TransCare®

Community Support Services

2013-2016 Strategic Plan

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A United Way Agency

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Background

TransCare® Community Support Services is a registered, charitable corporation providing home and community support services to seniors and adults with disabilities in the community since 1976. The agency is funded by the MOHLTC (CELHIN), City of Toronto and the United Way to provide community support services to seniors and adults with disabilities. TransCare® is governed by a community Board of Directors. The Board maintains the overall responsibility for administrative, human resource, financial and operational activities of the agency. On June 2011, TransCare® Community Support Services was accredited by Accreditation Canada, a national standards of excellence that accredits hospitals and other healthcare organizations. The three-year accreditation recognizes that TransCare® meets the national standards of excellence in quality client care and service delivery. TransCare® also adheres to the Imagine Canada Code of Ethical Fundraising and Financial Accountability.

TransCare® has over 37 years of experience in developing and implementing community services for both seniors and the disabled community ensuring staff has the appropriate resources to provide services that promote the health and well-being of both staff and clients. The over 190 employees and 275 volunteers deliver programs and services, and includes staff who can deliver multiple languages to meet the needs of our multi-ethnic populations. TransCare® recognizes that providing help for people, in particular seniors and adults with disabilities, to maintain healthy lifestyles and positive attitudes, facilitates them in dealing with daily living challenges. These services include:

- Home and Respite Care
- Supportive Housing
- Transportation
- Outdoor Maintenance
- Meals on Wheels
- Adult Day Program
- Community Dining & Recreation
- Client Intervention & Assistance

TransCare® is the lead agency in the Scarborough region for the Central East LHIN's Home at Last (HAL) and Home First initiative. In partnership with 4 agencies, HAL works with the hospitals to provide a smooth supportive transition from hospital to home for seniors. Settlement services include transportation, escort, personal care, picking up a prescription, meal preparation and follow-up. Home First is a collaborative program amongst 5 other agencies Home First is a philosophy that believes decisions about major lifestyles should be made from home, not from the hospital, providing the timely care, service and support to achieve this. Home First allows patients transitioning home to receive enhanced CECCAC and other community support services where required.

TransCare® Community Support Services received funding from Ministry of Health and Long-Term Care - Healthy Work Environments Partnership and Innovation Fund to develop a video

Promoting Healthy and Safe Living for Individuals and their Caregivers through Exercise. The video was designed with input by healthcare front line workers including PSWs and recreationists OT/PT, geriatric nurse, geriatrician and researchers to develop the video which is available free of charge to agencies across Ontario.

The agency will continue to challenge itself and is energizing its future growth with a renewed 3-year strategic plan for 2013-2016.

2. Central East LHIN Community First Integrated Service Plan 2013-2016

2.1 Provincial Priorities and LHIN System Imperatives

Ontario's LHINS have been a significant driver of health care improvements since 2006. The first two Integrated Health Service Plans has been and will continue to be a driver of change towards health care improvements focusing on engaging the community and integrating all partners to provide the best health care possible. In January 2012, the province unveiled Ontario's Action Plan for Health Care to meet the challenge of managing spending growth while continuing to provide high-quality care to all Ontarians. The goal of the Action Plan is to create an "obsessively patient-centered" health care system by ensuring care is based on evidence, care is delivered in the right setting and care is coordinated so that patients move from one provider to another seamlessly.

To align the high level goals with their IHSPs, Ontario's LHINs have developed several *system imperatives.* These imperatives guide decisions LHINs make regarding the allocation of resources among providers and the programs and projects to be funded at the local level. Ongoing accountability will be tracked through strategic planning, accountability agreements and performance measurement. The Action Plan identifies three area of focus and the LHINs have identified three additional system imperatives to support Right care, Right time, Right place:

Ontario's Action Plan	LHIN-Wide System Imperatives
Keeping Ontario Healthy	Keeping Ontario Healthy
Faster Access and a Stronger Link to Family Health Care	Strengthening and Enhancing Access to Primary Care
The Right Care at the Right Time in the Right Place	Implementing Evidence Based Practices to Drive Safety Enhancing Coordination and Transitions in Care Holding the Gains

2.2 Central East LHIN Vision and Mission

In the Central East's 2013-2016 Integrated Health Service Plan (IHSP), it reconfirms its vision statement that was originally created in the fall of 2006. The ongoing reconfirmation of this vision is testimony to the enduring hopes of residents and health care providers to improve the health of our communities through an integrated health care delivery system focused on wellness, equitable and time access to care, that delivers high quality outcomes.

