Erie St. Clair **LHIN**
RLISS d'Érié St. Clair
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Erie St. Clair
Local Health Integration Network

Annual Business Plan
2010/11

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Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

Annual Business Plan 2010/11

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1.0 Context

1.1 Mandate and Strategic Directions of the Erie St. Clair LHIN

The Erie St. Clair LHIN's Health Care Vision:

"A health care system that helps people to stay healthy, delivers good care to them when they are sick and will be there for their children and grandchildren."

The Erie St. Clair LHIN's mandate is to create a local health care system that:

- Provides a seamless experience for the patient
- Leads to better matches between the services provided and the multiple needs of patients and families
- Makes effective and efficient use of the resources and capacity within the system

The Erie St. Clair LHIN believes the health care system needs to be:

- Focused on the patient, of high quality, publicly funded, sustainable, universally accessible and results-based
- Operated in a transparent manner with honesty and integrity by being accountable to our community
- Coordinated with our health care providers working in cooperation with each other, using best practices and striving for excellence

The recently released Integrated Health Service Plan (IHSP) is the local strategic plan intended to integrate and improve outcomes of the local health system. The IHSP, which is consistent with the above vision and strategic directions of the Ministry of Health and Long-Term Care (MOHLTC), communicate the priority areas that will guide LHIN activities over the next three years (from Fiscal Years 2010 to 2012).

1.2 Overview of the Erie St. Clair LHIN's Current and Forthcoming Programs / Activities

In the first three years of activity, the Erie St. Clair LHIN's perception and activities were shaped through the initial Strategic Directions of the inaugural IHSP.

- Chronic Disease Management
- Reduce Dependence on Hospital Services
- Supporting People at Home
- Back Office/Administration Integration
- System Navigation
- Health Human Resources (HHR)
- Health Promotion/Illness Prevention
- Timely Access to Care

These directions became the foundation for our examination of funding initiatives, enhancements, fiscal recoveries and service coordination. The Erie St. Clair LHIN remained strategic in its activities through the development of networks, task orientated committees and governance advisory bodies that would guide the receipt of focused feedback and advance action-orientated initiatives.

As part of the activity framework used for the first three years of operation, the Erie St. Clair LHIN examined the context of service delivery on a county-by-county basis in order to:

- Understand the nature of the demand, supply and distribution of services
- Focus on areas of greatest unmet need and other disparities
- Understand the nature of high risk populations
- Understand unique geographic characteristics and the impact of geography on core service delivery and outcomes
- Develop consideration of known barriers and challenges
- Consider the availability of resources
- Partner with other interested organizations
- Understand primary care weaknesses and opportunities

Using the above context and experience as a baseline, the Erie St. Clair LHIN's main activity and actions were directed toward the following initiatives:

- Alternate Level of Care (ALC) improvements in Windsor/Essex (W/E) and Sarnia/Lambton (S/L)
- An examination of the potentially vulnerable and unsustainable small community Emergency Departments (EDs)
- A planning exercise, *StrategiCare;* established with the goal of examining the potential for enhanced regional integration of programs in Windsor/Essex hospitals
- An endeavour to promote the integration of the local Essex Community Health Centres (CHCs) for a more sustainable organization and platform for future enhancements
- An endeavour toward local Canadian Mental Health Association (CMHA) integration with the view of a developed standardized, efficient, and an increasingly effective LHIN-wide organization

In summary, the following four main system dimensions were the focus of Erie St. Clair LHIN activities intended to enable system improvements:

- <u>Improved Access</u>
  - The Erie St. Clair LHIN created long-term care (LTC), Complex Continuing Care (CCC) and other bed-based alternatives to sustain acute care services
  - The Erie St. Clair LHIN invested widely in meals enhancements to enable elderly to stay home
  - The Erie St. Clair LHIN invested in transportation to enable elderly to decrease incidence of social isolation and enable connection to health care services
  - The creation of an 'End of Life' team

- <u>Improved Quality</u>
  - Activities aimed at implementing best practices through the investment in ED and Critical Care Lead
  - The Erie St. Clair LHIN began the examination of diagnostic and pharmacy services
  - Investments in enabling programming for visually impaired residents through agencies such as the Canadian National Institute for the Blind (CNIB) were achieved
  - Investments in home palliative care services were achieved
  - Investments in standardized utilization tools were achieved
  - Investments in Geriatric Emergency Medicine (GEM) Nurses and Community Care Access Centre (CCAC) Case Managers in the ED

- Cost Effectiveness
  - Support and investment in Lean/Six Sigma initiatives
  - Participation in the *FLO Collaborative*
  - CCAC Transformational Operational Review
  - Timely recoveries and subsequent transfers of funding to organization with strategic and operational needs and pressures
  - Developing Earned Value Management to monitor all newly-funded projects
- Coordination
  - Windsor/Essex Hospitals enhanced integration initiatives
  - Windsor/Essex CHC integration
  - Erie St. Clair LHIN CMHA integration initiative

Planning Activities for the Next Fiscal Year

In the coming year the Erie St. Clair LHIN will focus on the following 11 considerations:

1. Tier II and Tier III Mental Health Divestments
2. An examination of the rehabilitation system
3. The continued development and refinement of Subacute Teams (Palliative and Chronic Medical)
4. The investment of LTC beds
5. The development and integration of local Community Health Centres (CHCs)
6. The integration of the local Canadian Mental Health Associations (CMHAs)
7. The continued integration of hospital services
8. Enhancements in Primary Care – including Diabetes
9. A clinical services review
10. Minimizing community impact on care by coordinating hospital services with community providers
11. Strategic alignment of actions that will drive improved health care outcomes for Francophone and Aboriginal communities.

1.3 Assessment of Issues Facing the Erie St. Clair LHIN

Future Demographics, Projections and Trends:

The Erie St. Clair population increase is growing at a slower rate, is more rural and has less population density than the population of Ontario as a whole. Erie St. Clair has a growing senior population and a decreasing younger population (i.e. 0-14 and 25-49 age groups), leading to a higher dependency ratio as compared to the provincial comparator. Although Erie St. Clair continues to be less diverse than the province, it will be important to consider the unique health care related needs of the Francophone and Aboriginal residents.

Economic Challenges:

The economic challenges experienced in 2008 and 2009 have resulted in a disproportionately high unemployment rate compared to the provincial and notional average. This may be exacerbated by the fact that the population of Erie St. Clair is less formally educated compared to the province as a whole. It is anticipated that the economic situation will result in an increase in the proportion of the population considered low income and will generate increased pressures on social, mental health and addictions services.

Health Status and Chronic Conditions:

The residents of Erie St. Clair perceive that they are healthier than they actually are. Erie St. Clair residents have a lower life expectancy rate, a higher age-standardized mortality rate and a higher potential years of life lost rate compared to the province. The Erie St. Clair population also has more chronic disease than Ontarians overall and, based on the prevalence of risk factors (smoking, alcohol misuse, physical inactivity, poor diet and obesity), are at risk of developing more chronic conditions, especially Diabetes. There is a need to consider how cancer, diseases of the circulatory system, diseases of the nervous system and mental health conditions can be managed more effectively to reduce associated mortality and morbidity.

Assessment of Service Utilization:

Opportunities exist to improve both access and appropriate utilization of EDs across Erie St. Clair. Although, the Erie St. Clair LHIN performed just above provincial targets for ED length of stay (LOS), there are specific opportunities within the region to decrease both the low acuity and high acuity LOS in hospital EDs. For the small hospitals across the Erie St. Clair LHIN, additional pressures are associated with the type of ED cases presenting in the departments. Specifically, in 2007/08, non-urgent and deferrable cases represented over 70% of the total visits to small EDs. Primary care alternatives need to be increased if this volume is to be reduced.

From a patient flow perspective, providing care at the right place and at the right time continues to be a system challenge across the Erie St. Clair LHIN. Regional opportunities exist to address the growing percentage of ALC days. In 2008/09, across the Erie St. Clair LHIN, the operational and financial impacts of this system challenge were clearly evident. Within our hospitals, approximately 11% of acute care beds, 34% of CCC beds and 7% of rehabilitation beds were occupied by patients requiring a different level of care in a different setting. The notional system cost associated with this ALC issue is approximately $38 million (as of 2009/10) and represents 228 persons in hospital beds (of all types) who do not belong there.

