Strategic Plan Refresh -2018-2019

TransCare®'s decision to refresh its Strategic Plan (SP), rather than renewing it (Strategic Plan), was based on several key elements that may have impacted our plan and operations going forward. The following are some of those elements:

1. Central East LHIN 2016-2019 Integration Health Service Plan (IHSP)- *Living Healthier at Home*.
2. Central East LHIN Health Links – Action Plan
3. Central East CELHIN and CECCAC merger
4. TransCare® and Scarborough Centre for Healthy Communities Integration
5. Ambulatory Care Project
6. Ministry of Health & Long Term Care -New Crown Agency for PSW Services
7. TransCare® Unionization and Collective Agreement Impact

1. Central East IHSP Plan – *Living Healthier at Home;* the following excerpt is from the Plan:

With the overarching goal of Living Healthier at Home - Advancing integrated systems of care to help Central East LHIN residents live healthier at home, the Central East Local Health Integration Network (Central East LHIN) 2016-2019 Integrated Health Service Plan (IHSP 4) will guide, direct and inspire health system change.

With **four measureable and defined strategic aims**, the LHIN and its health service provider organizations will again deliver on the LHIN's mission of better health, better care, and better value for the residents of the Central East LHIN by:

- *Continuing to **support frail older adults** to live healthier at home by spending 20,000 fewer days in hospital and reducing Alternate Level of Care days for people age 75+ by 20% by 2019.*
- *Continuing to **improve the vascular health** of people to live healthier at home by spending 6,000 fewer days in hospital and reducing hospital readmissions for vascular conditions by 11% by 2019.*
- *Continuing to support people to **achieve an optimal level of mental health** and live healthier at home by spending 15,000 fewer days in hospital and reducing repeat unscheduled emergency department visits for reasons of mental health or addictions by 13% by 2019.*

- *Continuing to* ***support palliative patients to die at home by choice*** *and spend 15,000 fewer days in hospital by increasing the number of people discharged home with support by 17% by 2019.*

The strategic aims for IHSP 4 have remained similar to those in IHSP 3; however, there have been changes in both **how improvement is to be measured and the quantifiable amount of each improvement**.

Each strategic aim focuses on reducing the need for hospital care (defined by emergency department visits and inpatient days including alternate level of care days) and provides the opportunity for *Health Links* community health service providers to achieve a key related Ministry LHIN Accountability Agreement (MLAA) or supporting indicator that coincides with each aim.

Core to this overarching system goal for Central East LHIN is the expectation that, within each *Health Links* community and *Health Links* network, LHIN health service providers will work together with patients and families who have complex health and social needs, to develop coordinated care plans that advance the goals of the patient and family.

At the end of the next three years, by 2019:

Patients and Family Caregivers will be able to say that: "*we are living healthier at home – our physical health, mental health, and social and emotional support is better* - and supported by our Coordinated Care Plans, we are receiving the right information, the right care and the right services. It means that we only have to go to the hospital or move to a long-term care home when continuing to live at home is no longer safe for us, or we require specialized or acute care. It also means we are making a contribution to health system change by working hand-in-hand with our care teams."

Health Service Providers will be able to say that: "by working better together to create a coordinated health care system through the advancement of Health Links, we have improved patient access, better connected them to services, and provided them with the necessary provision of education enabling them to make the right health decisions. It means patient goals are being met and health outcomes are improving. It also means we are making evidence-based decisions on value and quality, within available resources, that will sustain the health system for generations to come."

Central East LHIN Organization will be able to say to all of the Central East LHIN that: "Since 2016:

    - (A number to be established in year 1 of the IHSP in collaboration with our communities) residents are living healthier at home;
    - Hospital care needed by frail older adults has reduced 20%;
- Hospital readmission for people living with vascular disease has reduced 11%;
- Hospital care needed by people living with Mental Health has reduced 13%; and,
- Hospital end-of-life care has reduced 17% because more palliative patients are being supported to die at home by choice.

2. Scarborough Health Links Action Plan –the following information is a summary of the Central East LHIN – Health Links documents listed on their website:

Health Links was introduced as a key commitment in the Ministry of Health and Long-Term Care's 2012 Action Plan for Health Care to transform the system through increasing access to integrated, quality services to Ontario's complex patient population. Since their launch, Health Links have made tangible gains in improving care coordination and transitions between services.

The Central East LHIN has established 7 sub-regions of which Scarborough North and Scarborough South are establishing as Health Links Communities. There are 24 neighbourhoods defined in the two Scarborough Health Links Communities. Scarborough North has six neighbourhoods and Scarborough South has 18 neighbourhoods. These neighbourhoods were defined by the City of Toronto.

Summary of Demographics – Central East LHIN Indicator for Scarborough North Health Links area has a population of 176,615; of which 30,450 are over 65 years of age. Scarborough South Health Links has a population of 417,060; of which over 57,080 are over 65 years of age. Total population of 65 + for the region is 87,530. 63% of the population are estimated as visible minority.

In the Scarborough North Health Links community, the following organizations are working as a Health Links network to effectively identify every patient with complex health care needs and improve their health outcomes through the development and maintenance of Coordinated Care Plans.