Central East LHIN Vision:

Engaged Communities

People are supported and proactively engaged in:

- Managing their own health and wellness
- Providing direction and solutions for their health care system and their LHIN
- Coordinating the delivery of timely health care services

Healthy Communities

- Supportive and sustainable environments that address the social determinants of health and cultural competency
- Timely and equitable access to care
- The health of the population has improved

Central LHIN Mission:

To lead the creation of an integrated sustainable healthcare systems that ensure better health, better care, better value for money.

2.3 Strategic Directions and System Level Outcomes

The 2013-16 IHSP also continues to have a strong focus on the community and the integration of all partners and providers to provide the best care possible. The overarching theme is "Community First". However, the IHSP also sets out a new road map for health care improvement for the region. In order to achieve its vision, "Engaged Communities- Healthy Communities" mission, and mandate, the IHSP has adopted four new strategic directions that support the achievement of a high performing health care system as defined by the Health Quality Ontario. These strategic directions are derived from the Ministry of Health and Long-Term Care's (MoHLTC) Action Plan for Health and the common objectives of all 14 LHINs.

The Strategic Directions are:

Transformation Leadership: The Central East LHIN Board will lead the transformation of the health care system into a culture of interdependence.

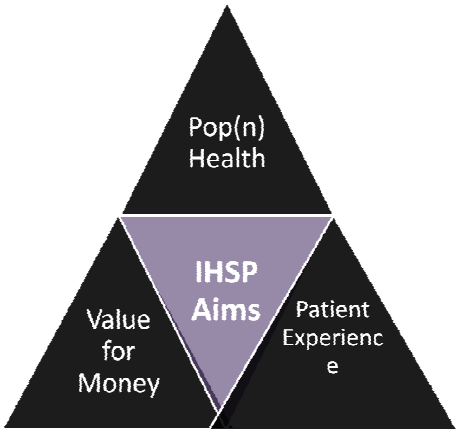
Quality and Safety: Health care will be "people-centered" in safe environments of quality care.

Health Service and System Integration: Create an integrated system of care that is easily accessed, sustainable and achieves good outcomes.

Fiscal Responsibility: Resource investments in the Central East LHIN will be fiscally responsible and prudent.

2.4 Strategic Framework: The Institute for Health Care Improvement's Triple Aim

The Triple Aim is the simultaneous pursuit of enhancements in population health, patient experience and value for money by controlling or reducing the health care cost per capita.



The Triple Aim strives to improve three things for a population at the same time. It does so by:

- Focusing on individuals and families
- Redesigning primary care services and structures
- Managing the health of a particular population(s)
- Establishing a cost-control platform
- Reinforcing system integration and execution
- Building coalitions with other sectors

2.5 Strategic Aims

Community First

The Central East LHIN has adopted the use of system level aims – or strategic aims. Strategic aims are specific and measurable in that they describe what is intended to be achieved, how much, for whom, and by when. They provide a focal point for health care providers to align their efforts in order to achieve common objectives for health care client. The over-arching aim is "Community First".

Approximately 86% of the Central East LHIN expenditures are directed to Hospitals (63%) and Long-Term Care Homes (20%), however, the short and long-term sustainability of access to hospital-based and institutional care, along with changes in health care delivery resulting from new technology and clinical practice, require a shift of focus to health care delivered in the community.

"Community" is generally defined as those non-hospital based services that help prevent and manage illness, thereby preventing hospitalizations resulting from poor disease management. These services typically include primary health care, home care, hospice care, mental health and addictions services, and supportive housing, to name a few. More recently, the definition of "community" is expanding to include services or programs that focus on patient and care-giver empowerment – such as the self-management for persons with chronic disease.

This Community First IHSP, specifically through the strategic aims and enablers, is a focused and disciplined approach to create an integrated community-based health system that is able to proactively respond to the emerging health care trends of our communities. With dramatic changes in-store ahead to health care finance, clinical practice, demographic shifts, and technology – these changes are too large and too important to leave to change. Home First taught us that we need to be less implicit and more explicit in the coordination of patient care across health care sectors.

Four Main Strategic Aims

1. Seniors

Improving health care for seniors is a top priority of the Central East LHIN. The population of seniors is growing, and this group often has complex health care needs. As a result, there will be increased pressure on caregivers, communities and our health care system. A focus on seniors will foster improvements in the health care experience of patients and their caregivers, as well as in the overall quality and sustainability of the health care system in the Central East LHIN.