Although by 2011 additional LTC beds will be in place across the Erie St. Clair LHIN, the challenges associated with the demand for LTC and utilization of other aging at home supports still need to be addressed. In 2008/09, the median time to long-term care placement exceeded the system target . With a growing senior population, opportunities exist to ensure that Erie St. Clair residents have access to the most appropriate services and that system improvements are made in the coordination and utilization of all aging at home supports (e.g. Long-Term Care Homes, retirement homes, home with community support services).

With the mounting economic challenges, it is important that the Erie St. Clair LHIN address opportunities to improve access to mental health and addictions services. The system trends are clear both in our hospitals and in the community. In our hospitals, the majority of mental health and addictions Emergency Department visits and inpatient cases are associated with several key diagnoses – neuroses, stress related disorders, mood disorders, mental and behavioral disorders due to psychoactive substance use and schizophrenia. In the community, mental health and addictions programs such as problem gambling, substance abuse, concurrent disorder, early intervention and crisis, have all seen an increase in the number of individuals seeking support.

2.0 Core Content - Integrated Health Services Priorities and Other Support Areas

For the 2010-2013 IHSP, the overall direction has moved from being primarily a strategic, conceptually-based plan to an action focused and results-based planning document.

The priorities are derived from seven Strategic Aims that form the basis for the Erie St. Clair LHIN achieving its mission. The seven Strategic Aims are:

1. Developing alternatives to Emergency Department care
2. Ensuring appropriate access to surgical, Intensive Care Unit (ICU) and medicine beds
3. Ensuring appropriate access to LTC supports closer to home
4. Reducing the impact of Diabetes
5. Reducing the impact of mental health and addictions
6. Addressing the impact of chronic disease
7. Improving system performance through maximizing the current strengths of the system

The five confirmed IHSP Strategic Directions for 2010–2013 are (details for each area are in the 2010-2013 IHSP):

- *Improved outcomes in ED care*
- *Improved outcomes in ALC*
- *Improved outcomes in Diabetes management (chronic disease management)*
- *Improved outcomes in mental health and addictions*
- *Improved outcomes in rehabilitation care and interventions*

Four enabling strategic projects are also planned for the three year period:

- *Diagnostic imaging, laboratory and pharmacy services planning*
- *Complex Continuing Care program standardization planning*
- *Development of a system-wide clinical services plan*
- *Health Human Resource planning*

In the establishment of the above activities, the Erie St. Clair LHIN initiated a detailed process that included consideration of the new Ministry/LHIN Accountability Agreement (MLAA) performance indicators, MOHLTC priorities, Community Engagement findings, Erie St. Clair LHIN Board input, and a comprehensive review of the data including population characteristics, population health, and an assessment of service resources and programs. The next section of this report will focus on the five confirmed IHSP Strategic Directions.

2.1 Emergency Department

TEMPLATE A: **PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY**
Integrated Health Services Priority:
Emergency Department
IHSP Priority Description:
In the Erie St. Clair LHIN ED services are available across all five main hospitals and at two rural hospital satellite sites. Like many hospital EDs they are facing a variety of planning issues, for example: • Recruitment and retention of qualified staff (e.g. Registered Nurses (RNs), Physician, Respiratory Therapists) • Increased use of the ED in underserviced areas • Challenge of providing care to special needs populations (violent, multi-need clients)

- Need for ongoing staff education
- Physical space needs
- Patient movement through system (bed utilization issues)
- Inter-facility transfers
- Managing sick time and overtime costs
- Management of the patients who frequently attend the ED (repeat visits)
- Succession planning for managers and front line staff
- Accessibility to specialty services at tertiary centers outside of LHIN area
- Access to Long-Term Care Home (LTCH) beds
- Lack of community resources in each county

Current Status

In the Erie St. Clair LHIN (and Ontario generally), the ED has all too often become the default portal through which many patients gain access to health care. The resulting ED congestion is a symptom of how the entire health system is performing, telling us how well our family health care, community care, mental health, and hospital programs are working to serve patients. Inappropriate use of the ED is essentially a waste of an expensive, limited resource. Information obtained from Ontario's ED Reporting System data indicated the following in 2009:

- Nine of 10 people with complex conditions requiring more time for diagnosis, treatment or admission to a hospital bed spent up to 14.6 hours in the ED - this is well above the provincial access target of eight hours

- Nine of 10 people with minor or uncomplicated conditions requiring less time for diagnosis, treatment and observation spent up to 4.8 hours in the ED. This is slightly higher than the provincial access target of four hours

In Erie St. Clair, the high volumes of non-urgent (CTAS 4) (CTAS: Canadian Triage and Acuity Scale) and deferrable (CTAS 5) visits to EDs of small hospitals reflect a lack of timely access to primary care services. For instance, the top conditions associated with ED visits that could be managed elsewhere (i.e. visits for conditions that could be treated in alternative primary care settings) are: upper respiratory infections, bladder infections, ear infections and eye infections. Moreover, in Sarnia/Lambton (S/L) and Chatham-Kent (C-K), the rate of ED visits that could be managed elsewhere is more than double the overall rate across the Erie St. Clair LHIN.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

ED Overall Goals:

- Establish stream-lined mental health services that are seamless between community providers and hospital

- Enhanced referral for unattached patients to existing primary care providers
- Enhanced adequate after-hours / weekend / holiday coverage by primary care practitioners
- Improved access to primary care for episodic care and ongoing care
- Improved access to primary care assessments in LTCHs
- Increased access to ICU / Coronary Care Unit (CCU) beds
- Improved response rate to lower acuity patients within the ED setting
- Increased patient flow from ED registration to inpatient admission
- Reduced ED visits and re-admission for chronic disease management patients
- Determine appropriate care pathway for patients with known community-acquired infections

The action plans will focus on the following priority populations within the ED:

- Admitted patients awaiting transfer from ED to acute beds
- Patients returning to ED for follow up (blood work, imaging)
- Patients referred to ED due to lack of urgent testing/consultation in the community or due to lack of after-hours primary care coverage
- High intensity of care patients requiring increased staffing and treatment resources
- Patients with CTAS levels 3, 4 & 5
- Patients with wound care/soft tissue infections
- Patients with known Methicillin-Resistant Staphylococcus Aureus (MRSA), Vanomycin-Resistant Enterococci (VRE) or who are infection control risks
- Patients requiring stabilization of their acute mental health issues
- Substance use/abuse patients

Consistency with Government Priorities:

The above goals are consistent with the government's priority to improve access to ED care by reducing wait times and the avoidable use of emergency services for patients who could receive care elsewhere.

Action Plans/Interventions

Action Plans/ Interventions:	% Completion by Year		
	2010-11	2011-12	2012-13
Develop strategies to better manage the assessment and admission process for mental health patients	50%	50%	-
Expand the ED hours of Nurse Practitioner (NP) / Physician Assistant (PA) coverage for treat and release patients	50%	50%	-
Develop a referral process to primary care initiated by the ED	75%	25%	-

Standardization of GEM RN role to avoid unnecessary admission	90%	10%	-
Improve ED throughput	30%	40%	30%
Continue/expand LEAN strategies	33%	33%	33%
Expand hours of operation for ED Fast Track utilizing Physicians and NPs (C-K)	40%	40%	20%
Develop a communication and education strategy for community and wait room patients to offer alternatives to ED	33%	33%	33%
Develop strategy for patients with known infectious diseases	60%	40%	-
Develop a primary care path for congestive heart failure (CHF) / chronic obstructive pulmonary disease (COPD)	50%	40%	10%
Develop mechanisms so that unattached patients (CHF / COPD) are auto-referred to NP	50%	50%	-

Expected Impacts of Key Action Items

- Reduce wait times by 10% for priority patients (e.g. mental health, CTAS 4 & 5)
- Reduce admitted patient holds in the ED by 35%
- Reduce left-without-being-seen incidents by 3-5%
- Reduction in low acuity ED visits by 10,000 visits
- Improved health promotion and illness prevention services to prevent need for re-admission by 5%
- Increase length of time between acute visits to ED for patients with CHF / COPD by 25%
- Decrease hospital acute LOS by 12 hours for patients with CHF/ COPD
- Increase utilization of community support services by 10%
- Improve patient discharge screening risk assessment completion to 100%
- Increase discharge follow-up for CHF / COPD patients by 50%

What are the risks/barriers to successful implementation?

