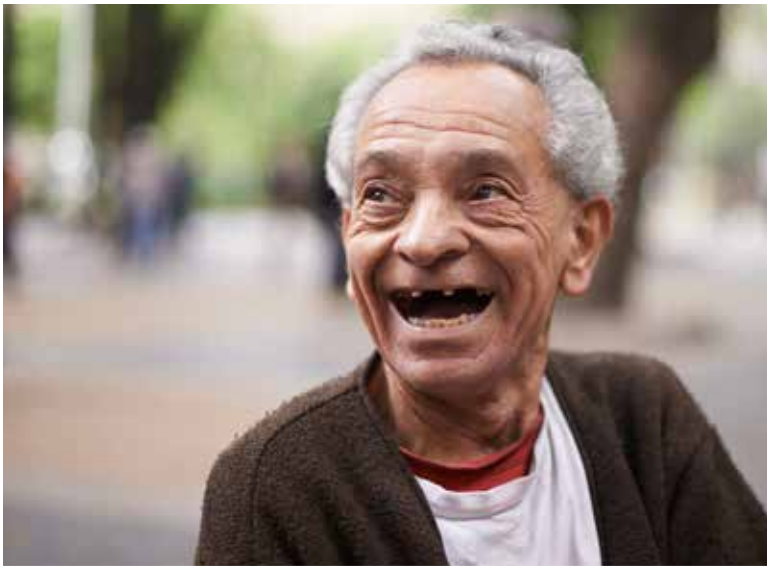
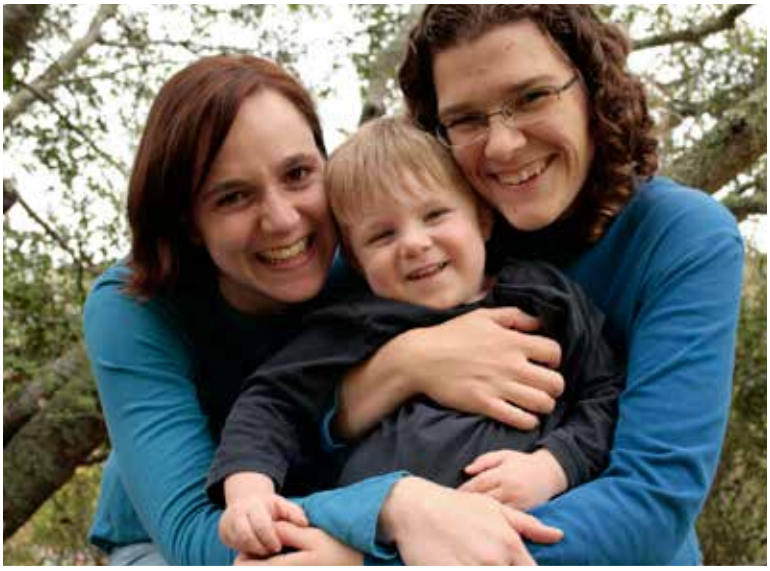
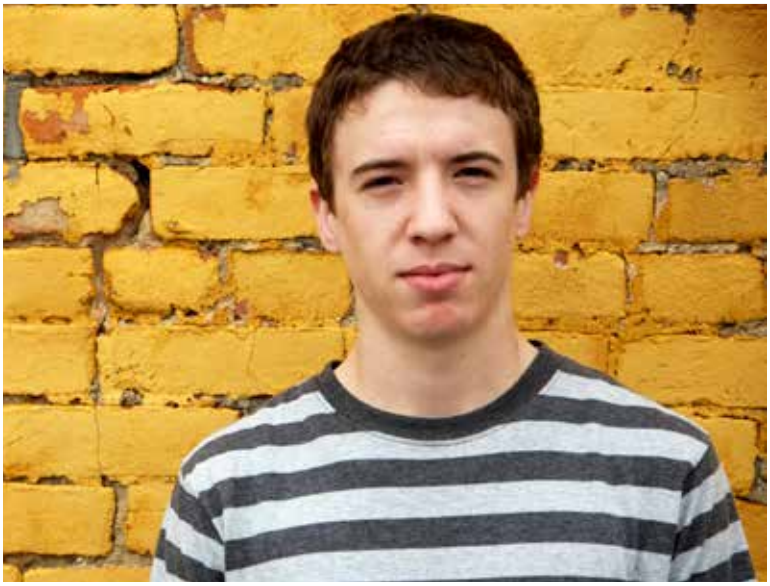
Waterloo Wellington **LHIN**