2. Vascular Health

Vascular diseases are a broad group of health conditions that affect almost all parts of the body. Vascular disease includes cardiovascular (heart disease), cerebrovascular (brain disease) including vascular dementia and stroke, and peripheral vascular disease which presents in other areas of the body such as kidneys, arms and legs. Vascular disease impacts our individual health and our health care system. It is this thickening or build-up inside arteries (atherosclerosis) that is commonly referred to as 'hardening of the arteries'. Vascular disease can damage eyes and cause blindness, restrict blood flow to the brain resulting in memory-loss (dementia) or stroke, cause heart attacks or heart failure, raise blood pressure, impair kidney function, and cause swelling or inflammation in arms and legs (peripheral vascular disease) which can lead to tissue loss (gangrene, wounds) and possible limb amputation. Some people are particularly high risk of developing vascular disease including:

- Seniors
- People with diabetes, reduced kidney function, heart disease, or who have experience a stroke
- Visible minorities.

3. Mental Health and Addictions

Mental health and addiction issues represents serious challenged to individuals, families, the health care system and society at large. Alcohol and illicit drug use in the Central East LHIN has an estimated economic cost, (direct and indirect) of $915.15 million annually, (Central EAST LHIN Addictions Scan, 2009). Groups that face the greatest risk or face the greatest challenges will be the focus over the next three years. They are:

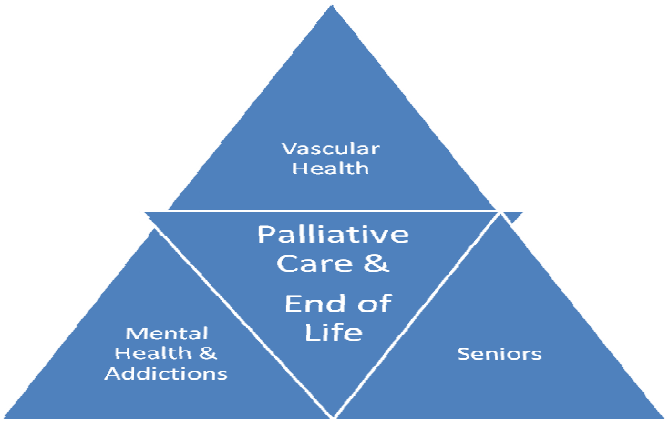
- Persons with concurrent disorders or physical disabilities
- Seniors or older adults with complex medical and social needs
- Persons with addictions, including expectant mothers
- First Nations, Métis, Inuit and Non-Status peoples
- Adolescents, school-age and transitional aged youth who are migrating from youth to adult system

4. Palliative and End of Life Care

Palliative and end of life care is an approach for people who are living with a life-threatening illness. It focuses on achieving comfort and ensuring respect for the person nearing death and maximizing quality of life for the patient, family and loved ones.

Palliative and end of life care is holistic in nature and aims to:

- Address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears
- Prepare for and manage self-determined life closure and the dying process
- Cope with loss and grief during the illness and bereavement



2.6 Common Enablers

Cascading from these strategic aims are a number of other indicators at the providers and client level that help everyone understand:

- How a particular health care provider contributes to the achievement of the system level strategic aim

- Changed in patient experience, population health and value-for-money at both the provider and regional level
- Improvements in quality as well as measures to ensure no adverse unintended consequences

Achieving these aims require a core set of enablers. The IHSP identifies a set of common enablers related to health system design and improvement that consistently weave between all of our strategic aims.

Those common enablers are:

- Improving Access to Primary Care
- Access and Wait Time – Including Emergency Department, Surgical and Diagnostic Services
- Health System Funding Reform
- System Design & Integration
- Transitions in Care & Electronic Health Information Management
- Quality & Safety

3.0 Environmental Scan

The Central East LHIN has the second largest population in Ontario. It is home to 1,572,500 people or 11.8% of the population of Ontario. The Central East LHIN also has the fourth highest projected growth rate. It is expected that by 2021 the population will have increased by 17.0%, compared to a projected increase of 13% for Ontario overall (IHSP Environmental Scan). The Central East LHIN is a mix of urban and rural geography and is the sixth-largest LHIN in land area in Ontario (16,673 km^2). It includes densely populated urban cities, suburban towns, rural farm communities, cottage county villages and remote settlements. The Central East LHIN stretches from Victoria Park to Algonquin Park. Due to its large population and diversity the Central East LHIN has been divided into three clusters for health system planning purposes. TransCare Services the Scarborough Cluster.