- Lack of access to primary care
- Growing elderly (aging) population
- Continued higher than provincial rates of hospitalization
- Continued higher than provincial rates of chronic conditions (e.g. arthritis, asthma, Diabetes, hypertension, mood disorder, anxiety disorder) driving up ED volumes
- Reduction of patient services in-hospital to meet balanced budget requirements
- Shortages of certain HHR
- Lack of willingness of organizations to work together to resolve ‘system’ issues
- Limited alternative options to ED in community due to funding constraints
- Lack of access to health care services for rural populations
- High unemployment rate that is expected to continue

2.2 Alternate Level of Care

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Alternate Level of Care

IHSP Priority Description:

In the Erie St. Clair LHIN ALC patients have impacted all five hospitals. Like many hospitals, they are facing a variety of operational issues related to the ALC issue, including:

- Higher than normal occupancy rate of ALC patients in acute care beds awaiting placement in the winter months
- Cancellation of surgeries and gridlock in the ED as a result of the ALC issue
- Lack of ability to transfer ALC patients out of CCC beds to other services, creates ALC in CCC beds
- Higher occupancy rates impact on ED holds and consequently timely hospital admissions for patients requiring inpatient care, this often results in ambulances unable to off-load their patients (rise in code 7's)
- There is a need to develop chronic disease management strategies aimed at reducing hospital admissions for targeted group
- Systemic data collection needs to improve the ability to capture real time ALC pressure points within the hospital, CCAC and community services system

Current Status

Every day, people in Erie St. Clair are receiving care in the wrong place. From 2005/06 to 2007/08, the number of ALC days increased by 30%. In 2008/09, across the Erie St. Clair LHIN, approximately 11% of acute care beds, 34% of CCC beds and 7.5% of rehabilitation beds were occupied by ALC patients. For patients hospitalized with an ambulatory care sensitive conditions (conditions where access to appropriate ambulatory care prevents or reduces the need for admission to a hospital), 90% of the total ALC days across the Erie St. Clair LHIN were associated with three conditions - congestive heart failure, chronic obstructive pulmonary disease and Diabetes.

Residents in the Erie St. Clair LHIN are waiting longer for a bed in LTCH. In 2008/09, the median time to LTC placement well exceeded the Erie St. Clair LHIN performance target of 53 days. Specifically, Sarnia/Lambton and Windsor/Essex had the highest median time to placement (averaging 124 days and 104 days respectively).

Further, patients are occupying ED space because there are no available acute care beds. In April 2009, Ontario hospitals estimated that approximately 18% of acute care beds were occupied by ALC patients (Ontario Hospital Association 2009).

Finally, the crux of the issue - community services - such as home care, LTC and other services including rehabilitation services - need to be prioritized and financed in such a manner that they move ALC patients out of the acute care setting. In turn, the above will increase the availability of acute care beds for patients waiting in the ED to be hospitalized.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

ALC Overall Goals:

- Increased community knowledge of hospital access implications and impact of ALC patients on emergent care processes
- Improved access to acute care capacity (medical, surgical and critical care) through process improvement
- Ensuring appropriate community care and affordable discharge options (including end of life care)
- Maximize functional conditioning of patients over the age of 60
- Improve ED wait times for CTAS 1, 2, and 3 levels
- Improved time to LTCH placement for inpatients and community
- Develop a fully implemented falls prevention program within the LTC community
- Creation of effective standardized educational programs for seniors with respect to services, supports and programs available to assist them in either: a) staying at home, b) transitioning to Rest/ Retirement Home or c) the transition to LTC
- Reduce inpatient hospital fall rates for all patient units
- Reduction in acute length of stay for chronic disease populations

The action plans will focus on the following priority populations for ALC:

- Patients admitted in Complex Continuing Care
- Geriatric mental health clients
- Post -acute (convalescent) clients
- Rehabilitation (long and short-term) clients
- Patients with behavioural problems
- Lower income patients
- Bariatric patients
- Patients with pre-existing infective disease

- Hospitalized (acute and post-acute medicine and surgical) patients that could functionally benefit from an ambulation intervention
- Frequently readmitted chronic disease patients (CHF, COPD)
- Patients positive for MRSA or VRE or have been identified in the previous year
- Elderly / seniors with care needs in excess of two hours / day, but who could still remain in their home with increased care

Consistency with Government Priorities:

The above goals are consistent with the government's priority to improve access to hospital care by improving patient flow, increasing access to hospital beds, and reducing the amount of time patients spend in ALC beds.

Action Plans/Interventions

Action Plans/ Interventions:	% Completion by Year		
	2010-11	2011-12	2012-13
Build on success of existing Temporary Care Program (TCP) and expand LHIN-wide	50%	50%	-
Review Compliance Branch issues and co-ordinate with potential rest / retirement homes to ensure patient safety regarding TCP	100%	-	-
Initiate an education planning group to develop marketing / educational initiatives to mitigate ALC risks	30%	20%	20%
Expand in-hospital ambulation programs LHIN-wide	75%	25%	-
Develop a marketing strategy related to bed utilization and ALC problem (and resolution)	30%	40%	30%
Develop a comprehensive falls prevention program LHIN-wide	30%	30%	30%
Develop key messages / market plan to highlight services offered by each long-term care home (video format)	80%	20%	-
Expand NP program – to cover nursing homes (with goal of preventing ED visits)	20%	20%	20%

Expected Impacts of Key Action Items
• Reduce ALC days by 5% in acute care • Increase percentage of patients returning to pre-hospital environment by 5% • Decrease the percentage of patients placed in LTC facility post acute by 5% • Ensure 75% of all appropriate patients on target units receive ambulation to avoid de-conditioning • Improved knowledge / satisfaction of patients and their families • Maintain percentage of ALC in hospital at or below MLAA negotiated target of 9% • Increased baseline access to acute, CCC and rehab bed capacity • Significant increase in the utilization of services for the senior population • 5% reduction of falls within LTC homes • Reduce average length of stay (ALOS) by 7% on all units providing targeted patient ambulation interventions
What are the risks/barriers to successful implementation?
• Delay in new LTC Home beds construction schedule • Continued shortage of appropriate LTC Home beds to accommodate patients' needs • Inability to ensure that patients are moved (in a timely manner) to the most appropriate care setting • Lack of disease management strategies for persons with a chronic illness aimed at reducing hospital admissions for these groups • Inability of home care to shift the focus toward preventing hospital admissions rather than the current focus on facilitating hospital discharges (more proactive verses reactive / crisis management) • Systemic data collection processes unable to capture real time ALC pressure points within the hospital system • Lack of early screening / procedures within the hospital for identification of high risk cases for acquiring ALC status that considers input from the wider community health care system • No resources to support extra training and staffing resources for LTC Homes to better manage "hard to place populations" • Inability to identify and apply best practices in discharge planning across the LHIN area • Inability to develop a single coordination mechanism for ALC patients and to establish an integrated wait list management structure • Growing elderly (aging) population • Inability to balance the demands of patients (choice), and the needs of acute care and non-acute services to ensure that reasonable access is maintained

2.3 Diabetes Care

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Diabetes Care

IHSP Priority Description:

In total, Erie St. Clair LHIN is home to 10 Diabetes providers. A further breakdown shows that just under half (4 or 40%) are located in W/E, with (3 or 30%) in S/L and (2 or 20%) based in C-K. With the exception of the Chatham-Kent Family Health Team and Erie St. Clair Community Care Access Centre (ESC CCAC), four of the diabetes providers are based out of CHCs, while four are based in hospitals. Paediatric care for diabetic children, youth and their families is provided in hospital settings namely, Bluewater Health (BWH), Chatham-Kent Health Alliance (CKHA) and Windsor Regional Hospital (WRH). Many of the diabetes providers are facing a variety of issues related to care and service delivery, for example:

- Lack of consistent approach to diabetes management by physicians and professionals
- Limited access to and availability of specialists (Endocrinologist) and family physicians
- Access to social work and / or Psychologist, Dietitian, Chiropodist, Recreational Specialists
- Treating special needs populations (e.g. Aboriginals, people with a Mental Illness, those with Developmental Disabilities, the blind, the deaf)
- Increasing medication costs
- Salary variations across programs between hospitals and community
- Lack of education / standard knowledge of Diabetes across primary care providers and clients
- Need a greater emphasis on prevention and self management strategies
- Physical space limitations at sites
- Coordination across the sector / other teams in the community (Family Health Teams, CHCs etc)

Current Status

Compared to provincial rates, the Erie St. Clair population has higher prevalence rates for Diabetes.