Scarborough North Health Links Network Organizations:
Carefirst Family Health Team
Carefirst Seniors & Community Services Association
Central East Community Care Access Centre
Durham Mental Health Services
East GTA Family Health Team

Hong Fook Connecting Health Nurse Practitioner-Led Clinic
Hong Fook Mental Health Association
Nurse Next Door
Scarborough and Rouge Hospital
Scarborough Centre for Healthy Communities
St. Paul's L'Amoreaux Centre
TransCare Community Support Services
Yee Hong Centre for Geriatric Care

In the Scarborough South Health Links community, the following organizations are working as a Health Links network to effectively identify every patient with complex health care needs and improve their health outcomes through the development and maintenance of Coordinated Care Plans:

Scarborough South Health Links Network Organizations:
Canadian Mental Health Association, Toronto Branch
Carefirst Family Health Team
Carefirst Seniors & Community Services Association
Central East Community Care Access Centre
Cota Health
Lakeridge Health Pinewood Centre
Momiji Health Care Society
Mon Sheong Scarborough LTC
Providence Healthcare
Scarborough and Rouge Hospital
Scarborough Centre for Healthy Communities
St. Paul's L'Amoreaux Centre
TAIBU Community Health Centre
Toronto Community Housing
TransCare Community Support Services
Victorian Order of Nurses

To date, Health Links have played a key role in attaching patients to primary care providers, improving coordinated care for patients living with multiple complex chronic conditions; and more meaningfully, engaging patients in their own health care. In addition, they have been crucial in strengthening relationships and communication between providers.

Moving forward, Health Links will continue to play an integral role in the health system landscape, as catalysts that will support the advancement of the Patients First: Action Plan for Health Care and the Central East LHIN's 2016-2019 Integrated Health Service Plan.

TransCare® participates at two levels, as a member of the Steering Committee and a member of the Design Committee. The agency has completed a number of Coordinated Care Plan through our Assisted Living and Supportive Housing Programs, and by CIA Coordinators targeting high need clients.

3. **SCHC & TransCare® - Integration Business Case; the following is a summary of the work that was done during period – winter to 2016 – winter 2017.**

TransCare® and Scarborough Centre for Healthy Communities (SCHC) met in the fall of 2016 to start the discussion to explore opportunities of integration among the two agencies. Notice was given to the Central East Local Health Network (CELHIN) in the spring of 2017, informing CELHIN that the two agencies were voluntarily exploring integration opportunities through the development of a Business Case by our consultants Lough Barnes Consulting Group. The process included sessions with employees and volunteers from both organizations.

LBCG undertook the process of assessing the opportunity, costs, and benefits of integration options through the development of a Business Case. The consultants examined SCHC and TransCare®'s documents and data, and engage internal and external stakeholders in focus groups and one-to-one interviews to review and assess the benefits, risks, and opportunities of integration options.

LBCG consultant interviewed senior management team and three of each agency's key stakeholders. For TransCare®, our contacts were; The City of Toronto – Toronto Community Housing senior manager, VHA Health Care CEO, and a senior manager from the CELHIN .

Meetings were also organized with employees and volunteers by mid-June. The following are some of the questions that the consultant asked, depending on the person(s) being interviewed:

- What are the health needs of your client population that are different than other population groups?
- What are the benefits of the amalgamation?

- How would you describe the culture of your organization?
- What are the values central to your organization?
- Do you understand the services the other organization provides? If so, do you see any overlap or redundancies?
- Do you see any opportunities to provide new services or expand existing services with the proposed integration/amalgamation?
- From your perspective, what would the impact of the integration/amalgamation be on the communities you serve?

A thorough review of the Business Case Report recommendations was considered by the Board of Directors of TransCare®. As a result of the review, the Board of Directors of TransCare® came to a decision not to proceed with a merger with SCHC at this time. The Board recommended that TransCare®'s Management Team continue the process of exploring the integration of programs and services that are common to both SCHC and TransCare®, and to include other service providers within the Scarborough region. In addition, the Board recommended that TransCare® and SCHC invite the CELHIN to assist the agencies through this process, building on other integration models and exploring opportunities that put the patient first.

TransCare®'s Board of Director will continue to dialogue with the Board of Directors of SCHC and other providers to continue to address gaps in services and formulate partnerships to ensure patients are receiving the right care at the right time.

At TransCare®'s Board of Directors meeting on November 7th, the following motions were carried:

> **Motion #1:**
> Considering the Business Case Report dated September 5th, 2017, as well as a number of other concerns, the Board of Directors of TransCare® does not wish to proceed with a merger with SCHC at this time.
>
> **Motion #2:**
> The Board is recommending that TransCare®'s Management team continue the process of looking at integrating programs and services that are common to both SCHC and TransCare®, and to consider working with other service providers within the Scarborough region.

In addition, the Board recommends that TransCare® and SCHC invite the CELHIN to assist us through this process, building on other integration models and exploring opportunities that put the patient first.

4. Ambulatory Care Project

TransCare® has been working with East GTA Family Health Team and The Scarborough and Rouge Hospital to develop an Ambulatory Care Centre for High Risk Complex seniors in the Scarborough area.