ANNUAL BUSINESS PLAN **SUMMARY**

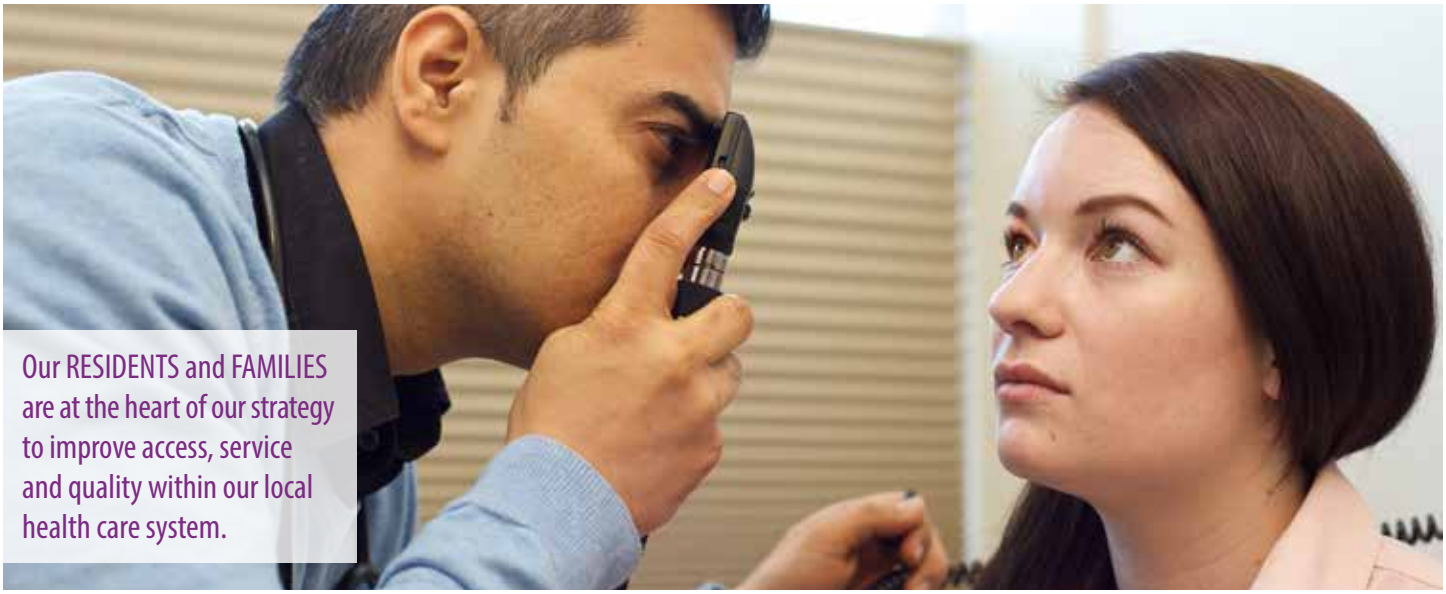
2015-16

Ontario
Local Health Integration Network

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

WATERLOO WELLINGTON LOCAL HEALTH INTEGRATION NETWORK

The Waterloo Wellington Local Health Integration Network (Waterloo Wellington LHIN) 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.

We work with local residents and health care providers to identify and meet the unique health needs of our community. The Waterloo Wellington LHIN 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.

Bruce Lauckner, CEO

2015/16 ANNUAL BUSINESS PLAN

The following pages summarize the plan to improve the local health system in 2015/16. It is the plan committed to by the Waterloo Wellington LHIN and our local Health Service Providers to local residents and government. It outlines the priority actions to achieve better health outcomes, better care experiences and better value for money.

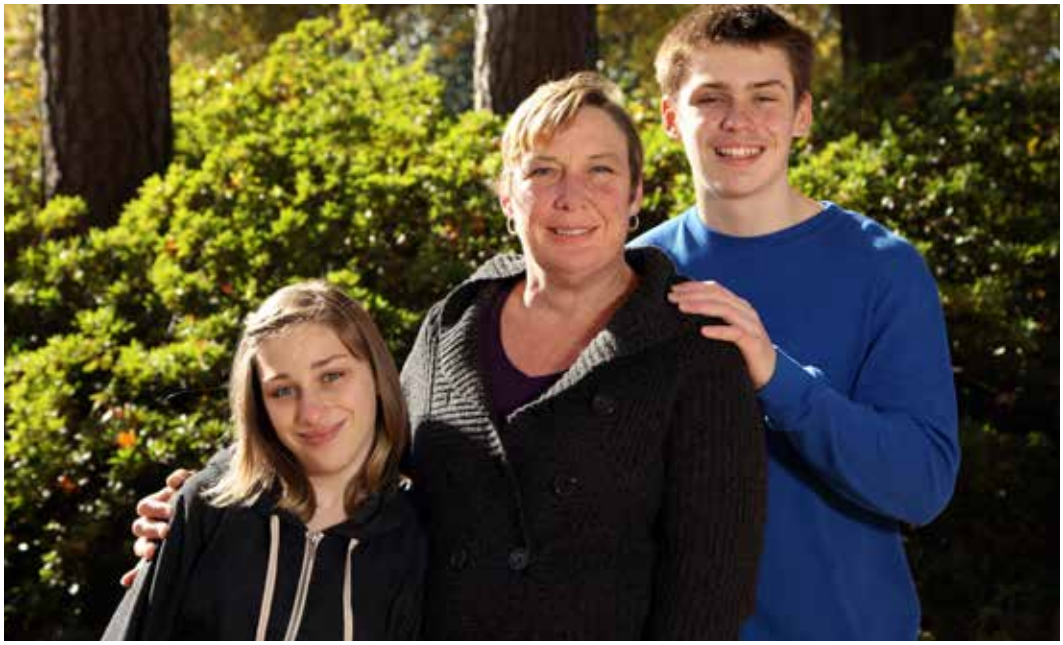
The Annual Business Plan was built based on the needs and ideas of our residents and health service providers. It's not our plan – it's the health care system's plan – and through partnership with our health service providers, residents and community leaders, we will deliver on it to improve the health and well-being everyone in Waterloo Wellington.

Let's make it happen... together.

Joan Fisk, Chair

IMPROVING LOCAL CARE: PROGRESS THROUGH THE EYES OF A FAMILY

Last year, we introduced you to the Thomas family from Guelph. Pam, a single mom, was doing everything she could to meet the complex health needs of her family. Her son Michael was struggling with mental health and addiction issues after his grandfather's stroke. Her mom was living in a long-term care home with Alzheimer's disease. Pam herself has diabetes and she was caring for her father after his stroke in her home. Her daughter Sara fell and broke her arm. The complicated health needs of the Thomas family are representative of those of thousands of other families across Waterloo Wellington.