Furthermore, the prevalence of unhealthy behaviours such as smoking, alcohol misuse, physical inactivity and poor diet, places Erie St. Clair residents at higher risk for conditions such as diabetes, circulatory diseases, and heart disease.

In 2005, approximately 36,000 residents of Erie St. Clair had a diagnosis of Diabetes, which is 14% higher than the province of Ontario average. During the same year, there were approximately 800 acute hospital visits (9% higher perception than the province) and 1,500 ED

visits (7% higher perception than the province) by Diabetes patients. More importantly, looking ahead at population health trends, Erie St. Clair residents will continue to be at a high risk for developing Diabetes and other associated chronic conditions.

Finally, key reasons for chronic disease exhibiting poorer outcomes in the Erie St. Clair LHIN are:

- Lack of information technology, to monitor and track patient care to best practices
- Lack of patient education and self management programming
- Cost, especially for the working poor who cannot afford medications
- Poor lifestyle choices
- Lack of timely access to primary care

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

Diabetes Care Overall Goals:

- Improved / stream-lined coordination across service providers (vertical and horizontal integration) within LHIN sub regions
- Improved system navigation within LHIN sub regions
- Reduce avoidable ED visits for Diabetes
- Improved, shared and standardized education programming (e.g. best-practice, on-going, professional development)
- Expand existing care capacity (primary care specifically)
- Optimize wait times for Diabetes services
- Centralized Intake for newly diagnosed patients
- Improved inter-professional collaboration and evidence-based practice for Diabetes interventions
- Improved and timely access to specialized consultations
- Increased compliance of health care practitioners with existing clinical practice guidelines
- Improved screening of identified higher risk populations

The action plans will focus on the following priority populations for people in need of Diabetes care:

- Individuals with Diabetes who do not have a primary care provider
- Seniors (65+) with Diabetes
- Women with gestational Diabetes
- Individuals who suffer from mental illness and Diabetes
- First Nations people with Diabetes
- Ethnic population who have Diabetes
- Rural or geographically isolated people with Diabetes who experience transportation challenges
- Pediatric individuals with Diabetes

Consistency with Government Priorities:

The above goals are consistent with the Ontario's Diabetes Strategy that will improve access to prevention programs and team-based care.

Action Plans/Interventions

Action Plans/ Interventions:	% Completion by Year		
	2010-11	2011-12	2012-13
Acquire necessary funds to establish new Diabetes education program team(s) across the ESC LHIN	90%	10%	-
Standardize job description, advertise, and hire team staff, purchase equipment for Diabetes Team(s)	90%	10%	-
Begin to initiate regional coordination centre (RCC) for Diabetes in Windsor (to serve the entire ESC LHIN)	10%	20%	30%
Explore opportunities to use tele-health / Ontario Telemedicine Network for specialized consultation	20%	20%	20%
Establish timelines and plan for divestment of Diabetes education program to community from hospital (C-K)	50%	50%	-
Investigate issues such as wage parity for professionals (across hospital and community)	10%	10%	10%
Consolidate back office operations	10%	20%	20%
Advance central intake, 1-800 number	10%	10%	30%
Work with regional Diabetes Education Programs (DEP) to share best practice tools related to client satisfaction / confidence surveys	20%	30%	40%
Explore 'one-stop' multi-disciplinary Diabetes model for the ESC LHIN	20%	20%	20%
Advance performance targets and metrics for the Diabetes sector	80%	20%	-

Expected Impacts of Key Action Items
• Expanded Diabetes Team to serve 100-200 new clients in the first year (team expected to serve up to 1000 clients within three years) • Better sharing of Diabetes resources among DEPs within the region • Improved clinical outcomes / process measures • 90% of patients with Diabetes having a foot exam completed annually • 90% of patients with Diabetes having their eye exam completed every 1-2 years • 80% of Diabetes clients reporting satisfaction with DEP services • 20-50% of Diabetes clients reporting improved confidence and ability to self-care for Diabetes management • Approximately 1-2% reduction in ED visits (depending on nature of visits) • Approximate 1-2% reduction in LOS for those hospitalized with Diabetes-related complications
What are the risks/barriers to successful implementation?
• Funding to support new service expansion • Lack of consistent approach to Diabetes management by physicians and professionals / mixed messages – Physicians, CHCs, Hospitals / not all physicians on the "same page" • Access / availability of Specialists (Endocrinologist) & Family Physicians • Access - Distribution of Diabetes Teams • Accessibility to clinic (i.e. parking fees, registration process at Ambulatory Care can be barriers) • Lack of HHR (Social Work and / or Psychologist, Dietitian) • Ability to effectively address the needs of priority populations – Aboriginals, mentally ill • Rising medication costs • Continued salary variations across programs (especially between hospital and community) • Lack of prevention and self management strategies • Lack of awareness of prevention strategies • Space limitations at current sites (e.g. CHC) • Lack of standardized community care plan for people with Diabetes • Confusing booking / referral processes within the Diabetes sector

2.4 Mental Health and Addictions

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Mental Health and Addictions

IHSP Priority Description:

Mental health services, broadly defined, comprise a mix of health, social, vocational, recreational, volunteer, occupational therapy, and educational services, as well as housing and income support. They include a range of activities and objectives ranging from mental health promotion and the prevention of mental health problems to the treatment of acute psychiatric disorders and the support and rehabilitation of persons with severe and persistent psychiatric disorders and disabilities. Addiction services include assessment and referral, day or evening programs, detoxification, residential programs and recovery homes. Ontario's hospitals also offer substance abuse treatment. In Erie St. Clair, mental health and addiction services are provided both within hospital and across the community sector. Many of the providers in this area are facing a variety of planning issues related to care and service delivery, for example:

- Funding sustainability and stabilization
- Wage harmonization across sectors from hospital to community
- Recruitment and retention / staffing
- Need for additional safe, stable and affordable residential / housing options
- Continued mental health and addictions stigma issues
- Shortage of physicians and Psychiatrists (access issues)
- Access and wait time issues for certain areas / services (e.g. early intervention, withdrawal management)
- Need for additional funding / additional community capacity / both in mental health and addictions
- Capital / space issues across a number of organizations
- Access to primary care for priority populations
- Need for more reliable / timely data to measure outcomes and ensure consistency with provincial benchmarks
- Need to complete the Tier II and Tier III divestment process
- Continued separation in client care (silos) between mental health and addictions
- Lack of training opportunities

Current Status

The MOHLTC and local communities have been planning for the reform of the mental health and addictions systems for approximately 10 years.