Objective of this project is to find opportunities for collaboration between the local hospital and community at large including primary care and other community service organization(s) in the Scarborough and surrounding area.

The goal of this project is to help better manage complex patients, especially frail, elderly patients with complex conditions and who also frequently visit the Emergency Department (ED).

Key Strategies:

a. East GTA FHT and TransCare® have been working in partnership at the community level on a number of signature initiatives e.g. medically complex patients demonstration project (a MOHLTC-OMA initiative), Scarborough Health Links (CE LHIN-led). The intention now is to apply this collaborative experience by working with an acute care facility of choice so that targeted patients can be better managed in the community and at home.
b. Experience has shown that an effective engagement of primary care throughout the care continuum can and do help reduce frequent ED visits, and complications following discharge that are often one of the root causes of their return to hospital. Therefore, this initiative will focus on frail, elderly complex patients admitted to the hospital. It will include all key players from hospital to General Physician to community service organization(s) needed to effectively plan and provide necessary support in an organized manner without creating low-value / no-value layers of bureaucracy.
c. It will start with high risk patients admitted to the hospital, prepare a concise, customised care plan shortly after their admission and tailored to each patient. Then, following discharge, the care plan will be rolled out and managed in a coordinated fashion – keeping the patient and their care giver at the centre of the entire decision making process, while ensuring clear

accountability for outcomes, patients' experience and sustainability.

- ❖ Alignment with emerging vision of health system and current priorities:
  This initiative is in alignment with the current priorities of the Government of Ontario / MOHLTC / CE-LHIN, and will benefit the community of Scarborough (its residences), and help alleviating some of the pressure points faced by hospitals. It will also provide valuable lessons for future expansion of the integrated care for this growing target population, and is scalable to expand into a community based ambulatory care centre working in close cooperation with the local hospital(s), primary care and other key stakeholders.

TransCare® and East GTA FHT are continuing to meet with The Scarborough and Rouge Hospital Senior Management team members.

5. Ministry of Health & Long Term Care – Announcement of New Crown Agency:

In a recent announcement, the Ministry of Health and Long-Term Care notified Health Care Providers about creating of a new Crown Agency to manage self-directed care performed by PSWs which is supposed to roll out in early 2018. There was no sector consultation before the announcement on this plan.

This new crown agency will directly recruit and employ PSWs, allowing patients who require more than 14 hours of care per week to decide which PSW they want to provide care to them , and how the level of frequency. This is very concerning to service providers that are already providing care in the most efficient manner given the limitations we face on a daily basis, including the shortage of PSWs and the limited funding we receive per client care hour.

The Ontario Community Support Association, representing non-profits agencies like TransCare®, as well as Home Care Ontario which represents the for-profit service providers, have expressed their concerns about the creation of yet another tier that will only confuse the patients seeking care in their homes. This will also have an impact on recruiting PSWs and on the current contracted PSW services through the LHINs.

The pilot sites have been selected outside the GTA area. TransCare® will continue to monitor the impact that may have on agencies within those areas.

6. United Way Greater Toronto – Change in Funding:

TransCare® is a United Way Greater Toronto funded agency since 1984 and receives funding grants in 7 program areas. In 2016, the United Way Toronto announced their merger with York Region. In addition, they informed us about changes from their funding grant streams to a new investment framework. The framework now focuses on addressing the issue of poverty in 'our city and region'. Agencies now have to be placed in two funding categories: program funding agencies or limited anchor agencies (per area). To be considered as an anchor agency, the agency must service all age groups including youth. TransCare® did not qualify to become an anchor agency.

TransCare® must decide on three (3) programs that would fit their assessment criteria for funding including:

- Agency capacity to deliver the program
- Alignment with the CSS Strategy
- Compelling case
- Program design
- Program impact
- Case for United Way funding.

Others considerations were taken into account including: to balance United Way investments across the geography of our city and region; diversity equity seeking groups and population; and, a mix of different services/program types.

7. TransCare® Unionization and Collective Agreement Impact

In April 2014, the agency was notified by the Labour Board that a number of employees in various departments were seeking representation from the United Food and Commercial Workers – Local 175 (UFCW) Union. After one full year of negotiations with the Union, representatives of the bargaining unit employees voted in favour of the final negotiated Collective Agreement (CA). The CA was ratified by **TransCare®'s** Board of Directors at the May 26th, 2015 meeting. The term of the CA is for three years ending March 31, 2018.

The impact of the Union on the agency's daily operations was minimal. However, time in dealing with grievances impacted the Executive Director, Human Resource and Management on the whole. Most of which were misunderstandings of the Collective

Agreement, negative messaging by the Union to its members and the agency's business operating practicing rights and obligations.

Negotiations to renew the Collective Agreement is underway.

Plans for Renewing the Strategic Plan:

TransCare® has in place a 'Strategic Plan Refresh Deliverable' document, which will be shared with Board and Management. This document will also be include in the 2018-2019 Business Operating Plan.

TransCare® will be securing a consultant to renew its Strategic Plan in the fall of 2018.