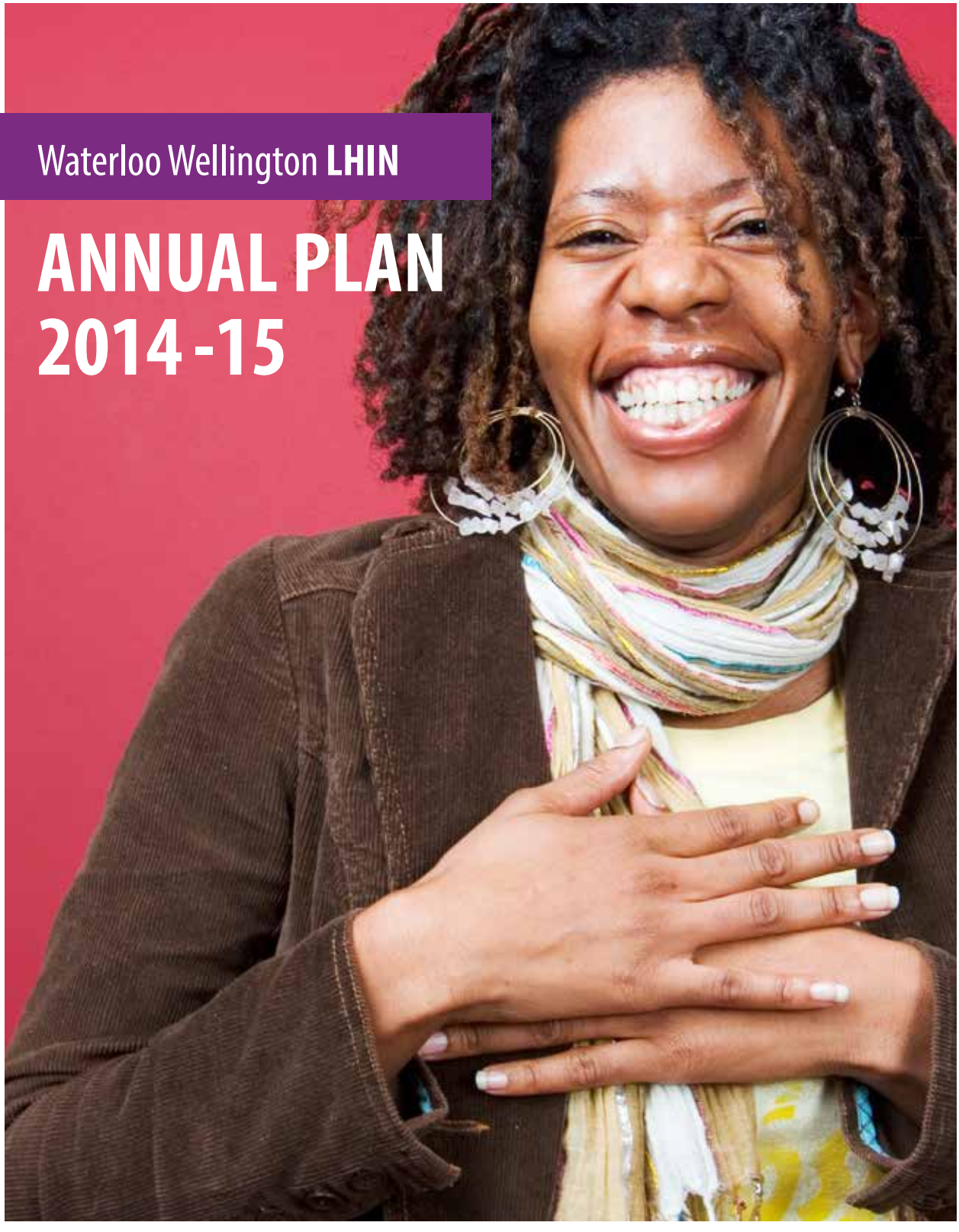
Waterloo Wellington **LHIN**

ANNUAL PLAN 2014-15



The Collective Commitment of Health Service Providers and the WWLHIN to our Community

Ontario

Waterloo Wellington Local Health Integration Network

Réseau local d'intégration des services de santé de Waterloo Wellington

" Our local health system is transforming from a series of fragmented programs and services into a truly integrated system of care that is centred on our residents' needs, rather than on organizations. The health and well-being of our residents is, and must continue to be, the top priority."