Re-occurring themes and issues include that:

- The focus now must be on implementing reform
- There is a need for increased funding and appropriate transitional funding
- Services for people with a mental illness and / or addiction need to be better coordinated and integrated at the local level
- More support is needed for a coordinated and comprehensive mental health service system, which provides a continuum of care
- Consumers need the best available access to services and medications
- There is a need to focus on accountability, outcome measures, evidence-based research, and evaluation
- A service delivery model for mental health and addictions services in Ontario must be designed, along with a supporting policy framework
- Consumer / survivors and their families need meaningful participation in the reform process
- Ontario's diverse population must be addressed during the reform process
- There needs to be a plan for the change management process
- An effort must be made to improve education, training, and public awareness

Further, the Erie St. Clair LHIN region has been extremely hard hit in the economic downturn. Mental health and addictions, areas traditionally underserviced, are being significantly impacted in the ED, acute setting and community resources as a result of the current economy. Descriptive data reveals:

- *In the ED*, 77% of the mental health and addictions visits are associated with the following three diagnoses: neuroses, stress related and somatoform disorders; mood disorders; and mental and behavioral disorders due to psychoactive substance use
- *In the acute setting*, 77% of active cases are associated with mood disorders and schizophrenia and other psychotic disorders
- *In the community*, increases in new admissions indicate a growing need for problem gambling and substance abuse programs. For individuals seeking substance abuse treatment services, the top three substances identified are: alcohol, cocaine and narcotics

Finally, anecdotal information identifies that suicides and abuse events are increasing with the localized severe downturn of the economy.

In conclusion, mental health and addictions is a growing issue in the LHINs and is in need of a comprehensive and measured action-oriented approach.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

Mental Health Overall Goals:

- Develop alternatives to use ED
- Reduced admissions to inpatient mental health services
- Provide community based care to elderly adults with mental health problems to prevent or delay admission to hospital or placement in a LTCH
- Provide appropriate services for people with mental illness (moderate or serious), to maintain them in the community of their choice of residence
- Improve multi-communication through integrated information systems
- Increase stabilized housing programs for all priority populations
- Develop strategies with selected partners to lessen the effects of unemployment

The action plans will focus on the following priority populations for people in need of mental health care:

- Concurrent Disorders (mental health and addiction) clients
- Early intervention clients (newly identified youth with psychotic disorders / mental illness)
- General population who are unemployed, or at risk, and those still working but are below the poverty line
- Mental health clients without primary care providers
- Gero-psychiatry - (psycho-geriatric) populations
- Crisis population
- Adults with mood disorders
- Seriously mentally ill adults
- Older adults with gero-psychiatric issues in community settings

Addictions Overall Goals:

- Increased access to withdrawal management services
- Reduced reliance on primary care, ED and in-patient services for withdrawal management and addiction services
- Increased capacity (service volumes) and reduced wait times (referral to service initiation) of out-patient services for opiate dependent adults, youth and seniors
- Improved integration and delivery models for services in order to appropriately meet patient needs across their lifespan (youth, adult and senior)
- Ensure that a continuum of addiction services are available to opiate dependent adults, youth, and seniors within Erie St. Clair

The action plans will focus on the following priority populations for people in need of Addictions Services:

- Opiate dependent adults
- Youth with addictions issues
- Seniors 65+ with addictions issues

Consistency with Government Priorities:

The above goals are consistent with the government's commitment to strengthen mental health and addiction services in the province, including cutting wait times in EDs for people with mental illnesses and addictions.

Action Plans/Interventions

Action Plans/ Interventions:	% Completion by Year		
	2010-11	2011-12	2012-13
Mental Health			
Staff to work together across organizations to minimize the number of assessments, learn one another's role, and utilize community based resources more effectively in order to ensure timely discharges and transfer of care for patients	10%	10%	20%
Plan and initiate alternatives to hospitalization	10%	10%	10%
Initiate Tier II and Tier III Planning Process and Structures	75%	25%	-
Continue to advance the 'integrated assessment project' LHIN-wide	30%	30%	30%
Establish withdrawal management services for each LHIN sub-region	-	10%	20%
Expand Tele-crisis services LHIN-wide	10%	10%	20%
Enhance community service capacity for priority areas: early Intervention, crisis services, psycho-geriatric teams, mobile outreach, PACT Team capacity, etc.	10%	10%	20%
Enhance and re-engineer crisis follow-up	10%	10%	30%
Increase community education and promotion of community crisis services	20%	20%	20%

Initiate an 'employment task force' (in W/E) and develop a strategy to resolve issues in this area	30%	40%	20%
Establish a community based mood disorders program; provide information and education about the service to primary care providers, ED physicians / staff and other key referral sources	-	10%	10%
Advance performance targets and metrics for Mental Health sector	60%	10%	10%
Addictions (Adults with Addictions):			
Re-activate former outpatient withdrawal management model and expand current day treatment services (W/E)	10%	10%	20%
Expand addiction medicine services at a new site; integration to create gender responsive services at satellite site (W/E)	10%	10%	10%
Assess suitability of patient for referral to outpatient / day treatment service and reduce non-acute inpatient admissions (W/E)	20%	20%	20%
Expand existing day treatment program (S/L)	10%	10%	10%
Expand existing addiction medicine program for gender responsive services (W/E)	10%	10%	10%
Establish non-medical withdrawal management services (C-K)	10%	20%	10%
Addictions (Youth and Seniors with addictions):			
Reintroduce outreach program into secondary schools system	10%	20%	20%
Develop a critical path towards the establishment of youth specific residential treatment	10%	10%	10%
Develop pre-operational plan, operational framework, service structure, policies and procedures	20%	20%	30%

Expected Impacts of Key Action Items

Mental Health:

- Reduce mental health ALC days by 5%
- Reduce time for referral to admission to service by 50%
- Reduce hospital admission rates by 5%
- Reduce hospital LOS by 2 days with the implementation of enhanced clinical pathways
- Ensure that 25% of presenting clients in the hospital will have a community plan on discharge

- Reduced mental health ED visits by 60-120 patient visits / year
- Reduced readmissions to the ED by 10% / year
- Adherence to treatment plan: increase in completion of outpatient treatment by 20%
- Reduced Inpatient gero-psychiatry admission by 5-10%
- Eliminate the ACT wait list
- Repatriate patients within 4-6 months of using Regional Mental Health Services

Addictions:

a) Opiate Dependent Adults

- Wait times (referral to intervention) for outpatient withdrawal management and addiction medicine services reduced by 5 to 10 days
- Wait-list attrition reduced by 20 to 40%
- Number of ED visits reduced by patients presenting for withdrawal management and addiction medicine by 10%
- Acute care deferrals from inpatient withdrawal management services reduced by 25%
- Successful treatment compliance rates increased by 20%
- Outpatient active caseload volumes increased by 120 patients
- Increased partnerships / horizontal integration of services

b) Youth and Seniors with addictions:

- Reduced time, cost and barriers to access service

What are the risks/barriers to successful implementation?

- Increasing demand and lack of services (capacity) in the community for the mentally ill and those with addictions
- Problems accessing primary care for this population
- Ongoing delay in divestment of Tier II (bedded) and Tier III (non-bedded) services from Regional Mental Health
- Chronic underfunding in both sectors
- Inability to effectively respond to changing population diversity and emerging language needs
- Access to service for rural areas
- Continued over reliance / dependency on hospital services
- Qualified HHR staff (Physicians and Psychiatrists)
- Continuing unemployment contributing to rising mood and anxiety disorder rates
- Continued separate planning, funding and service delivery silos between mental health and addictions
- Lack of safe, stable and affordable residential housing options for this population
- Continued stigma for this population
- Lack of 24 / 7 community based mental health services

2.5 Rehabilitation Care

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Rehabilitation Care

IHSP Priority Description:

Rehabilitation services cover a large number of treatments designed to help those who have experienced some kind of trauma. Often rehabilitation is provided by an interdisciplinary team of therapists which may include Physiotherapists (PTs), Occupational Therapists (OTs), Speech-Language Pathologists, Social Workers and Registered Dietitians, providing services to clients in their homes, schools, workplaces, hospitals and residential care facilities. While these specialists use the newest technology and techniques possible, it can take months or even years to complete the process depending on the injury.

In the Erie St Clair LHIN, a comprehensive range of inpatient and outpatient rehabilitation services is available to adults who experience debilitating illness or injury, e.g. cardiac, complex care, complex injury, geriatric rehab, LTC, neuro, spinal cord, and musculoskeletal rehabilitation needs.