A priority for Pam over the last year was to take better care of herself. Working two jobs and the stress of caring for her family meant her diabetes wasn't being well managed. Through the help of her new family doctor at the Guelph Family Health Team, and the Waterloo Wellington Diabetes Program, Pam attended education classes, learned about nutrition, and started exercising. Her diabetes is now well managed and her risk for other chronic diseases such as heart disease is much lower. Over the past year, referrals to the diabetes program have increased by 30% - meaning more people like Pam are receiving education and support and living healthier.

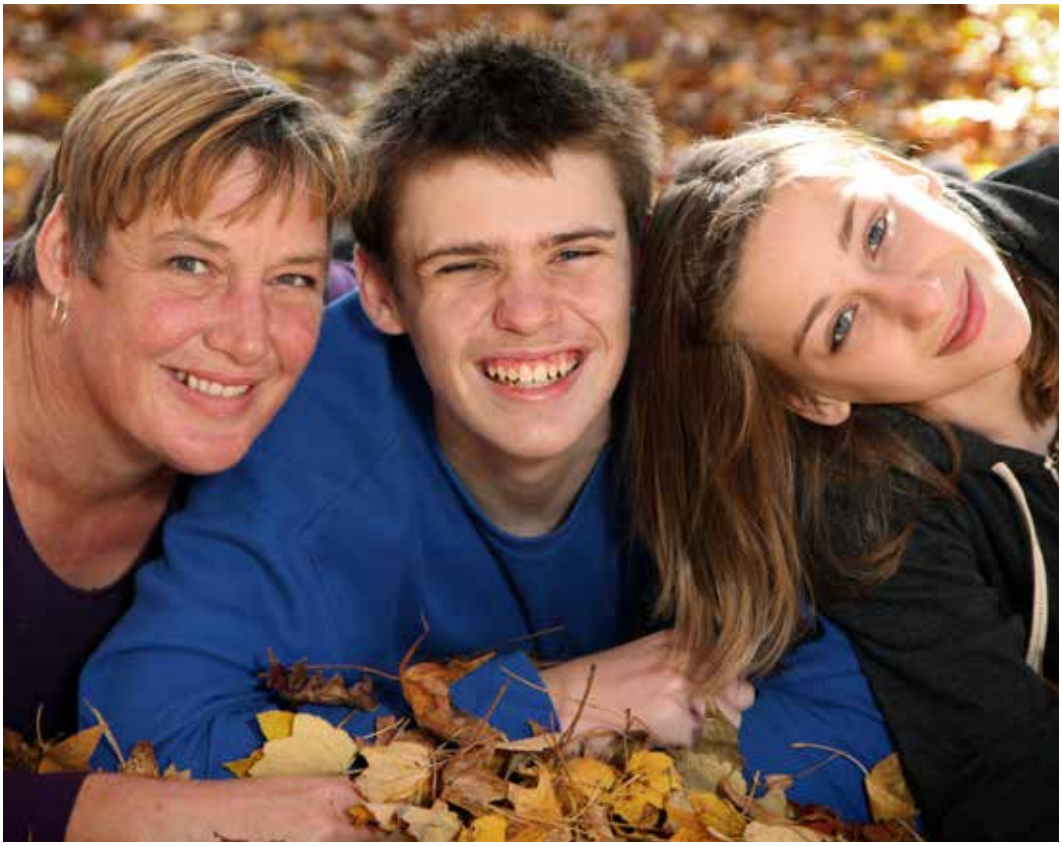
While Pam's dad received exceptionally high-quality care for his stroke that allowed him to go home with Pam faster, he had a number of other health issues that were far too complex for Pam to manage and he was visiting the emergency department on an almost weekly basis. Pam's family doctor connected them with the Guelph Health Link and a coordinated care plan was developed to wrap a variety of supports around him. Pam now has better support which is contributing positively to her health and her dad is receiving a multitude of supports at home and in the community.

Pam's mom has been thriving in long-term care with the Behavioural Supports Ontario program. She has also benefited from enhancements to the Nurse-Led Outreach Team program which provides additional primary care support in long-term care. This helps to prevent unnecessary visits to the emergency department (ED). Waterloo Wellington has the lowest rate of long-term care ED visits in Ontario.

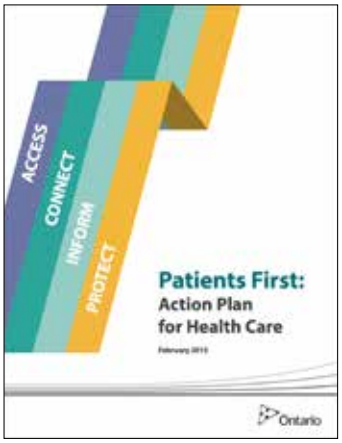
Michael was connected to mental health supports through the new "Here 24/7" – the first centralized intake and referral for mental health and addictions programs in Canada. Since its launch, more than 11,500 residents have been supported. Michael was able to receive help for both his mental health concern and his addiction. With the expansion of telemedicine services, he was also able to have a consult with a child psychiatrist close to home in Guelph without having to travel to Toronto. He is doing better in school and even joined a sports team again for the first time in many years.