– Joan Fisk
Chair, Board of Directors

BACKGROUND

Under the Local Health Systems Integration Act, 2006 and the Ministry-LHIN Performance Agreement, Local Health Integration Networks are required to publish a three-year strategic plan called the Integrated Health Service Plan. This Plan represents the commitment of the LHIN and 77 health service providers to the communities we serve. It is developed based on extensive input from and engagement with health service providers and other stakeholders, and is approved by government.

The 2013-16 Integrated Health Service Plan for Waterloo Wellington identifies three strategic priorities:

- Enhancing access to primary care
- Creating a more seamless and coordinated health care experience
- Leading a quality health system using evidence-based practice.

LHINs are also required to produce an Annual Business Plan that includes the key initiatives that will be undertaken in the current year. This 12-month plan outlines the specific initiatives that networks and councils across the health system identified as necessary to achieve results for our residents in the three strategic priorities noted above. The initiatives reflect the outcomes of extensive engagement with residents, health service providers, and other stakeholders as well as provincial commitments. The document that was submitted to government for approval also contained additional information related to the WWLHIN and its operations

2014-15 Annual Plan

One of the things we have heard from health service providers and others is a desire for greater education and clarity on each year's priorities throughout the period covered by the Integrated Health Service Plan. While most providers and a number of other stakeholders were involved in the creation of elements of the plan closely related to their work, not everyone would be aware of the aspects in which they were less involved.

This 2014-15 Annual Plan therefore summarizes the key elements of the overall Annual Business Plan to help better inform our health service providers, residents and other stakeholders, and to continue to ensure focus on the priorities identified by our community.

Specific targets and status are published and updated regularly on our website, and utilized frequently at our networks and councils. Data is often published at both the community and health service provider level allowing Boards of our health service providers to monitor progress, ensure appropriate interventions where improvements are necessary, and celebrate successes along the way. We welcome feedback on the information provided so that we can, over the coming year, continue to improve alignment and engagement in achieving system improvements for local residents.

WHY LOCAL IS SO IMPORTANT

Deeply rooted in our community

No one knows better what is needed for our community than those who live here, work here, and receive health care here. That doesn't mean we can't learn from others. What it does mean is that solutions need to be tailored to fit our unique needs.

The Waterloo Wellington area is 90 per cent rural yet 90 per cent of our residents live in urban areas. We have a growing high-tech hub, four internationally recognized post-secondary institutions, a nationally famous farmers' market and thriving agricultural industry, a vibrant arts and culture community from Drayton to Guelph and beyond, and much, much more. Our diverse population includes French-speaking, Aboriginal, Mennonite, and immigrant residents. While we have high education rates, we also have concentrated areas of poverty.

The medical, health care and business professionals who work at the WWLHIN and our health service providers understand our community because we are also local. Our children play sports and go to school together. We shop at the same grocery stores, we celebrate at the same festivals, and when we need medical care, we go to the same hospitals, doctors, and clinics. We meet at the same libraries and community centres, and we interact with many of the same service organizations as volunteers or clients. Often, we interact with the same people who are our patients, our clients, our residents.

The true benefit of being local is knowing the needs of our residents and seeing through their eyes so that we can implement solutions to improve their overall health and well-being.

ABOUT THE WATERLOO WELLINGTON LHIN

The Waterloo Wellington Local Health Integration Network (WWLHIN) is responsible for planning, integrating (connecting and improving) and funding health services to improve the health and well-being of approximately 775,000 residents in Waterloo Region, Wellington County, the City of Guelph, and the southern part of Grey County.

OUR JOB

The Waterloo Wellington Local Health Integration Network (WWLHIN) staff work with local residents and health care providers to identify and meet the unique health needs of our community. The WWLHIN team is comprised of doctors, nurses, and other health care and business professionals who are dedicated to providing a resident-focused approach to local health care funding, design, and improvement.

Our sole purpose – our mission – is to lead a high-quality, integrated health system for our residents. We are obsessed with acting in the best interests of our residents' health and well-being, and always mindful that a decision affecting one part of the population or one service cannot be made without considering the impact on the whole.

We work closely with clinicians, administrators and staff in our 77 health service providers and a range of other community partners. Together we are 'community building' and a big part of that is ensuring better health and better futures for all our residents.

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

OUR MISSION IS:
To lead a high-quality integrated health system for our residents.

OUR VISION IS:
Better Health – Better Futures.

