2020-2022 Strategic Plan

Strategic Direction *Quadruple Aim	Outcome	Priority	Initiatives	Tactics
Better Patient & Population Outcomes *System Transformation	**Access to Care**	Minimize barriers to access & service	1. Reduce wait times	• Program Redesign based on stepped care model (ICM, EI, Bereavement, Concurrent) • Focused care based on improved assessment tools and goal setting
			2. Improve transitions in care	• Acute care to Community Programs • After care/Rapid re-entry • Transfers from GMHOT • Referrals to PC from Coordinated Access
			3. Redesign CHC patient flow	• Same day/next day appointments
		Health equity & social responsibility	1. Focus on special population needs	• Newcomers, Agricultural workers, Substance-use disorders
			2. Indigenous Healthcare	• ICS training for all staff
	System Navigation	Lead collaborative initiatives to build an integrated seamless system of MH&A services	1. Single point of access expansion	• Move addictions intake & assessment to TSC • Streamline referral process • Maximize TSC Programs • Enhance “By Names” Mtg. • Housing model change
			2. Maximize Community MH&A funding	• Implement Aylmer Safe Beds • Dual Diagnosis • Implement permanent model for MOST

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				• Determine Peer Support Model (incl. new Vocational Maintenance model)
			3. Integration of MH&A with Primary Care	• Expand Team Care model • Leverage Health Link model to engage solo practitioners • Implement Depression workshop
			4. Improved access to care coordination for CHC clients	• Obtain embedded LHIN clinical care coordinator(s) • Creation of MH&A Pharmacy Collaboration
			5. Team Care	• Create an internal pathway to connect TCC clients with MH&A services to improve transitions of care
Better client, family, caregiver experience *Client/Service effectiveness	**Effective & Appropriate**	Highest quality, people & community centered care	1. Include clients as partners in their care	• Continue recovery orientation Implementation • Commitment to co-design • Develop supports for families
			2. Re-Launch of the CHC program	• Rebranding and public re-grand opening of the CHC
	Health-related quality of life improved	Community vitality & belonging	1. Increase mental health awareness through education, advocacy & community engagement	• Continue to grow the Sole Focus Project (e.g. other branches, zero suicide program, responsible use of substances) • Improve coordination of MH promotion services across WE (in partnership with WEPHU)

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			2. Social prescribing	• Embed in CHC operations • Partner with Hospice and LAF to connect clients with social supports
Better value & efficiency *Organizational Capacity	**System resources optimized**	Demonstrate value for money	1. Utilize evidence-informed research & data to measure program outcomes 2. Implement Right-sizing Project 3. Liaise with partners to determine best utilization of resources	• ICM review • Staff develop/monitor Program scorecards • Benchmark against other high performance org. • Align new staffing enhancements with strategic layoffs to help address near-term structural deficit • Continue work with other providers to deliver bereavement services of varying intensity • Develop integrated housing supports
Better Provider experience *Community Engagement	**Confidence in the system**	Ensure Programs and Services are responsive to the evolving needs of the community	1. Engage in ongoing collaborative planning with partners 2. Continue to develop and implement Recovery Orientation	• OHT Planning & SRAT • Participate in developing a WE Addictions system • Offer CMHA MH promotion activities to other Primary Care Providers & WEPHU • Enhance opportunities for clients and families to participate in program development • Introduce peer support workers
	Provider health is supported	Invest in our people	1. Retool Project	• Investment in strategic professional development for leadership and staff

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		Commitment to healthy workplace	1. Psychological Health & Safety Standard	• Develop/implement work plan based on 2019 survey results