Key Facts about the Central East LHIN (2012 IHSP Environmental Scan)

- Residents have a slightly longer life expectancy compared to Ontario overall.
- Highest unemployment rate in the province (10%)
- 16% of resident living in low-income – 3rd highest among the province's 14 LHINs. In Scarborough over 25% of the population lives in low income.
- 5th highest in percentage with low education levels.
- Relatively large immigration population – in Scarborough, 58% of the population are immigrants

LIFE EXPECTANCY IN THE CENTRAL EAST LHIN

Central East Ontario	2007	2009
Life expectancy at birth (yrs),	82.1	81.5
Life expectancy at age 65 (yrs),	20.9	20.3

TransCare Catchment Area

It's a dense urban area that includes roughly 41% of the Central East LHIN's population. This area is characterized by cultural diversity and has a relatively young population, only 5% of Scarborough residents are over the age of 65. However the percentage of seniors is expected to grow over the next three years. The Scarborough region, as a distinct area of the Central East LHIN, is expected to grow significantly and show similar growth patterns to the rest of the City of Toronto. As compared to the rest of the Central East LHIN, Scarborough has:

- The highest population density in the Central East LHIN
- The largest concentration of visible minorities
- Some of the highest levels of low income families

Cultural Diversity

In addition there is a significant portion of TransCare's catchment area with extremely high diversity in the Scarborough Cliffs and Agincourt Rouge.

Scarborough-Rough River (128,905):

1. English (37.4%)
2. Tamil (13.8%)
3. Cantonese (13.1%)
4. Mandarin (4.6%)
5. Tagalog (Philipino, Filipino) (4.3%)
6. Urdu (3.2%)

Scarborough-Agincourt (107,465):

1. English (30.2%)
2. Chinese, not otherwise specified (15.8%)
3. Cantonese (14.4%)
4. Mandarin (12.0%)
5. Tamil (5.0%)

Scarborough-Guildwood (105,900):

1. English (57.6%)
2. Tamil (8.0%)
3. Gujarati (6.0%)
4. Tagalog (Philipino, Filipino) (3.9%)
5. Urdu (3.2%)

Scarborough Centre (105,880):

1. English (47.7%)
2. Tamil (8.5%)
3. Tagalog (Philipino, Filipino) (6.1%)
4. Chinese, not otherwise specified (3.8%)
5. Cantonese (3.5%)

Scarborough Southwest (103,270):

1. English (59.3%)
2. Bengali (6.1%)
3. Tagalog (Philipino, Filipino) (5.0%)
4. Tamil (3.4%)

Population Growth:

According to Stats Canada (2011) the neighborhoods in the City of Toronto that experienced the highest increase in population from 2001 to 2011 are:

Toronto:
Waterfront Communities- The Island (133.6%)
Niagara (83.4%)
Bay Street Corridor (37.7%)
Church-Yonge Corridor (29.6%)
Mount Pleasant West (25.4%)
Moss Park (24.3%)
Junction Area (15.5%)
Cabbagetown-South St. James Town (13.7%)
Casa Loma (12.3%)
University (11.4%)

North York:
Willowdale East (66.7%)
Bayview Village (42.4%)
Willowdale West (31.6%)
Lansing-Westgate (24.4%)
Banbury-Don Mills (16.7%)
Bathurst Manor (15.2%)
Newtonbrook West (12.5%)
Englemount- Lawrence (10.1%)

Scarborough:
Rouge (59.6%)
Clairlea-Birchmount (24.0%)
Bendale (21.4%)

Etobicoke:
Islington-City Centre West (20.9%)
Kingsway South (11.9%)
East York:
Thorncliffe Park (15.7%)

Seniors Population

The 2012 IHSP Environmental Scan shows that the Central East LHIN has the largest number of seniors (65+) in the province and the population is growing. By 2016, seniors will account for 16% and by 2021 they will account for 18% of the Central East LHIN's population. Seniors have high health care needs. The 2012 IHSP Environmental Scan found that:

- 123 of every 1000 seniors aged 75+ in the Central East LHIN require Long-Term Care- 3rd highest rate in Ontario
- Over 40% of the 85+ population live alone in the community
- Seniors' cohort comprises the vast majority of the alternate Level of Care (ALC) days. There was an increase from 64,822 days in 2006/7 to 117,859 days in 2010/11- the 3rd highest in the province. This is largely due to patients not receiving the care they need and resources not being used to their full capacity.

Vascular Health

17% of Central East LHIN residents have multiple chronic conditions, which is significantly higher than the provincial rate (15.2%). Comorbidities make vascular disease management more complex and can result in additional health issues. Based on data collected to measure hospital performance over 15% of people with vascular disease were readmitted to hospital within 30 days of their discharge in the Central East LHIN. This suggests that the immediate health care needs of some of those with vascular disease are not being appropriately met.