OUR CORE VALUE IS:
Acting in the best interest of our residents' health and well-being.

OUR STRATEGY: ONE FAMILY'S EXPERIENCE

A good way to explain the WWLHIN's strategy, as well as some of the improvements that have been made already and the priorities for the coming year, is to look at the experience of one family. This one family's health care needs are representative of thousands of families across Waterloo Wellington.

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

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

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

Sara is a bright light in her family. A bubbly tween, Sara tries to make everyone happy by making jokes, dancing, and singing. School doesn't come easy to her but she tries her

hardest. With her family history of diabetes and mental illness, Sara is at a higher risk for developing these illnesses and will need monitoring to keep her healthy and well.

HOW FAR WE'VE COME

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

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

Pam and her family doctor spoke about the need to work together to better manage her diabetes. Because of work done to create a single process to refer all patients in Waterloo Wellington for diabetes programs and support – Pam was quickly referred to a diabetes education program and since then her overall health has improved and she is receiving regular testing. Having a single referral process has reduced the wait time for residents like Pam to receive support and has increased the overall number of residents receiving support.

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

He went home from the hospital sooner than he would have a few years ago because of an increase in the quality and amount of health care available in the home. At home, he was able to receive care from a nurse, personal support worker (a person who helps with daily personal activities such as bathing, dressing, meal preparation, taking medications, bandage changing and more), physiotherapist, and others in his home.

Being at home made him happy and comfortable, but it had another benefit – it reduced the amount of time other families waited in the emergency department for their loved one to be placed in a hospital bed.

10,000 more
people with diabetes are accessing education and support services.

MORE THAN 60,000
people will access information and services through the new "Here 24/7" each year.

As many as
100 MORE RESIDENTS
will return home after a stroke rather than going to long-term care.

WHERE WE ARE GOING

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

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

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

Going forward we will continue to build on the improvements we have made in each of our three priority areas:

Enhancing your access to primary care

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

Primary care can include a doctor, nurse practitioner, nurse, or even your chiropractor, physiotherapist or social worker. This team forms the basis of care for your general health. Work continues to help all residents who want a primary care provider to find one.

Work is also underway to support primary care in new ways. **Health Links** are a great example. We now have all four Health Links up and running in Waterloo Wellington and are seeing great results. Many primary care providers are now better connected than ever with new in-home teams, community support services, addiction and mental health programs, long-term care and more. Through Health Links, residents with very complicated health needs are already receiving special care plans involving multiple care providers to ensure their needs are being better managed, duplication avoided, and money saved.

This means that someone like Michael who needs treatment for multiple health concerns can receive better care through a team approach that connects him with all of the right people. This includes traditional health care providers but in some cases also others in the education sector, social services and more. Through this approach we are addressing a greater range of needs leading to better health and avoidable health issues down the road.

Better coordinating your care

If primary care doctors, nurses and others are going to more effectively manage care for Pam and her family, they need easy access to a range of services. That's where **coordinated access** comes in.

Michael needs help for both his substance abuse and his depression, and his primary care team needs an easy way to provide that for him. We have recently implemented Here 24/7 – a "one front door" approach to coordinate access to addictions and mental health services in the community. With one number to call it is now much easier for residents like Michael to receive the advice and care they need. With one call, he will get connected with the care that will best support him and his family.

Over the next year we will build on the successes of Here 24/7 and other coordinated processes like Easy Coordinated Access to community support services or our diabetes referral program. And we will further streamline other complex referral systems in place making it easier for doctors and their patients to access care. We will continue to remove barriers for people waiting for an alternative level of care and implement a range of recommendations from the Provincial Seniors strategy.

By doing these things, more people like Pam and her family will find it easier to access and navigate the myriad of providers and services in our health system.

Improving the quality of the care you receive

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

Using evidence-based care, our health service providers are implementing more integrated clinical programs allowing more people like Pam's father to receive life-saving treatments previously unavailable to all our residents locally.

We will continue to improve the speed and access to care for those requiring the most critical care through implementation of the provincial life or limb policy. And we will continue to make and sustain gains with respect to the time it takes to access diagnostic services, cancer surgery, cardiac surgery and the like. While wait times are one component, the other is the quality of care provided. We will continue to strive to have the best quality care possible following the lead of programs such as cancer care where we recently were named the top quality program in the province.