Lastly, Sara is doing great. Her arm healed with the support of the orthopedic clinic team at Guelph General Hospital. Her family is doing better, which makes her happy and she is receiving regular care from her primary care doctor. In fact, when she was sick earlier this year she was able to get in to see her doctor the same day – which meant she was able to receive treatment sooner and was back to school faster.

The progress in the health of the Thomas family demonstrates how even those faced with many challenging health issues can thrive with the right supports. When the health system works together to better support individuals – their families and the entire community benefits.



PUTTING PATIENTS FIRST – PROVINCIAL PLAN



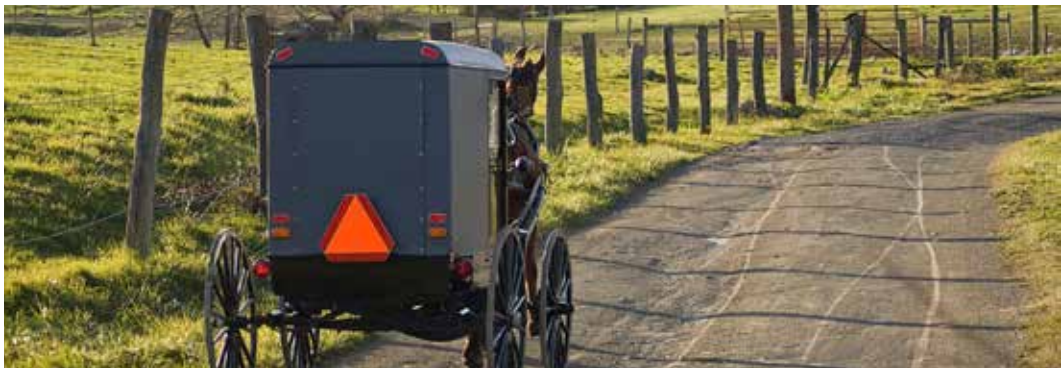
In 2015, the province introduced the next phase of transformation of the health care system. Patients First: Ontario's Action Plan for Health Care sets out four key policy pillars that will have a significant impact on our work in the coming year and beyond. Those pillars are:

- Improve Access – providing faster access to the right care
- Connect services – delivering better coordinated and integrated care in the community, closer to home
- Support people and patients – providing the education, information, and transparency they need to make the right decisions about their health, and
- Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come.

PUTTING PATIENTS FIRST MEANS:

- Supporting Ontarians to make healthier choices and help prevent disease and illness.
- Engaging Ontarians on health care, so we fully understand their needs and concerns.
- Focusing on people, not just their illness.
- Providing care that is coordinated and integrated, so a patient can get the right care from the right providers.
- Helping patients understand how the system works, so they can find the care they need when and where they need it.
- Making decisions that are informed by patients, so they play a major role in affecting system change.
- Being more transparent in health care, so Ontarians can make informed choices.

This is the provincial framework for our local plan.



PUTTING PATIENTS FIRST – LOCAL PLAN

The Waterloo Wellington LHIN works within the provincial context to deliver meaningful change at the local level. We take the province's vision and then consider the unique health needs of our diverse population, especially those at highest risk for poor health, and work with our health service providers and community leaders to address the root causes of these situations and identify where the pieces of the health system need to be better connected.

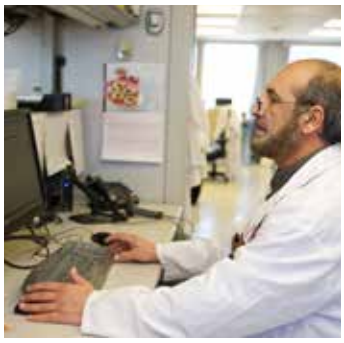
2015/16 is the final year in the current Integrated Health Service Plan, the year that we complete delivery on the objectives for system improvement identified as top priorities by our residents and health service providers.