Nine out of every ten Canadians over age 20 have at least on risk factor for vascular disease and one in three have more than one risk fact (Public Health Agency of Canada: 2009). Type 2 diabetes, although not a vascular disease, is one of the largest contributing modifiable risk factors to vascular disease. Hearth disease and stroke are the number one cause of death and disability among those with type 2 diabetes; and , adults with diabetes are two to four times more likely to have heart disease or a stroke than adult without diabetes (American Heart Association). A number of factors contained in the IHSP Environmental Scan suggest that a focus

on vascular health is warranted in the Central East LHIN. Obesity puts people at risk for vascular disease and, 53% of the Central East LHIN's residents are overweight or obese. The incidence of obesity has been increasing over time. The prevalence of some health conditions that are related to vascular disease is higher in the Central East LHIN than across the province (see table below). In particular, the Central East LHIN has the highest rate of diabetes across the province.

PREVALENCE OF CHRONIC CONDITIONS IN THE CENTRAL EAST LHIN

Condition	Central East LHIN	Provincial Average
Diabetes	7.9%	6.9%
Heart disease	5.5%	4.9%
High blood pressure	17.6%	17.4%

Income is a social determinant of health status, and ethnicity is a significant factor in chronic disease, especially diabetes and vascular conditions. In the Central East LHIN overall, about 10 of every 100 families were living with low income in 2005. This percentage (9.9% of families) was somewhat higher than the provincial average (8.6%). Scarborough Cliffs has the highest percentage of population with low income in the Central East LHIN (25% compared to a LHIN average of 15%), and a higher than average incidence of diabetes. Agincourt-Rouge is #1 in the rate of all common chronic disease, with the exception of obesity where it ranks #2.

Diabetes (ICES 2011)

- For every 100 adults living in the Central East LHIN who were free of diabetes in March 2009, about one was diagnosed with diabetes in the subsequent year. This incidence rate (1.05 per 100) was slightly higher than the Ontario average (0.97 per 100 adults).
- The highest incidence rate was seen in Scarborough Cluster (1.16 per 100).
- For every 100 adults in the Central East LHIN, about 11 were living with diabetes. This prevalence (10.80 per 100) was higher than the Ontario average (9.64 per 100).
- Diabetes prevalence was highest in Scarborough Cluster (12.45 per 100).
- Overall, for every 100 adults living with diabetes in the Central East LHIN on March 31, 2006, about four had at least one hospitalization or emergency department (ED) visit for hyper- or –hypoglycemia in the subsequent five years. This rate (434 per 10,000 adults with diabetes) was lower than the provincial average (486 per 10,000).
- About eight of every 100 adults with diabetes in the Central East LHIN in 2006 were hospitalized for a cardiovascular condition at least once in the ensuring five years. This rate (793 per 10,000 adults with diabetes) was below the provincial average (888 per 10,000).
- In the Central East LHIN overall, about 55 of every 100 adults with diabetes had at least one other chronic medical condition besides diabetes between 2006/07 and 2008/09. This rate (54.97 per 100) was nearly identical to the provincial average (54.84 per 100).
- There was some variation in rates across sub-LHINs, ranging from 50.12 per 100 in Scarborough Cluster to 64.30 per 100 in North East Cluster.
- In the Central East LHIN, nearly one-third of adults with diabetes made more mental health visit(s) between 2006/07 and 2008/09. This rate (31.27 per 100 adults with diabetes) was very similar to the provincial average (32.89 per 100).
- The highest rate of mental health visits was in Durham Cluster (34.25 per 100).

Mental Health and Addictions

In the 2011 IHSP Environmental Scan the Central East LHIN was ranked 10th among the 14 LHINs in repeat unplanned emergency visits within 30 days for Mental Health conditions, with a return rate of 17.6%. The Central East LHIN was ranked 5th in repeat unplanned emergency visits within 30 days for substance abuse conditions in 2011, with a return rate of 22.0%. An early return visit suggests that the care that was needed in order to remain at home or in the community was not provided. Addressing the care needs of those with mental health and addiction issues will decrease pressure on emergency departments in the Central East LHIN, but more importantly it will also improve outcomes for those individuals.

The Impact of Mental Illness and Addictions (ICES 1012)

- The burden of mental illness and addictions in Ontario is more than 1.5 times that of all cancers and more than seven times that of all infectious diseases.
- Five conditions have the highest impact on the life and health of Ontarians: depression, bipolar disorder, alcohol use disorders, social phobia and schizophrenia.
- Depression is the most burdensome condition with twice the impact of bipolar disorder, the next highest condition. The burden of depression alone is more than the combined burden of lung, colorectal, breast and prostate cancers.
- In terms of deaths, alcohol use disorders contributed to 88% of the total number of deaths attributed to these conditions and 91% of the years of life lost to dying early.