MEETING THE NEEDS OF OUR DIVERSE POPULATION

As part of our plan development, we have consulted with a wide range of residents and groups. This is absolutely critical as our duty is to all 775,000 residents, not just those who are the most organized or vocal.

As we move forward with implementation, all our health service providers will continue to focus on incorporating equity into everything we do. We will continue to ensure that the unique health needs of our diverse population groups are considered as new solutions are put into place.

It is important to point out that our health service providers have Charter and legislative requirements to address the unique needs of our French-speaking and Aboriginal Communities. All of our health service providers are expected to have plans to provide care to the diversity of residents in our local communities including French- speaking and Aboriginal (see below and the following page) as well as Mennonites, immigrants, and others.

FRENCH LANGUAGE SERVICE PLAN

The French-speaking community of Waterloo Wellington includes an increasingly culturally diverse population, as new immigrants make up the majority of new French-speaking people in our region. Most recent data suggest that there are approximately 10,500 residents who include French as their first language and over 15,000 who have knowledge of French and speak French at home (this includes many recent immigrants).

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

Over the last year, with the support of our region's French Language Health Planning Entity (Entité2), we have been able to identify and prioritize many of the health care needs of our French speaking community. While the initiatives outlined in the plan apply to all, we will continue to implement and initiate new activities that will improve services specifically for French-speaking residents. Our plan for 2014-15 includes:

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

ABORIGINAL SERVICE PLAN

The Aboriginal residents of Waterloo Wellington include a culturally diverse community of approximately 10,200 people, according to the National Household Survey 2011. The majority of these individuals reside in urban centres across the region. Local leaders within the community tell us that the number is much higher as many within the community do not identify themselves as Aboriginal.

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

As our health service providers implement this plan, we will build upon efforts initiated over the past year to develop collaborative opportunities with the Aboriginal community to better identify opportunities to improve their health. Given the strong relationship between the social determinants of health and the health status of the Aboriginal community, we must ensure the participation of other sectors to maximize results.

The WWLHIN and a number of health service providers are working with the Aboriginal community to develop an Aboriginal Plan for our area. The action plan will build on previously identified priorities including:

- Improving access to primary care to address the rate of chronic diseases;
- Improving access to mental health and addiction services in partnership with existing service providers;
- Improving access to palliative care building on existing services for this community.

Health service providers are also required to develop equitable programs and services that are offered using culturally appropriate approaches for the Aboriginal community.

As we progress in the development and implementation of health services that are appropriate for our Aboriginal community, we have been asked to consider not only the needs of this community, but also the cultural background and long history of mistrust and lack of empowerment that our Aboriginal peoples have endured. Key to this is building joint understanding. The LHIN is pleased to have begun the process through the recent offering of a comprehensive cultural safety and competency program delivered to all health service providers, as well as the Board members and staff of the Waterloo Wellington LHIN.

2013-16 PRIORITIES

ENHANCING ACCESS TO PRIMARY CARE

CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED BEST PRACTICE

ACCELERATING SYSTEM CHANGE

2014/15 ANNUAL PLAN INITIATIVES

The following pages summarize the initiatives that our networks, councils and health service providers will undertake to achieve the results outlined in the IHSP in each of three priority areas:

- Enhancing access to primary care
- Creating a more seamless and coordinated health care experience
- Leading a quality health care system using evidence-based best practice

Progress on each of these initiatives is lead and closely monitored at specific council or network tables as well as at individual health service provider levels. The LHIN also produces a summary dashboard based on our reporting obligations to our Board, community and government.

This information is communicated regularly at our Board of Directors meetings, posted to our website, and also utilized at network and council meetings.

Many of our health service provider Boards also review all or parts of the dashboard at their regular Board meetings – a best practice. We welcome any suggestions on how we can continue to enhance understanding and alignment to this plan.

PRIORITY: ENHANCING ACCESS TO PRIMARY CARE

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

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

A strong relationship between our residents and our doctors, nurse practitioners, or other primary care providers is the foundation for building an effective and efficient health care system – one that achieves better health, better care and better value, and brings Waterloo Wellington one step closer to being the best place in Canada to live and grow old.

The Opportunity:

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

2013-16 IHSP Objectives:

- Establish family health care as the hub of the health care system to improve your access to services and positive health outcomes.
- Improve timely access to primary care through:
  - Connecting more people with a primary care provider.
  - Working with primary care providers to help improve appropriate, timely access to care.
- Develop and implement a model for community based chronic disease prevention and management including:
  - Build on the success of our approach to regional diabetes services and apply that model for other chronic diseases.
  - Provide coordinated support for frail seniors with complex conditions.
  - Improve timely information sharing between primary care and all other providers.