Reasonable and timely access to health care services remains a critical issue in Erie St. Clair and across Ontario. While much of the policy attention has been concentrated on hospitals, physicians, nurses and surgical / diagnostic services, there have been a series of events within the last decade that have also affected rehabilitation services. A key change impacting this area has been the partial delisting of community based physical therapy services (affecting the overall supply of OTs and PTs). A recent report (2007) by CIHI found that although the absolute number of PTs and OTs is increasing, this growth is not keeping pace with the overall population growth. Moreover, a number of other factors are also sharply rising the demand for rehab services (both at the community-based level and for more traditional hospital or institutional based services) these include:

- Overall population growth
- An increasingly large cohort aged 65+ or older
- Increasing rates of chronic and complex conditions along with changes in hospital discharge patterns
- Increasing public expectations related to care
- Advances in treatment and management of disease / conditions

Providing resource intensive medical and hospital interventions without ensuring a reasonable supply of rehabilitation services is a poor investment. From a cost standpoint, it may increase utilization of expensive institutional services. From an outcomes standpoint, it may result in unnecessary and preventable disability.

Current Status

Generally, any kind of rehabilitation strives to meet one goal - to improve the lives of those who have been diagnosed with a disease or who have experienced injuries. Moreover, rehabilitation, regardless of cause and treatments needed, can help people in regaining their social status by enabling them to live normal and healthy lives. For patients who have been diagnosed with diseases, such as lung and heart problems, spinal disorders, cancer or other diseases / injuries that may affect physical functions; rehabilitation can provide the needed help for the patients to return to work or home.

Studies have further shown that inpatient rehabilitation can reduce inpatient LOS and improve or maintain ambulation during prolonged hospital stays. The benefits of ambulation during prolonged hospitalization for coronary events have been widely recognized. After hospital discharge, the process of physical reconditioning is continued at home.

Within the Erie St. Clair LHIN, it will be important to continue to pursue rehabilitation opportunities both in hospital (e.g. ambulation programming) or in community (e.g. intensive rehab outreach teams). These interventions are expected to have a positive benefit of lowering hospital LOS, leading to improved ALC flow, maintaining or improving a patient's ambulation capability and keeping people in their homes longer and safer with supervised supports resulting in lower rates of hospitalization and re-hospitalization for post operative clients.

TEMPLATE A:

PART 2: GOALS and ACTION PLANS

Goal (s)

Rehabilitation Care Overall Goals:

- Improve access to outpatient rehab services and day programs for stable patients not requiring an inpatient bed
- Facilitate appropriate utilization of inpatient rehab beds
- Improve flow from acute care (reduce acute care LOS and ALC days) and decrease inpatient rehab bed wait time and wait time for outpatient rehab services
- To improve activation for the complex inpatient geriatric population with low intensity long duration rehabilitation services
- Provide access to a pulmonary rehabilitation program service delivery model
- Improve flow through by increased patient and family capacity to self-manage along the continuum
- Create / expand / enhance sub-acute, primary care and community partnerships to facilitate guided transition to community
- Create / expand / enhance feedback linkages from community to primary health to maintain successful healthy living in the community, avoiding ED visits and ED-Acute Care re-admissions

The action plans will focus on the following priority populations for people in need of rehabilitation care:

- Geriatric populations
- Frail individuals over the age of 65 with multiple chronic conditions such as CHF, COPD, cardiovascular disease (CAD), musculoskeletal conditions (arthritis, osteoporosis) and / or progressive neurological conditions (Dementia, Alzheimer, Multiple Sclerosis, Parkinson's Disease)
- Complex disability patients (stroke)
- Individuals with chronic respiratory diseases, lung disease: COPD
- Individuals with heart failure
- Elderly patients with fractured hips
- Neurological, vascular and ortho populations
- Frail individuals over the age of 65 with reduced mobility, balance, endurance, strength and weight loss, evidence of depression, dementia, delirium, and / or incontinence

Consistency with Government Priorities:

The above goals are consistent with and support the Government's commitment to reducing wait times in ED and improving patient flow, increasing access to hospital beds and reducing the amount of time patients spend in ALC beds.

Action Plans/Interventions

Action Plans/ Interventions:	% Completion by Year		
	2010-11	2011-12	2012-13
Expand in-hospital ambulation program(s) LHIN-wide	70%	30%	-
Launch Rehabilitation Team (in W/E) and then LHIN-wide	30%	30%	30%
Initiate 'clinical review' determine future state for rehab in Erie St. Clair	100%	-	-
Review area and increase outpatient programs as needed LHIN-wide (e.g. satellite clinics)	10%	10%	10%
Review CCC cohort – determine best future use for bed resource	50%	50%	-
Complete assessment of allied health care needs in Erie St. Clair LHIN region (with consideration of rehab within assessment)	40%	10%	10%
Expand Day Rehab services LHIN wide	10%	10%	10%
Institute an automatic e-referral system for the rehab sector	10%	20%	20%

Enhance Pulmonary Rehab Program services (C-K)	10%	30%	30%
Advance a Hip Fracture program / strategy LHIN-wide	30%	30%	30%
Advance Transitional Stroke program LHIN-wide (focus on S/L to start)	10%	10%	10%
Advance performance targets and metrics for Rehab sector	60%	10%	10%

Expected Impacts of Key Action Items

- 5% reduction in LOS for selected chronic conditions
- Improve Activities of Daily Living (ADL) functioning by 10% or maintain ADL functioning for 6 months post-programming
- Improve perceived health status / quality of life ratings by 10%
- Improve strength, range of movement balance, pain, mobility and cognition by 5%
- Improve caregiver burden ratings by 10%
- 100% of clients report good to excellent satisfaction ratings with community rehabilitation intervention team
- Increase satisfaction to develop a higher return to home instead of reliance on complex continuing care or LTC homes
- Increase patients discharged from rehabilitation to home by 10%
- Decrease the total LOS (acute plus rehabilitation) by two days for top Case Mix Groups (CMGs) such as stroke, hip fracture, etc
- Decrease incidence of skin breakdown by 5-10%
- Decrease total LOS for fractured hip by 5-7%

What are the risks/barriers to successful implementation?

- Continued fragmentation across the rehabilitation sector
- Reduction of current services in-hospital (including rehabilitation services) to meet balanced budget requirements
- Growing elderly population
- Continued higher than provincial rates of hospitalization
- Continued higher than provincial rates of chronic conditions (e.g. arthritis, Diabetes)
- Resource constraints especially shortages of certain HHR (OT, PT, RT)
- Lack of willingness of organizations to work together to resolve ‘system’ issues
- Limited alternative options to ED in community due to funding constraints
- Limited community-based rehabilitation supports resulting in longer hospital LOS for those needing these services
- Continued lack of access to primary care
- Lack of disease management strategies for persons with a chronic illness aimed at reducing hospital admissions / and subsequent de-conditioning for these groups

3.0 LHIN Operations and Staffing Templates

3.1 LHIN Operations Spending Plan

Template B: LHIN Operations Spending Plan						
LHIN Operations Sub-Category ($)		2009/10 Forecast	2009/10 Allocation	2010/11 Planned Expenses	2011/12 Planned Expenses	2012/13 Planned Expenses
Salaries and Wages		**2,490,000**	**2,470,000**	**2,433,100**	**2,506,100**	**2,521,300**
Employee Benefits						
	HOOPP	215,000	220,000	231,500	238,400	245,600
	Other Benefits	266,400	250,000	240,000	247,200	248,500
Total Employee Benefits		***481,400***	***470,000***	***471,500***	***485,600***	***494,100***
Transportation and Communication						
	Staff Travel	104,700	107,500	107,000	107,000	107,000
	Governance Travel	26,000	26,000	26,000	26,000	26,000
	Communications	40,000	40,000	40,000	40,800	41,600
	Other Benefits	-	-	-		
Total Transportation and Communications		***170,700***	***173,500***	***173,000***	***173,800***	***174,600***
Services						
	Accomodation	200,800	189,900	190,000	193,800	197,700
	Advertising	3,000	2,000	10,000	10,000	10,000
	Banking	-		-		
	Community Engagement	25,000	30,000	60,000	60,000	60,000
	Consulting Fees	362,100	326,600	216,000	121,400	90,000
	Equipment Rentals	5,900	6,000	6,000	6,100	6,200
	Governance Per Diems	139,000	139,000	139,000	139,000	139,000
	LSSO Shared Costs	330,000	330,000	360,000	360,000	360,000
	Other Meeting Expenses	65,500	50,000	57,500	58,700	59,900
	Other Goveranance Costs	98,100	92,200	81,500	83,100	84,800
	Printing & Translation	500	5,000	5,000	5,000	5,000
	Staff Development	17,000	17,000	42,500	42,500	42,500
Total Services		***1,246,900***	***1,187,700***	***1,167,500***	***1,079,600***	***1,055,100***
Supplies and Equipment						
	IT Equipment	-	-	10,000	10,000	10,000
	Office Supplies & Purchased Equipment	34,000	35,000	40,000	40,000	40,000
Total Supplies and Equipment		***34,000***	***35,000***	***50,000***	***50,000***	***50,000***
LHIN Operations: Total Planned Expense		**4,423,000**	**4,336,200**	**4,295,100**	**4,295,100**	**4,295,100**
Annual Funding Target				**4,295,100**	**4,295,100**	**4,295,100**
Variance				**-**	**-**	**-**