Palliative and End of Life Care

There is significant need for palliative and end of life care services and supports. As the population continues to age, chronic illness and advanced co-morbid conditions are becoming increasingly common. In particular:

- Over 14% of the LHIN's population are seniors aged 65 years and over. By 2016, seniors will account for 16% of the LHIN's population; by 2021 they will account for 18%.
- Chronic conditions account for 6 out of 10 deaths, 1 out of 5 acute hospital discharges, and 1 out of 4 acute hospital days for LHIN residents.
- Heart disease (including ischemic heart disease (IHD), congestive heart failure (CHF) and stroke) accounts for an additional 10% of all hospital days and 9% of all acute care discharges.

In achieving this aim, the Central East LHIN anticipates incremental measures of change over the next three years. By 2016, the Central East LHIN will increase the number of palliative patients who die at home by choice and spend 12,000 more days in their communities by 2016.

4.0 2013-2016 Strategic Plan

2013-2016 Strategic Plan

On May 28, 2013 TransCare Board of Directors and management team conducted a review and refresh of its Strategic Plan - including the Strategic Drivers; Mission, Vision and Values; the Balanced Scorecard and the Strategic Objectives. The 2013-2016 Strategic Plan was aligned with the 2013-2016 Central East LHIN's 2013-2016 Integrated Health Services Plan and client needs identified through the 2013 Environmental Scan . This will guide TransCare's service delivery over the next three years.

4.1 Strategic Drivers

Below are the 2013-2016 Strategic Drivers.

External or Internal	Strategic Driver	Opportunities
External	LHIN-wide Priorities	Target new services and service enhancements to which have the potential to impact: • Seniors • Vascular Health & related chronic disease (i.e. diabetes) • Mental Health & dementia • Palliative & end of life care
External	Demographics	Target high needs, under-served neighborhoods for affordable housing for seniors and community primary care and chronic disease management – especially diabetes and vascular disease.
External	Revenue threats	Threats: • Contracted services - dependent on contracts - limited sustainable funding • Decreasing donations (philanthropy) Focus on enhancing revenues through: • Fundraising • Partnerships • Expand Home Care Supplies to be growing, sustainable alternative revenue source Ensure tight cost control management.
Internal	Capability	Maintain commitment to quality and regulatory compliance. Enhance staff communication processes

4.2 Mission, Vision and Values

Mission

To provide quality community support services that improve the health and wellbeing of seniors and adults with disabilities and chronic conditions.

Vision

Clients can access a range of services to maintain healthy lifestyles.

Values

Accessible care.
A safe environment for client, staff and volunteers.
Client centered, best practice processes.
Volunteer spirit in the community.
Collaboration with other service providers.

4.3 Balanced Scorecard

TransCare will continue to utilize its balanced scored card through 2013-2016 and the four quadrants and focus will remain unchanged.

Quadrant	Focus
Client	Respond to population needs
Learning and Development	Foster a positive work life and volunteer experience
Internal Business Processes	Integrate and Strengthen Operations
Finance	Risk Management

4.4 Summary of TransCare's 2013-2016 Strategic Objectives

TransCare's 2013-2016 Strategic Objectives are summarized in the table below.

Quadrant	Strategic Objective	Focus
Client	1. Respond to population priority needs	Vascular Disease -and related chronic disease such as Diabetes
	2. Improve quality of care	Evaluating programs - quality assurance
	3. Improve client safety	Falls
Learning and Development: Foster a positive work life and volunteer experience	4. Provide staff training opportunities	Dementia and mental health
	5. Improve staff communications	Increase in consistent and regular communication of organizational progress and events.
Internal Business Processes: Integrate and Strengthen Operations	**6.** Continue to build operational platform and explore opportunities for growth	Focus on opportunities for new services/revenue streams.
Finance: Manage Risk	7. Control costs and reduce expenses	Operate with a balanced financial position.
	8. Continue to invest in quality and compliance	Agency is committed to building operational bench strength and will undergo accreditation in June 2014.
	9. Increase productive enterprise revenue	• Continue to build stronger partner relationships • Explore opportunities for alternate, non-traditional revenue sources.

4.5 Description of TransCare's 2013-2016 Strategic Objectives

Strategic Objective #1(Client): To respond to population priority needs

TransCare services a highly diverse population in the Scarborough region. This area is characterized by cultural diversity and has a relatively young population, only 5% of Scarborough residents are over the age of 65. However the percentage of seniors is expected to grow over the next three years. The Scarborough region, as a distinct area of the Central East LHIN, is expected to grow significantly and show similar growth patterns to the rest of the City of

Toronto. Scarborough Cliffs has the highest percentage of population with low income in the Central East LHIN (25% compared to a LHIN average of 15%), and a higher than average incidence of diabetes. Agincourt-Rouge is #1 in the rate of all common chronic disease, with the exception of obesity where it ranks #2. TransCare will align services to the CE LHIN IHSP's four strategic aims:

1. Seniors

Improving health care for seniors is a top priority of the Central East LHIN. The population of seniors is growing, and this group often has complex health care needs.