2014-15 Key Initiatives:

- Establish individualized, coordinated care plans for high needs residents through Health Links across Waterloo Wellington.
- Build partnerships between health, social services, education, justice, and other community partners to improve population health.
- Improve health equity through improved access to care close to home.
- Improve access and implement best practice guidelines for diabetes care and chronic disease prevention and management.
- Implement enabling technologies including:
  - Ontario Laboratory Information System (OLIS)
  - Hospital Report Manager (HRM)
  - Technology supporting Health Links.

Specific targets for the coming year are shown on the chart below. Beginning July 2014, see dashboards on the WWLHIN website for quarterly progress.

EXPECTED ANNUAL PERFORMANCE OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS	Target
High needs residents will have individualized **coordinated care plans** developed through a Health Link in Waterloo Wellington	2,400
All Complex Patients within a Health Link will **have a Primary Care Provider**	100.0%
Residents will experience a **decreased** rate of **hospital readmissions** for **chronic conditions**	14.0%
Fewer residents will be **hospitalized for chronic medical conditions** that can be treated effectively in community	▼20%

PRIORITY: CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

Our residents tell us they don't always know where to go to get the care they need.

Some care providers also tell us that even when they know what care is needed, they don't always know the best place to send their patients.

In the transitions or handoffs between providers, there lies great risk to quality of care. This can often lead to repeat use of the health system, whether it is emergency department visits or readmissions or gaps in care which could negatively impact health outcomes.

People tell us they want us and our providers to continue to make the system easier to navigate, easier to get to the care they need, and easier to understand.

The initiatives in this strategic priority continue to improve the way that residents experience care by redesigning the way care is delivered. That starts with looking at things from the eyes of the patient and more often asking: "What do you need?" rather than just : "Here's what we have to offer."

A lot of the work in this priority area is about re-thinking what we do within a new context – a system of providers now working more closely and with more dependence on each other than ever before.

The Opportunity:

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

2013-16 IHSP Objectives:

Integrating services to improve your experience and health outcomes. Integrations will include:

- Streamlining access to similar types of care/services (horizontal integration).
- Coordinating services across organizations involved in your health care journey (vertical integration).
- Ensuring seamless, coordinated care in your community (geographic integration).
- Improving care for seniors through implementing the Provincial Seniors Strategy.

2014-15 Key Initiatives:

- Expand and improve upon streamlined, coordinated access to services across the continuum of care:
- Strengthen and maximize the current quality and capacity of community services.
- Remove barriers for people waiting for an alternate level of care.
- Improve care for seniors through implementing key recommendations of the Provincial Seniors Strategy.
- Improve the quality and safety of care in long-term care homes.

Specific targets for the coming year are shown on the chart below. Beginning July 2014, see dashboards on the WWLHIN website for quarterly progress.

EXPECTED ANNUAL PERFORMANCE OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS	Target
Residents will have more **connections to health care services** through coordinated access centres	42,500
Following service authorization, **residents** will **wait no more than 5 days** for in-home nursing and personal support worker service	95.0%
Residents will spend **fewer days in hospital** when they should be receiving their care in a **more appropriate location (ALC)**	9.5%
Residents will experience **timely access to long-term care** assessments	TBD

PRIORITY: LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED PRACTICE

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

In Waterloo-Wellington, health service providers are building integrated clinical programs. An integrated clinical program is a single standard of care that is based on best practice evidence for specific patient groups. It means providers from across the continuum of care (e.g. primary care, community care, acute care, long-term care) and throughout Waterloo Wellington are working together to make seamless transitions of care and implement consistent, evidence-based quality care for residents.

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

This priority area also involves the province-wide implementation of quality based procedures aimed at incenting more care and higher quality care. Health system funding reform and the implementation of more evidence-based care pathways are accelerating this work.

Requirements for quality improvement plans are now in place in more and more sectors and these health service provider specific improvements nicely complement the broader program and system work that is underway.

We often get asked how quality is defined. Quality has many dimensions and is nicely described by Health Quality Ontario's framework outlined on the next page.