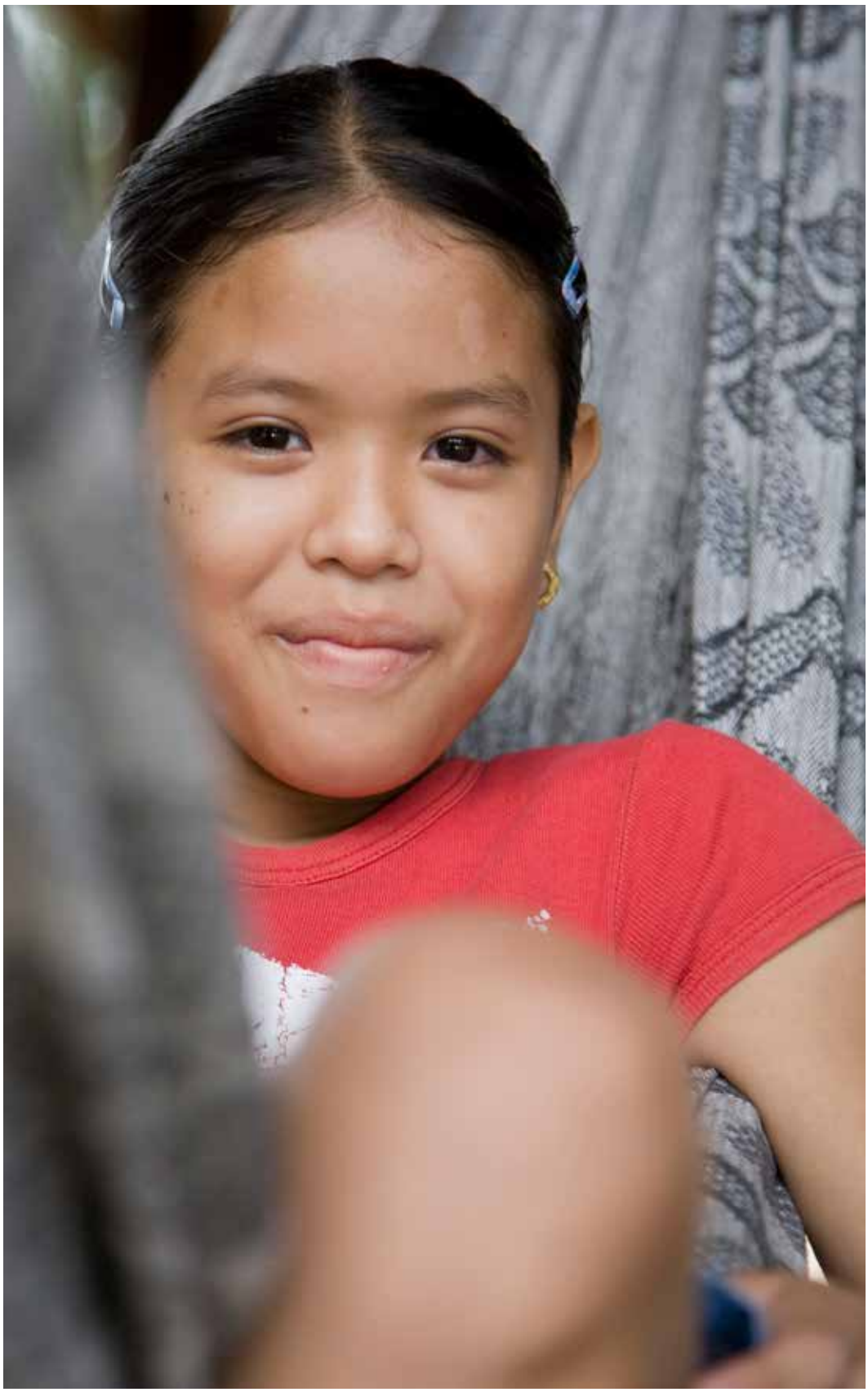
The following pages of the Annual Business Plan (ABP) summarize the initiatives that the health system will undertake to achieve the results outlined in the Integrated Health Service Plan (IHSP) in each of three priority areas:

- 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 led 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. The LHIN is required to oversee and manage performance to ensure the objectives of the Annual Business Plan are met.

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





PLAN FOR THE YEAR AHEAD

Following the plan to improve the health system in 2015/16. It supports the achievement of our Integrated Health Service Plan and the provincial priorities. It outlines the key initiatives and outcomes to be achieved over the year by all health service providers in Waterloo Wellington toward a high quality, integrated health system for residents.

MEETING THE NEEDS OF OUR DIVERSE POPULATION

As part of our plan development, we consulted with a number of specific groups including our French-speaking and Aboriginal Communities.

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

We, and our health service providers, need to take a more intentional focus on those who tend to have poorer health outcomes such as those who live in poverty and those with fewer social supports. Improving the health of a population requires an explicit focus on narrowing the health outcome equity gap.

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

IMPROVING HEALTH EQUITY – FRENCH LANGUAGE AND ABORIGINAL SERVICE PLANS

The Waterloo Wellington LHIN has a vision of Better Health and Better Futures for all our residents. That can only be attained through addressing health inequities including those experienced by our French-speaking and Aboriginal residents.

The Waterloo Wellington LHIN, local Health Service Providers and the French Language Health Planning Entity are collaborating to implement the 2015/16 French Language Service Plan. This plan includes improving access to mental health, chronic disease prevention and management, and home and community care services in French.

Through the implementation of the 2015/16 Aboriginal Services Plan, local Aboriginal residents will be engaged in designing and implementing services to meet their unique needs. Areas of focus include mental health services, chronic disease prevention and management, and palliative and end-of-life care. The Waterloo Wellington LHIN will continue to support ongoing cultural competency training for Health Service Providers and will be engaging the community through an Aboriginal Circle.

OUR PRIORITY: ENHANCING YOUR ACCESS TO PRIMARY CARE

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

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

Ontario's Action Plan for Health Care recognizes family health care as the hub of our health system. A strong relationship between our residents and our doctors, nurse practitioners or other primary care providers is the foundation in building an effective and efficient health care system – one that achieves better health, better care and better value and brings Waterloo Wellington one step closer to being the best place to live and grow old in. Ensuring that every Ontarian who wants one has a primary care provider will be a high priority.

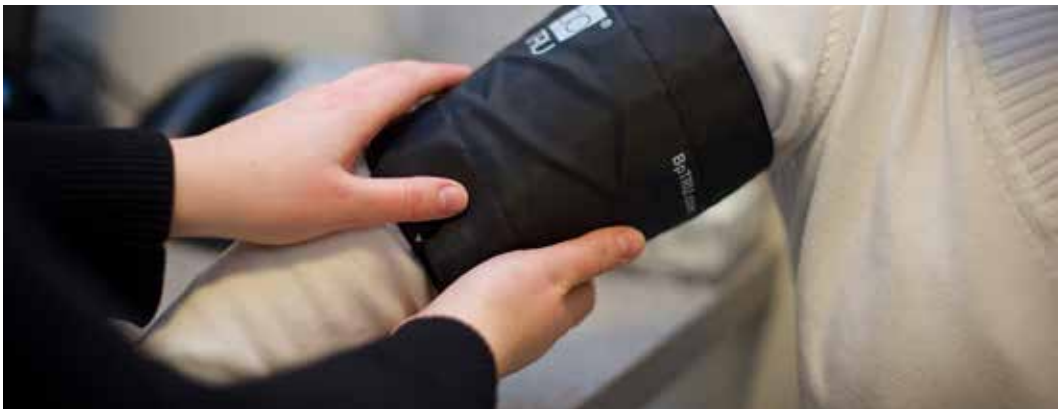
We will continue to expand our cross-sector work with police, education, social service agencies, municipalities and more to address the social determinants of health. We will expand the tangible benefits of our Connectivity Tables and strategic investments in things that positively impact population health outcomes. We will take a more intentional focus to help those who tend to have poorer health outcomes such as those who live in poverty and those with fewer social supports. Improving the health of a population requires an explicit focus on narrowing the health outcome equity gap.