3.2 LHIN Staffing Plan

Template C: LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2008/09 Actuals as of Mar. 31 FTEs	2009/10 Forecast FTEs	2010/11 Forecast FTEs	2011/12 Forecast FTEs	2012/13 Forecast FTEs
CEO	1	1	1	1	1
Senior Directors	2	2	2	2	2
Controller	1	1	1	1	1
Community Engagement	2	2	2	2	2
Planner	4	3	3	3	3
Account Manager	3	3	3	3	3
Data	2	2	2	2	1
Funding & Allocation	2	2	2	2	2
Administrative Functions	7	6	6	6	6
Program Assistant	5	5	5	5	5
Total FTEs	29	27	27	27	26

Note – no additional staff due to limited funding and reduce 1 in 2012/2013 due to cutbacks/inflation

4.0 Communications Plan

Outcomes	To communicate the purpose and direction of the Annual Business Plan (ABP) and Erie St. Clair LHIN initiatives and to gain commitment on the plan and its strategies, internally to Erie St. Clair LHIN staff, and externally to funded health service providers (HSPs)
Key messages	• The Erie St. Clair LHIN's ABP is the strategic plan of the LHIN for the next year. It encompasses the priorities and strategic integration directions of the IHSP, system opportunities and risks and outlines how the Erie St. Clair LHIN will proceed in the coming years of 2010-2011. • The ABP will assist the public in understanding how the LHIN is planning to address the needs of the community. • The Erie St. Clair LHIN ABP is approved by the LHIN Board of Directors and MOHLTC.

Tactic	Audience	Strategy	Engagement	Timelines
Draft sent to Board for review	1. LHIN Board	To inform Board as to the contents of the ABP	Inform/Educate	January 2010
Develop key messages	1. HSP 2. Media 3. Public	To communicate effectively and consistently about the purpose of the ABP	Inform/Educate	January 2010
Discuss and approve ABP draft at open Board meeting	1. LHIN Board 2. Media 3. Public	To discuss and gain approval in an open and transparent manner	Involve	January 2010
Board meeting highlights	1. HSP 2. Media 3. MPPs 4. MOHLTC	To communicate approval of draft ABP (Note: Post to web)	Inform/Educate	January 2010
Coordinated messaging with HSP's identified in the ABP	1. HSP 2. Media 3. Public	To allow for consistent key messaging to ensure the accurate information is being communicated to and by all parties	Collaborate	Ongoing

Website posting	1. Public 2. HSP 3. Stakeholders 4. Erie St. Clair LHIN Staff	Coordinated same day release with other 13 LHINs to all providers, stakeholders and general public To communicate purpose of ABP, highlights and timelines	Inform/Educate	September 2010
Facebook update to fans	1. Stakeholders	Post update on Facebook site to communicate purpose of ABP, highlights and timelines	Inform/Educate	September 2010
Include in MPP-LHIN update	2. MPPs	To continue to keep MPPs informed of LHIN strategic direction and initiatives	Inform/Educate	September 2010

Communication and Community Engagement Tactics and Vehicles:

- Communication Partnership – LHIN Communication Leads, MOHLTC
- Communication Partnership – LHIN HSP, public relations and stakeholders contacts
- Communication Partnership – LHIN Aboriginal and eHealth Leads
- Government and Community Relations Strategy
- Continued communication and physician engagement
- Maintenance of strong media relations
- Inclusion of ABP Goals and IHSP messaging in ongoing communication and community engagement activities
- Continued use of Erie St. Clair LHIN communication products
    - *2009/10 Annual Report*
    - *Erie St. Clair LHIN website and social media site (Facebook)*
    - *Connection Newsletter*
    - *News Releases*

Communications/Community Engagement will be leveraged to support the major milestones, organizational objectives, and brand building of the Erie St. Clair LHIN in 2010/11.

Annual Business Plan Projects:

A number of major projects will be rolled out this year for which communications and community engagement will be critical components. A communications calendar will be developed that accounts for these projects and their milestones with pro-active media and stakeholder communications. These communications will be linked to the organizations need to further positive stakeholder relations and greater understanding of the Erie St. Clair LHIN role and responsibility within the health care system. Our IHSP "Navigating Change in the Right Lane" will be the primary focus of Community Engagement in 2010/2011.

ESC LHIN Major Initiatives

Specific and multi-directional communications plans will be developed to support major projects such as: IHSP, Hospital Annual Planning Submission (HAPS), Aging at Home, and other Erie St. Clair LHIN lead initiatives. Where appropriate and required, communications will be coordinated with Provincial-LHIN Working Groups and the MOHLTC.

Community Education and Partnership Building

In keeping with the theme of proactive communications and needs expressed by our community through IHSP II community engagement, the Erie St. Clair LHIN will be enhancing our website with health information so that it will become the first place people will turn for local health care information. This information will be communicated through other traditional means as well as through our newly developed Facebook social media site.

Community engagement will lead in organizing the 2nd Annual Erie St. Clair LHIN Conference. The conference will bring together HSPs and health care stakeholders from across the three counties of Erie St. Clair, for a one-day conference where new partnerships are formed and knowledge is transferred. The Conference will carry a thematic message consistent with our IHSP and ABP.

Priority Population/Programs

Community Engagement related to specially funded initiatives each will require unique communications plans. The Community Engagement works with the Aboriginal Lead and e-Health Lead to ensure proactive communications and community engagement is taking place.

The Erie St. Clair LHIN Aboriginal Lead will be holding small conferences / workshops, focused on Aboriginal Diabetes and mental health, where engagement and collaborative planning will take place in partnership with First Nations people. Additionally, regular meetings of the Local Aboriginal Planning Entity will also be held to assist the Erie St. Clair LHIN in planning health care to address aboriginal needs.

The Erie St. Clair LHIN e-Health Lead works closely with Erie St. Clair LHIN planners to ensure the e-Health messaging and initiatives are communicated. Knowledge transfer sessions with HSPs have also been planned for 2010, as well as the launch of an Erie St. Clair e-Health newsletter.

5.0 In-Year Funding Allocation

Throughout the course of the fiscal year, additional in-year funding grants are provided to the LHIN in order to promote improved care outcomes, integration opportunities, and operation efficiencies. The following sections identify the major funding distribution by the Erie St. Clair LHIN.