The Opportunity:

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

2013-16 IHSP Objectives:

- Create one truly integrated and sustainable system of acute care.
- Develop and implement a Waterloo Wellington LHIN–wide system-level plan for clinical care services.
- Create regional programs across the health system to provide specific care pathways, ensuring your access to evidence-based care.
- Implement initiatives to improve patient safety, such as a regional life and limb policy, that will ensure the transfer of critically ill patients to the closest, most appropriate care institution, in the most efficient, expedited and safest way possible.
- Implement evidence-based practices to ensure the same high quality standard of care is provided across all sites for similar services.

Quality Improvement Guide, Health Quality Ontario

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

2014-15 Key Initiatives:

- Improve patient outcomes through the delivery of best practice care, at the best practice price, in alignment with province-wide quality-based procedures.
- Expand and enhance integrated programs that ensure quality and deliver best practice care across the continuum of care. Key improvements will include.
  - *Cardiac*:
    i. Identify and implement improvements including remote pacemaker monitoring trial.
  - *Critical Care*
    i. Implement the provincial life or limb policy across Waterloo Wellington.
    ii. Implement critical care high performing checklist.
  - *Emergency Department*
    i. Implement best practices across the continuum of care to meet emergency department wait times.
    ii. Implement standardized care pathways (beginning with asthma & influenza).
    iii. Implement best practices for patient triage.

- *Hospice Palliative Care:*
  i. Improve admission process.
  ii. Improve service delivery model to support clients at home.
- *Mental Health and Addictions*
  i. Develop and implement service improvements based on the experience of high needs residents.
  ii. Improve youth addictions services.
  iii. Improve access to more effective mental health services for youth and young adults.
- *Rehabilitative Care*
  i. Implement standardized patient pathways across sites.
- *Surgery*
  i. Design and implement an integrated access system for orthopedic surgery.
  ii. Develop and implement the Waterloo Wellington Vision Plan including possible community-based specialty clinics.
- Implement new integrated programs which will include the establishment of a program sponsor and clinical council for each program, identification of standards and care pathways, and a move towards more equitable access and consistency of quality across Waterloo Wellington:
  - Integrated Diagnostic Imaging Program.
  - Integrated Wound Program.

Specific targets for the coming year are shown on the chart below. Beginning July 2014, see dashboards on the WWLHIN website for quarterly progress.

EXPECTED ANNUAL PERFORMANCE OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS	Target
Residents will obtain non-urgent **MRIs** within the **4 weeks**	90.00%
Residents will obtain non-urgent **CT** scans within **4 weeks**	90.00%
Residents will receive non-urgent **Cardiac By-pass Surgery** within **90 days**	90.00%
Residents with a **life or limb threatening condition** will be **transferred** to an appropriate facility within **4 hours or less**	90.00%
Patients **requiring admission from the emergency department** will be transferred to a hospital **bed in 8 hours or less**	8.0
Patients with **complex needs** requiring care in an **emergency department** will be seen and **sent home in 7 hours or less**	7.0
Patients with **minor, uncomplicated** needs requiring care in an **emergency department** will be seen and **sent home in 4 hours or less**	4.0
Residents will have the ability to **die at home or within a community setting** rather than in hospital	▼10%
Fewer residents will have repeat visits to the **emergency department** for **Mental Health** Conditions	13.2%
Fewer residents will have repeat visits to the **emergency department** for **Substance Abuse**	18.1%
Residents will receive non-urgent **hip replacements** within **26 week**s	90%
Residents will receive non-urgent **knee replacements** within **26 weeks**	90%
Residents will receive non-urgent **cancer surgery** within **12 weeks**	90%
Residents will receive non-urgent **cataract surgery** within **26 weeks**	90%