2. Vascular Health

Vascular diseases are a broad group of health conditions that affect almost all parts of the body. Vascular disease includes cardiovascular (heart disease), cerebrovascular (brain disease) including vascular dementia and stroke, and peripheral vascular disease which presents in other areas of the body such as kidneys, arms and legs. Some people are particularly high risk of developing vascular disease including:

- Seniors
- People with diabetes, reduced kidney function, heart disease, or who have experience a stroke
- Visible minorities

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- Persons with concurrent disorders or physical disabilities
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Palliative and end of life care is holistic in nature and aims to:

- Address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears
- Prepare for and manage self-determined life closure and the dying process
- Cope with loss and grief during the illness and bereavement

Strategic Objective #2 (Client): To improve quality of care

In order to continue to focus on delivering the best care possible to clients, TransCare recognizes the importance of identifying quality of care as a strategic objective. Tangible efforts aimed at investigating and tracking the quality of TransCare's major programs and services will continue to be a priority through 2013-2016. In addition, TransCare will focus its efforts in 2013-2014 in the preparation for Accreditation which is scheduled for June 2014.

Strategic Objective #3(Client): To improve client safety

Improving client safety has been identified as a key area of focus; involved staff members are universal in seeing this objective as a priority. Current best practices, safety plans, incident reporting structures and various initiatives aimed at preventing incidents (in particular falls) are all seen as specific areas for enhancement and reasons for identifying client safety as a strategic objective. A focus on client safety is in direct alignment with TransCare's accreditation expectations and goals.

Strategic Objective #4(Learning and Development): Provide staff training

TransCare, in recognizing the value of its staff, staff happiness and staff productivity, has clearly envisioned its overarching goal for the learning and development quadrant as the following: "fostering a positive work-life". Developing and maintaining staff teams that are confident, prepared and equipped to care for TransCare clients is crucial to both staff happiness, organizational success. TransCare aims to continue to create a standard of high quality training that directly translates into high quality care provided by professional and capable staff. Two areas of training that were identified as requiring a focus include dementia care and mental health education/training.

Strategic Objective #5(Learning and Development): Improve communication

TransCare has consistently maintained a satisfied workforce and shown a high level of job satisfaction across the organization. TransCare will continue to highlight this priority in its 2013-2016 strategic plan. In response to the recent staff survey conducted in May 2013, TransCare is committed to improvements in its communication processes to ensure staff "feel more connected" and are well informed. TransCare will focus on developing strategies to offer more consistent and regular communication.

Strategic Objective #6(Business Processes): Continue to build operational platform and explore new opportunities for growth

TransCare will continue to refine business processes to ensure that they are efficient and responsive to meet its future needs as TransCare explores new opportunities for growth in services and revenues.

Strategic Objective #7(Finance): Control costs and reduce expenses

As a non-profit organization operating in uncertain times, TransCare recognizes the need to operate with a balanced financial position. Tight cost management is important considering the various initiatives, potential cost changes and partnership/contract changes that the

organization may face in upcoming months and years. The agency's risk management plan will highlight key financial risks and actions to mitigate that risk.

Strategic Objective #8(Finance): Continue to invest in quality and compliance

TransCare recognizes there is a very real cost of quality, and risk management in terms of regulatory compliance. Further, the expectation of funders with respect to quality and reporting continues to increase, even though funding does not. TransCare will continue to build operational benchstrength and standards of excellence as it undergoes accreditation in June 2014.

Strategic Objective #9(Finance): Increase productive enterprise revenue

One of the key findings from the 2013 environmental scan includes the need to continue to explore opportunities for alternate and non-traditional revenue sources to complement existing and traditional funding sources. TransCare's current revenue sources and funding contracts may not be relied upon with absolute certainty; as well, relating to increasing revenue, client demand and a need for increased efficiency may suggest that additional service/care models may be preferred and more worthwhile over some current models.

