018-2019 Annual Business Plan (ABP) including engagement activities and draft content and direction of corporate objectives and initiatives to support the Strategic Directions of the WWLHIN.

CORE CONTEXT

- For 2018/19, the WWLHIN Board is considering Corporate Objectives and initiatives that reflect accomplishments to date, make drastic improvements to the local health system, improve population health and wellness and reflect obligations found in the Minister of Health and Long Term Care's Mandate letter to LHINs.
- As was required by the Ministry of Health and Long Term Care (MOHLTC) the WWLHIN submitted a draft ABP template on December 31, 2017 and is waiting on feedback from the Ministry in February 2018.
- Engagement with WWLHIN staff and system partners will continue during Q4 FY17-18 to ensure alignment across health service providers and community partners
- The final ABP due March 1, 2018 to the MOHLTC
- The Annual Business Plan also includes the LHIN's resource allocation, staffing and communications plan.

RECOMMENDATION

N/A

BACKGROUND INFORMATION

LHIN Board Expectations:

LHINs are required to develop annual business plans to indicate how they will advance their strategic priorities in their Integrated Health Service Plan. In Waterloo Wellington, our strategic priorities were updated in 2017-18 when the Patients First Act was introduced as we shifted our focus on making it easier. 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. From prenatal to end-of-life, and everything in between, we are working to make it easy for you to be healthy, and to get the care and support you need.

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

Ministry Expectations:

The Agencies and Appointments Directive (AAD) requires all provincial agencies with governing boards, including Local Health Integration Networks, to provide an annual business plan (ABP) to the Minister for approval. The ABP summarizes key initiatives for the year, publicly sets accountabilities and provides guidance to staff and the system for the organization's operations.

Minister's Mandate Letter:

The Minister's Mandate Letter outlines priorities for the LHINs to integrate into their local planning. New priorities for 2018-19 include:

- Chronic Disease Prevention/Health Promotion
- Value for money focus
- Long-term care homes
- Palliative care
- Dementia care

In addition to the requirement outlined in the AAD, the Minister's 2018-19 Mandate Letter and the LHIN IHSP, LHIN ABPs must take into consideration:

- Patients First: Action Plan for Health Care
- The Patients First Act, 2016,
- The Local Health System Integration Act, 2006
- The LHINs new role in the delivery of home and community care services and as a health-system manager
- French Language Services and Indigenous People and
- The Memorandum of Understanding and Accountability Agreement between the Ministry and the LHIN

All LHINs are expected to use the format included in the 2018-19 Guidelines that were provided by the ministry as the foundation for their ABPs and complete the templates in full but are free to customize the design, communications and layout of their ABP.

The WWLHIN has been acknowledged for its resident friendly version of the ABP.

Content to be included in the required template includes: context, LHIN-Delivered Home and Community Services and Priorities, Operationalizing the Remaining Priorities, French Language Services, Indigenous Peoples, Performance Measures, Risks and Mitigation Plans, LHIN Operations and Staffing Plans, Integrated Communications Strategy and Community Engagement.

Process and Timelines:

LHINs were required to submit their draft ABPs to the Ministry by December 31, 2017 for review. Final, board approved, ABPs incorporating Ministry feedback are required by March 1, 2018. ABPs are not final until approved by the Minister of Health & Long Term Care although Waterloo Wellington and many LHINs communicate the plan and directions in advance to the field since approval is often not received until well into the next fiscal year.

NEXT STEPS

1. Staff will continue to use the Board approved ABP 2018/19 Planning principles to guide the development of the 2018-2019. The latest draft of the 2018/19 ABP can be found in Appendix A.

2. Staff will share draft content with the Board, management, staff, patient advisory groups and community leaders during January and February 2018.
3. The Annual Business Plan also includes the LHIN's resource allocation, staffing and communications plan. These items will be included in the next version for Board approval.

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 initiate 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%

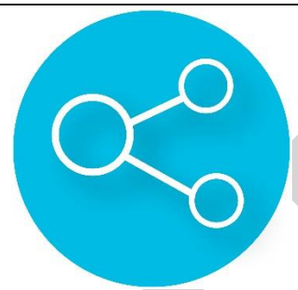
CORPORATE OBJECTIVE	INITIATIVES FOR 2018-19	LHIN CONTACT	PROPOSED ACTIONS TO ACHIEVE OUTCOMES	YEAR-END OUTCOME
Embed the Patient Voice across the health system	Engage the Patient and Family advisory Council (PFAC) in specific projects to improve the patient experience (i.e. patient declaration of values)	Jenny Flagler-George	• Leading through the PFAC, update the Patient Declaration of Values and ensure adoption by all health service providers. • In collaboration with the PFAC, develop new patient-focused communications materials	• New Patient Declaration of Values launched • New Patient welcome book and information materials created and distributed

			• 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	Connie Macdonald	• 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)	Sarah Farwell	• 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	Rebecca Webb	• 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	Blair Phillipi	• 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	Karyn Lumsden	• 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	• 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

			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.	• 100% of HSPs with roles carrying out care coordination functions are engaged in system-building integration opportunities • 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 speciality care, closer to home (i.e. cardiac, vision care)	Zach Weston	• 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 speciality 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	Emmi Perkins	• Implement the Health Quality Ontario Palliative Quality Standard including Advance Care Planning,	• HQO Palliative Quality Standard implemented • More Primary Care providers have access to palliative approach to care

	access to a palliative approach to care for all residents.		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.	
	Facilitate planning and integration at the sub-region level by implementing effective sub-region governance	Kunuk Rhee	• 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 • 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	**INITIATIVES FOR 2018-19**	**LHIN CONTACT**	**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	Tomoko King	• 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	Tomoko King	• 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	Zeynep Danis	• 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	Elliot Fung	• 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	Elliot Fung	• 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 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	Mohamed Alarakhia	• 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 (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.	• Patients will have access to referral information • Two sub-regions will leverage the CHRIS solution to support care plan collaboration • 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**	**LHIN CONTACT**	**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	Elliot Fung	• 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.	Elliot Fung	<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 & Older Adults (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: ○ Opioid Strategy ○ Supportive Housing Strategy ○ Dementia Strategy ○ Compassionate Communities Approach ○ Child and Youth Mental Health ○ Sexual Assault Taskforce ○ 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.	Stephanie Ellens-Clark	• 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. • Access to the LHIN funded interpretation service in 2018-19 by CSS, Community Mental Health and Addictions and Primary Care sectors for equitable and linguistically appropriate care.

	Improve Indigenous health and wellbeing through collaboration with Indigenous leaders, providers, and patients.	France Tolhurst	• 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	• Qualitative updates from indigenous leaders on progress in collaborating to improve indigenous health.
	Improve the health and wellbeing of French-speaking residents	France Tolhurst	• 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	**INITIATIVES FOR 2018-19**	**LHIN CONTACT**	**PROPOSED ACTIONS TO ACHIEVE OUTCOMES**	**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.	Kunuk Rhee	• 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	Sarah Farwell	• Host 2 critical conversations events • Include clinicians in performance meetings with HSP's • 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	• Two critical conversations held to provide specialists/primary care to learn and share expertise • 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.	Kunuk Rhee	• 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.	Kunuk Rhee	• 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	Simon Akinsulie	• 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.	Karen Bell	• 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?

- *Being known as the most physically and psychologically safe place to work.*

Metrics

- 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	LHIN CONTACT	PROPOSED ACTIONS TO ACHIEVE OUTCOMES	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.	Andrew Davidson	• 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.	Sarah Palubeski	• 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.	Lesah Wood	• 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.