ACCELERATING SYSTEM CHANGE

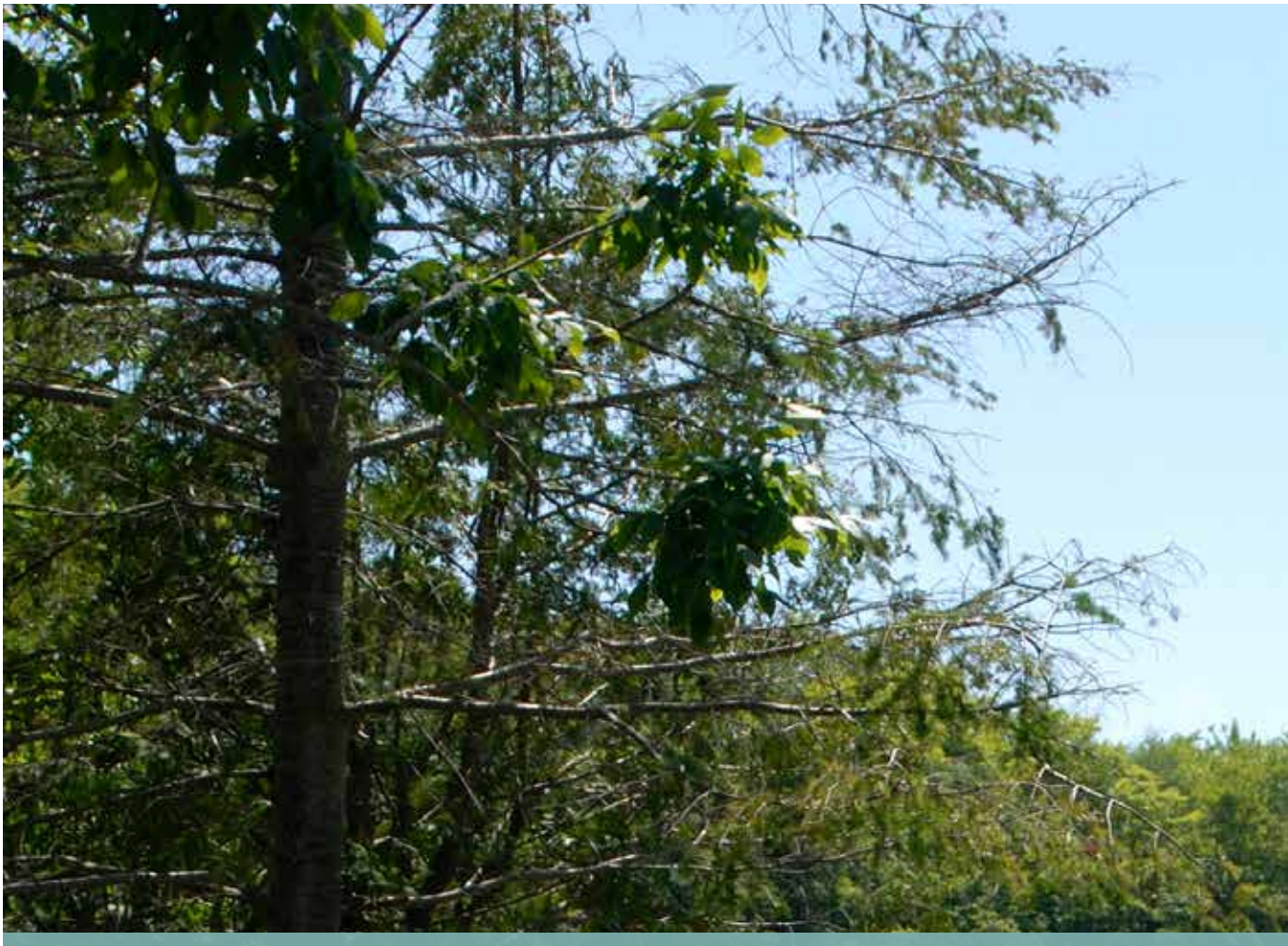
Our local health system is transforming from a series of fragmented programs/services into a truly integrated system of care that is organized not around organizations, but around our residents.