TransCare
Community Support Services

STRATEGIC PLAN
2013-2016 Deliverables

GOAL	OBJECTIVES	PROGRAM INITIATIVES & RESPONSIBILITY	MEASURE	TARGET	2013	2014	2015
Client							
1.0 **Lead with a culture of client care**	1.1 Respond to population priority needs • Seniors • Vascular Disease -and related chronic disease such as Diabetes • Mental Health • Palliative and End of Life Care	Cluster program delivery - retirement community **(Donna & Gurprit)**	Extension of services	3 in 3 years	1	1	1
		Explore funding sources for expansion of services	Increased funding for services	2	1	1	
		Advocate for chronic disease services for seniors in their homes **(Odette, Donna, Gurprit)**	Expanded services focused for seniors focused on chronic disease	3 in 3 years	1	1	1
		Link patients to appropriate rehab support services (knees; hips). **(Odette, Donna, Gurprit)**	Patient communication plan	100%		YES	
		Increase funders awareness of the value and impact that PSWs provide in home-based services to expand services delivered by PSWs. **(Odette)**	Increased services delivered by PSWs	10%	2%	2%	1%
		Build capacity for palliative and end of life care services. **(Donna & Gurprit)**	Palliative and end of life service	Implemented	Assess need & Plan	Train & Implement	Evaluate
	1.2 Improve quality of care • Evaluating programs - quality assurance • Accreditation	Implement "screener" (RAI CHA) for clients in specific programs. **(Gurprit)**	RAI Screener tool implemented	100%	50%	80%	100%
		Implement regular care plan reassessments for high need clients and formalized process for case conferencing. **(Gurprit)**	Care plan reassessments on high need clients on regular basis and process for case conferencing	100%	ADP, SH	IHS, MOW	100% R
		Continue to advocate a one stop entry into home/supportive services for patients. **(Odette)**	Progress towards one stop entry with funders/service.	60%	20%	20%	20%
		Client satisfaction measurement. **(Odette)**	Overall client satisfaction survey results	>=4[2]	70%	80%	90%
		Preparation for Accreditation. **(All)**	Accredited by Accreditation Canada	Achieved		YES	
	1.3 Improve client safety • Falls	Falls prevention strategy and client safety plan. **(Donna & Gurprit)**	Prospective analysis CI projects	1/year	1	1	1
		Incident reporting and follow up **(All)**	Retrospective analysis CI projects	1/year	1	1	1
Learning & development							
2.0 **Foster a positive worklife and volunteer experience**	2.1 Provide training opportunities • Mental Health • Dementia	Provide staff training in palliative and end of life care. **(Donna & Gurprit)**	All staff trained	100%		YES	
		Provide staff training in mental health and addictions. **(Donna & Gurprit)**	All staff trained	100%			YES
	2.2 Improve communication	Develop and implement an action plan for the 2013 Staff Survey. **(All)**	Action plan developed and implemented	100%	Action Plan Developed	Action Plan Implemented	Action Plan Completed

GOAL	OBJECTIVES	PROGRAM INITIATIVES & RESPONSIBILITY	MEASURE	TARGET	2013	2014	2015
Internal business processes							
3.0 **Integrate and strengthen operations**	3.1 Continue to build operational platform to support growth.	Implement an Ethics Committee. **(All)**	Ethics Committee implemented	100%	Development	Implement	Evaluate
		Conduct a SWOT analysis on all services delivered by TransCare to identify opportunities for growth. **(All)**	Completed SWOT Analysis and identification of new/enhanced service delivery opportunities.	100%	SWOT	New Service proposals	New Service implemented
	3.2 Organizational Performance	Prepare for Accreditation. **(All)**	Accredited by Accreditation Canada	Achieved		YES	
	3.3 Focus on opportunities for new services/revenue streams.	Develop and implement an exercise service for patients delivered by PSWs. **(All)**	Exercise service implemented	100%	Development	Implement	Evaluate
		Develop a service focused on needs of mental health patients (Extreme Clean). **(All)**	Mental health service implemented	100%	Development	Implement	Evaluate
		Develop and implement a Palliative/End of Life service. **(All)**	Palliative Service implemented	100%	Development	Implement	Evaluate
Finance							
4.0 **Manage risk**	4.1 Control costs and reduce expenses	Quality & risk plan **(Sam)**	$ variance	<=5%	5%	5%	5%
	4.2 Continue to invest in quality and compliance	Accreditation process. **(All)**	Fees; training; management and staff time	vs 2012	=2012	(.50)2012	(.20) 2012
		Conduct SWOT/Gap Analysis on Health and safety program	Identification of Health and Safety Program enhancement	100%	Gap Analysis	Enhancement	Evaluation
		Emergency and Fire plan **(Sam)**	Annual refresh and four drills	100%	100%	100%	100%
	4.3 Increase productive enterprise revenue	Home Supplies **(Sam)**	3-year revenue increase over year-end 2012	20%	5%	5%	10%
		New ventures identified through service SWOT**(All)**	Launch new business initiatives	1	Launch	rev>=cost	rev>cost

Ref: TransCare Strategic Plan 2013-2016 [1] Program names: ADP = Adult Day Program; SH = Supportive Housing; MOW = Meals on Wheels; IHS = In-Home Services [2] Assuming a 5-point Likert scale Rev Date: June 14, 2013