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.

EXPECTED OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS:

- High needs residents will have individualized coordinated care plans developed through a Health Link in Waterloo Wellington
- All Complex Patients within a Health Link will have a primary care provider
- Fewer residents will have to be readmitted to hospital for chronic conditions
- Fewer residents will be hospitalized for chronic medical conditions that can be treated effectively in community
- Residents will have more connections to health care services through coordinated access centres



2015/16 KEY INITIATIVES TO ACHIEVE THIS STRATEGIC PRIORITY:

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

- Health Links
  - Build on the four Waterloo Wellington Health Links to improve coordinated access to care for residents with complex conditions.
  - Ensure residents with complex conditions have access to primary care.
- Social Determinants & Collaboration Outside of Health Care
  - Continue to grow partnerships amongst and between health, housing, social services, education, justice, and other community partners to improve population health.
  - Identify more effective support for those at risk in our community through efforts such as Connectivity/Situation Tables.

Improve timely access to primary care.

- Access to Care Close to Home/Enabling Technologies
  - Review and optimize use of telemedicine and telehomecare

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

- Chronic Disease Prevention & Management and Diabetes
  - Improve access and implement best practice guidelines for diabetes care and chronic disease prevention and management focused on congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

Improve timely information sharing between primary care and other providers.

- System Coordinated Access/Enabling Technologies
  - Build, enhance, and sustain coordinated access to services through the System Coordinated Access project which includes access to Community Support Services, Rehabilitative Care, Palliative/End of Life Care, Mental Health and Addictions services, Diabetes Education, and others.
  - Support primary care in ensuring coordinated, equitable, informed access to specialist care and explore options for shared care planning.

Improve access to appropriate cardiac care.

- Cardiac Care
  - Improve access to appropriate levels of congestive heart failure care (CHF) in community, primary and acute care settings.

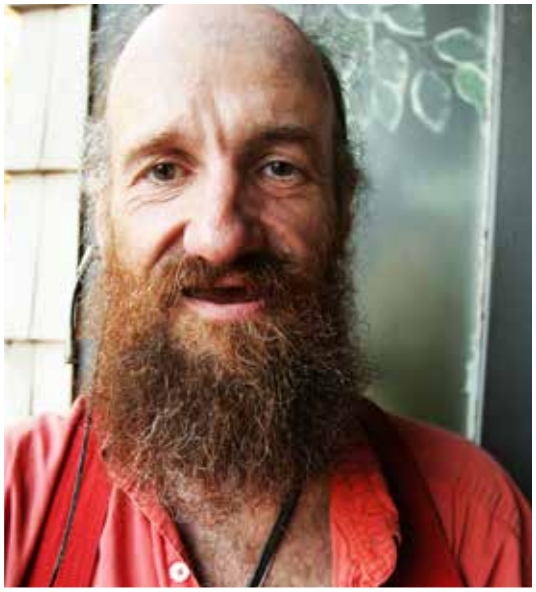
OUR PRIORITY: LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE-BASED PRACTICE

THE OPPORTUNITY:

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

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

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



Quality care is determined by*:

* Quality Improvement Guide, Health Quality Ontario.

ATTRIBUTES	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.

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

EXPECTED OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS:

- Residents will have the ability to die at home or within a community setting rather than in hospital
- Residents will experience improved quality and safety of care in Long-Term Care homes
- Residents will receive non-urgent Cardiac By-pass Surgery (CTAS IV) within 84 days
- Patients requiring admission from the emergency department will be transferred to a hospital bed in 8 hours or less
- Patients with complex needs requiring care in an emergency department will be seen and sent home in 7 hours or less
- Patients with minor, uncomplicated needs requiring care in an emergency department will be seen and sent home in 4 hours or less
- Fewer residents will have repeat visits to the emergency department for Mental Health Conditions
- Fewer residents will have repeat visits to the emergency department for Substance Abuse
- Residents will receive non-urgent hip replacements (CTAS IV) within 26 weeks
- Residents will receive non-urgent knee replacements (CTAS IV) within 26 weeks
- Residents will receive non-urgent cancer surgery within (CTAS IV) 12 weeks
- Residents will receive non-urgent cataract surgery within (CTAS IV) 26 weeks
- Residents will obtain non-urgent MRIs (CTAS IV) within the 4 weeks
- Residents will obtain non-urgent CT (CTAS IV) scans within 4 weeks

2015/16 KEY LOCAL HEALTH SYSTEM INITIATIVES TO ACHIEVE THIS STRATEGIC PRIORITY:

Implement evidence-based practices to ensure the same high-quality standard of care is provided across all sites for similar services.