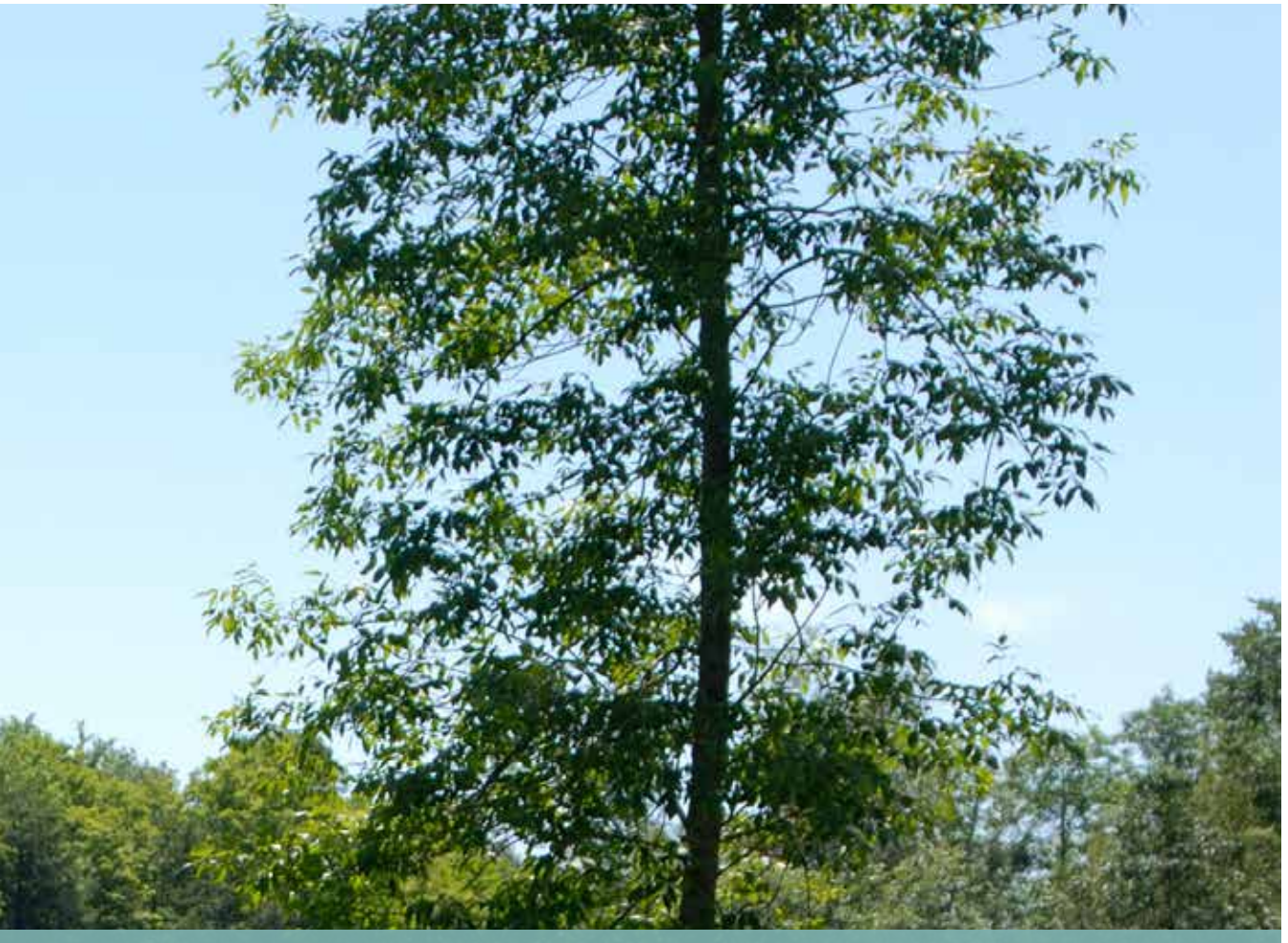
We know that the timely achievement of results for all of our residents is dependent on our being able to quickly remove barriers to change, and support the transformation of the system, by putting our residents' health and well-being first.

A focus on accelerating integration, great collaboration at both the clinical and governance levels, funding reform, and the use of appropriate enabling technologies tools that clinicians want and will use, are all examples of actions that are underway both locally and provincially.

Barriers to success will be quickly removed to ensure we generate better health, better care, and better value for residents. A much improved system is within reach.

We, the WWLHIN and local health service providers, will build more links across the health system through governor-to-governor engagement and the support of those who champion integration. We will work with community leaders to address the root causes of poor health and health equity for our residents. We will use tools that support clinical and operational decision making, to improve system flow and ensure people have timely and well-informed care throughout their life-long health care experiences. We will pursue and support further integration of our system. We will support those who collaborate in the best interests of our residents' health and well-being.





" We look forward to working closely with our health service providers during 2014-15 to realize the improvements planned for our health system . . . and to continued alignment and engagement as we all work together to achieve our collective commitment to the residents of Waterloo Wellington."

- Bruce Lauckner
Chief Executive Officer

Waterloo Wellington Local Health Integration Network

50 Sportsworld Crossing Road, East Building, Suite 220, Kitchener, Ontario N2P 0A4
Local: 519-650-4472
Toll-Free: 1-866-306-LHIN (5446)
Fax: 519-650-3155
Email: waterloowellington@lhins.on.ca