- Quality Improvement
  - Accelerate best practice care through the system-wide adoption of electronic clinical order sets for Quality Based Procedures.
  - Enhance quality and ensure delivery of best practice through current integrated programs and implement new integrated programs.

Expand and enhance integrated programs that ensure quality and deliver best practice care across the continuum of care. Key improvements will include:

- Palliative Care
  - Improve the end-of-life experience for palliative residents and their families by ensuring options for people to die in the place of their choice.
  - Support advance care planning processes across the continuum of care and throughout the community.
- Long-Term Care
  - Improve the quality and safety of care in Long-Term Care homes.
- Emergency Department
  - Continue implementation of best-practices in Emergency Department care.
  - Improve care and experience for mental health and addictions patients.
- Mental Health and Addictions
  - Ensure all residents have access to complexity capable services at the right time, in the right place.
  - Improve access to intensive mental health services including optimizing Assertive Community Treatment Teams and support coordination.
  - Expand availability of mental health and addiction supports in housing.
- Pharmacy
  - Implement protocols for anti-microbial stewardship.
- Diagnostic Imaging
  - Reduce duplicate diagnostic imaging procedures.
  - Reduce wait times for diagnostic imaging procedures by optimizing service delivery models.
- Critical Care
  - Implement standardized clinical protocols and ICU best-practice design.
  - Develop and implement long-term ventilation program standards.
- Surgery
  - Improve access to specialized vision (eye) care and promote seamless eye care experience by strengthening the relationships between primary care, ophthalmology, and optometry.

OUR PRIORITY: CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

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.

Over the years, our residents have told us they did not always know where to go to get the care they need. Some care providers said that even when they knew what care is needed, they often did not know the best place to send patients. In the transitions between providers there lies great risk to quality of care; this can often lead to repeat use of the health care system, whether it is emergency department visits or readmissions; or gaps in care which could negatively impact health outcomes. We've made improvements to co-ordinate services and make navigating the system easier but there is still work to be done. We need to integrate and coordinate even more services to create a fully seamless experience of care that ensures that our residents receive the right care, at the right place, at the right time.

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

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

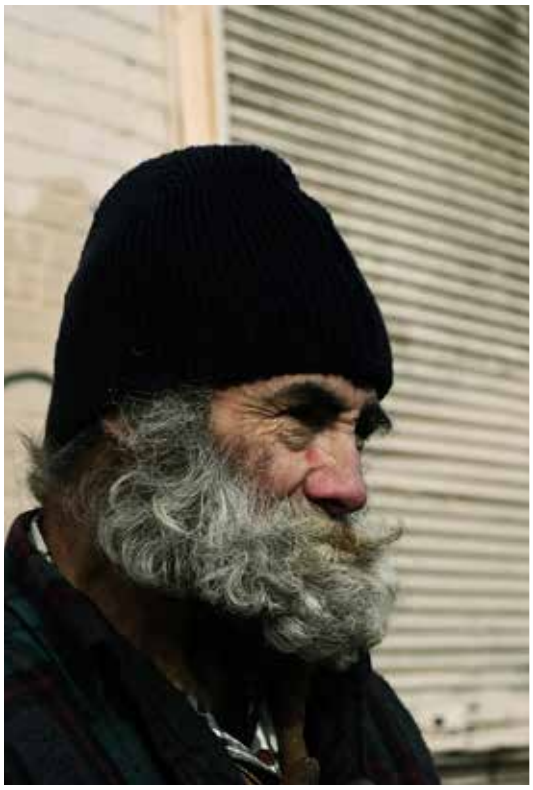
EXPECTED OUTCOMES FOR WATERLOO WELLINGTON RESIDENTS:

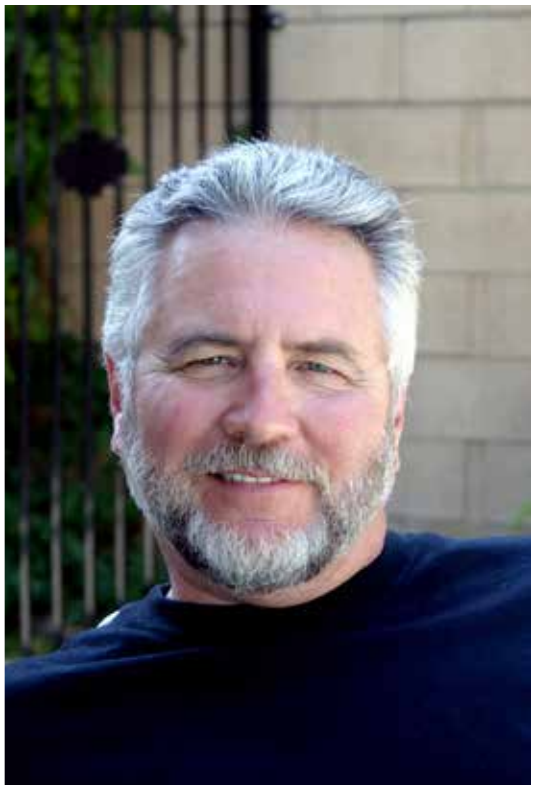
- Following service authorization, residents will wait no more than 5 days for in-home nursing and personal support worker service.
- Residents will spend fewer days in hospital when they should be receiving their care in a more appropriate location.
- Residents will experience timely access to long-term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

2015/16 KEY INITIATIVES TO ACHIEVE THIS STRATEGIC PRIORITY:

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

- Community Care
  - Establish efficient and integrated personal support service delivery for residents in the community.
  - Improve health outcomes and experience for residents by increasing timely access to equitable and integrated community services.
- Seniors Care
  - Continue to improve care for seniors through effective assess and restore services, dementia and Alzheimer strategies, and improving access to specialized geriatric services.
- Patient Transitions
  - Improve patient experience and flow by integrated discharge and patient transition practices, including patients with mental health conditions and addictions from hospital.
- Alternate Level of Care
  - Remove barriers for people waiting for an alternate level of care (ALC).





LOOKING AHEAD – ONE FAMILY'S EXPERIENCE

We have an ambitious plan to improve the health system in 2015/16, which may be best fully understood through the eyes of our residents. What will full implementation of the 2015/16 Annual Business Plan mean for residents of Waterloo Wellington? Let's consider the Ramos family…

The Ramos family lives in Cambridge. Anna (22) has two children, Miguel who is five and Mya who is three. Anna has stayed home since having Miguel and they live with her boyfriend Tyler (24) in an apartment. Tyler works in the manufacturing sector and money has been really tight supporting the four of them. However, his biggest stress is his mom, Maria.

Maria often sleeps on the couch in their tiny two-bedroom apartment. She lives with her boyfriend, an alcoholic who abuses her. When Maria stays with Tyler, her boyfriend will sometimes show up under the influence and threaten the family. When this happens, Anna packs up the kids and heads to her mom's house and Miguel misses school for a few days. Maria has turned to prescription painkillers for coping. She is unemployed and has Chronic Obstructive Pulmonary Disease (COPD) a chronic lung condition that makes it difficult to breathe.

HOW WE WILL BETTER CARE FOR THE RAMOS'

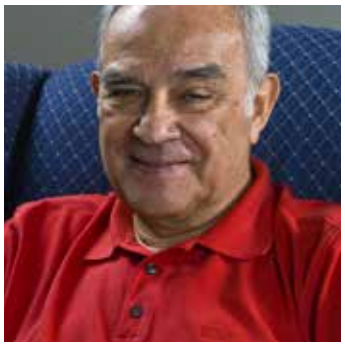
The Ramos family's health needs are representative of many other families across Waterloo Wellington. Their needs, however, are not solely within the health care system. They require support from the education system, social support system, community safety services such as the police, employment services, and more. How well they are supported by all of these sectors will impact their health far greater than health care services alone.

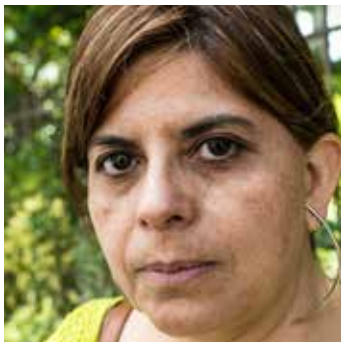
The Waterloo Wellington LHIN's strategy includes improving access to health care services for the Ramos' but it also reaches beyond, collaborating with other sectors to address the social determinants of health to improve the health and well-being of local residents. One example is connectivity tables – where all of our public service agencies come together to collectively identify individuals at elevated risk (like Maria) and work together to wrap supports around the entire family.

ENHANCING ACCESS TO PRIMARY CARE

Access to regular and consistent primary care is essential to the health of the Ramos family. The Waterloo Wellington LHIN is investing additional funding in Community Health Centres (CHC) to support them in taking on more patients. In Cambridge, Langs CHC could then enroll the Ramos family to provide them with access to primary care and a range of other social supports. While more than 95 per cent of residents in Waterloo Wellington have a primary care provider, there is much work to be done in enhancing the experience of residents when receiving primary care. For example, how easily care can be accessed after hours and on weekends. Over the next year, work will continue on health links to better support those with the most complex care needs in our community. Coordination and implementation of best practice guidelines for COPD will better support Maria in managing her disease. While work on expanding system coordinated access to other areas of the health system will also help the Ramos' and their new primary care team connect them with the care they need faster and more efficiently.

CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE





As residents like the Ramos' receive care from different parts of the health system, the transition between providers needs to be as seamless as possible. This means many different providers need to work together. Tyler's grandfather Raul is showing early signs of dementia; he also needs a knee replacement. Raul is also having trouble with his vision and will need cataract surgery. A review of personal support services this year will identify areas of improvement to better support Raul in his home. And investments in geriatric services means Raul will be able to see a geriatrician sooner when needed, as well as access specialized day programs and enhanced supports for his dementia. Work on better coordinating access to specialist care, community support services and rehabilitative care, will also improve efficiency and enhance the care experience for Raul and his family.

IMPROVING THE QUALITY OF CARE YOU RECEIVE

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

One example of integrated care locally is the cardiac program at St. Mary's General Hospital. Here, all residents in Waterloo Wellington have access to some of the highest-quality cardiac care in the country based on best practice. That level of care is being expanded to other areas through the development of integrated programs, as well as the implementation of clinical order sets – an electronic system to integrate the latest best practices for the best health outcomes of those patients. A new Waterloo Wellington vision care strategy will also improve the care Raul receives when he needs his cataract surgery.

A significant focus will be placed on enhancing palliative care so that when the time comes, Raul and others can experience the end-of-life care that best matches their wishes. This includes improving advance care planning – educating and engaging the public and caregivers on the need to have conversations about end-of-life care sooner. It will also free up resources in hospitals for those who truly need to be there.

Additionally, efforts will continue in reducing emergency department wait times, improving quality in long-term care, and much, much, more.

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