5.1 Urgent Priority Fund

Urgent Priority Fund Allocation Schedule Erie St. Clair Local Health Integration Network				2009/10 Total Funding Allocation
			TOTAL INCREMENTAL ALLOCATED	**$ 2,527,772**
Project Title	**Service Provider Name**	**Provider Site**	**Project Description**	
Watford CHC satellite	North Lambton CHC			$ 191,000
Record the new projects to be reviewed and acknowledged in 2009/10 below.				
HDGH Psychiatric Assessment Team	HDGH	Windsor	To reduce ED demand - better allocation of patients	$ 450,000
CHC Review	LDMH	Leamington	Integration work for the two Windsor CHCs (building frameworks and governance models, implementation)	$ 30,000
Utilization Management Software	CKHA	Chatham	eHealth related (software for the hospitals along with rest of province) providing discharge / ALC information for patients	$ 200,000
Erie St. Clair CCAC Operational Review	Erie St. Clair CCAC	Chatham	Operational review of client based services and administration	$ 250,000
Diagnostic Imaging Windsor/Essex	HDGH	Windsor	Services - for additional Duagnostic Imaging	$ 20,000
Charlote Eleanor Englehart Hospital (CEEH) Complex Continuing Care (CCC) Beds	BWH	Sarnia	Transitional beds within Lambton County	$ 200,000
Malden Park Beds	WRH	Windsor	Interim beds while construction begins/continues	$ 170,000
PMO Lead - eHealth Ontario	CKHA	Chatham	PMO eHealth Ontario - joint costs with other LHINs for eHealth related initiatives	$ 50,000
Care Transitional Beds – Chatham	CKHA	Chatham	4 CCC (Reactivation/Restoration) Beds at the Sydenham Site	$ 100,000
Care Transitional Beds – Lambton	BWH	Sarnia	4 CCC (Reactivation/Restoration) Beds via BWH	$ 70,600
Care Transitional Beds – Lambton	Fiddick's Nursing Home	Sarnia	1 CCC (Reactivation/Restoration) Beds	$ 22,050
Companion Transport Program	BWH	Sarnia	Companion Transport Program	$ 7,350
Aboriginal Consultant	CKHA	Chatham	Ongoing project for required engagement	$ 55,000
Sarnia/Lambton Transportation Providers Brochures	Erie St. Clair CCAC	Chatham	Support Required	$ 7,000
CEEH CCC Beds Part Two	BWH	Sarnia	Transitional Beds within Lambton County 7 CCC (Reactivation.Restoration) Beds at the Petrolia site	$ 200,000
Chronic Care Transitional Beds - Essex	HDGH	Windsor	Transitional Beds within Essex County	$ 340,000
Transportation of Dialysis Patients to Dialysis Centre	Essex Community Service	Windsor	Transportation of County Resident/Dialysis Patients to Dialysis Centre (HDGH)	$ 12,000
Transition Costs for Adult Mental Health Funded Services	BWH	Sarnia	Adult Mental Health patient - transitional support	$ 41,470
ED / Critical Care Lead Admin	HDGH	Windsor	Support for temporary Lead positions for the Erie St. Clair LHIN	$ 35,000
Integration - Tecumseh Seniors Transit and Lakeshore Community Services	Lakeshore Community Services	Windsor	Support the facilitated integration of the Tecumseh Seniors Transit	$ 76,302

5.2 LHIN Funding: In-Year Revenues

ERIE ST. CLAIR LOCAL HEALTH INTEGRATION NETWORK
Statement of Financial Activities
For The Year Ended March 31, 2010

	Prior Year YTD 2008/2009	Actual YTD 2009/2010	Budget 2009/2010	% Var	
Revenue					
Transfer Payments	4,121,329	4,288,226	4,211,200	1.8%	
ED/ALC Funding	33,300	100,000	100,000	-	
Diabetes Funding	-	25,000	25,000	-	
AHTF Funding	-	126,500	126,500	-	
French Language Services		36,942	-		
Capital Revenue	228,576	230,825	230,800	-	
eHealth	425,000	600,000	600,000	-	
ED Lead	60,087	75,000	75,000	-	
	4,868,292	**5,482,493**	**5,368,500**	2.1%	1
Expenses					
Salaries	2,074,947	2,327,994	2,320,200	0.3%	
Contract Salaries & Benefits	119,480	189,500	174,600	8.5%	
Benefits	388,592	440,882	445,200	-1.0%	
Subtotal (Salaries & Benefits)	**2,583,019**	**2,958,376**	**2,940,000**	0.6%	
Governance	230,132	246,336	257,200	-4.2%	
Travel	93,502	93,118	107,500	-13.4%	2
Consulting Services	317,282	277,231	326,600	-15.1%	3
Communications/Forums	37,501	43,336	22,400	93.5%	4
Supplies/Equipment/Maintencance	235,046	140,241	110,900	26.5%	5
Subtotal (Other Business Expenses)	**913,463**	**800,262**	**824,600**	-3.0%	
Accommodations	228,196	135,124	97,100	39.2%	6
Lease Expense	129,951	144,460	144,500	-	
Common Services - LSSO	300,000	362,714	330,000	9.9%	7
LHIN Collaborative		12,286	-	-	
Amortization Expense	228,576	230,825	230,800	-	
AHTF Expenses	-	126,500	126,500	-	
French Language Services	-	36,942	-	-	
eHealth	425,000	600,004	600,000	-	
ED Lead	60,087	75,000	75,000	-	
Total Operating Expenses	**4,868,292**	**5,482,493**	**5,368,500**	2.1%	
Net Income (Loss)	-	-	-		

Statement of Financial Position

Cash	680,448	481,524	300,000	
Prepaids	20,000	12,054	-	
Accounts receivable - MOHLTC	580,600	3,299,486	580,600	
Accounts receivable	-	5,000	-	
FINANCIAL ASSETS	**1,281,048**	**3,798,064**	**880,600**	
Accounts payable and accrued liabilities	643,856	448,107	300,000	
Due to MOHLTC	14,913	14,913	-	
Due to HSPs	580,600	3,299,486	580,600	
Due to LSSO	17,179	-	-	
Deffered Revenue	24,500	35,558	-	
Deferred capital contrbutions	288,582	64,604	57,000	
LIABILITIES	**1,569,630**	**3,862,668**	**937,600**	
NET DEBT	**(288,582)**	**(64,604)**	**(57,000)**	
Capital assets	288,582	64,604	57,000	
ACCUMULATED SURPLUS (DEFICIT)	-	-	-	

* - as of October 28, 2009 as presented to the Finance Committee

Notes:
1 - Funding announcements after budget approval - French Language Services & 2% Base increase
2 - Savings in travel allotment for the year, not the increase estimated, consistent with 2008/2009
3 - Reduced consulting expenses to offset other required expenses
4 - Increase in communication expenses due to Health Care Connect & promotional items
5 - Increase in meeting expenses due to additional initiatives required and office supply purchases
6 - Increase due to equipment purchases not budgeted for initially
7 - Increase as approved by the CEO and Board to the LSSO

5.3 Health Service Provider In-Year Allocations

Erie St. Clair Local Health Integration Network Community Sector Stabilization Fiscal Year 2009/10	
Sector	**Base Funding**
Aquired Brain Injury	23,726
Assisted Living	115,489
Addictions	171,070
Community Mental Health	587,587
Community Health Centre	268,200
Community Support Services	292,607
Total Stabilization Increase for 2009/10	**$ 1,458,679**
Note: Represents 2.25% of 2008/09 Base Funding	

Erie St. Clair Local Health Integration Network Community Care Access Centre Funding Amounts Fiscal Year 2009/10				
Organization	**Initiative**	**Base Funding**	**One-Time Funding**	**Total Funding**
CCAC	Stabilization/Expansion	3,948,566		3,948,566
CCAC	Service Maximums Incremental	1,640,400		1,640,400
CCAC	Wait Times Strategy		933,000	933,000
Total Funding for 2009/10		**$ 5,588,966**	**$ 933,000**	**$ 6,521,966**

Erie St. Clair Local Health Integration Network Hospital Funding Amounts Fiscal Year 2009/10				
Sector	**Initiative**	**Base Funding**	**One-Time Funding**	**Total Funding**
Hospital	Funding Formula	11,682,000		11,682,000
Hospital	Small Hospital	96,400		96,400
Hospital (WRH)	Neonatal Intensive Care Units	1,950,000		1,950,000
Hospital (H&K; Cataract; MRI; CT)	Wait Time Strategy		7,293,800	7,293,800
Hospital (Paed Surgery; General Surgery)	Wait Time Strategy		1,715,400	1,715,400
Hospital	WTS ER Pay for Results		1,679,600	1,679,600
Hospital (WRH)	Operating Pressures	421,700		421,700
Hospital (WRH)	PCOP	180,254		180,254
Total Funding for 2009/10		**$ 14,330,354**	**$ 10,688,800**	**$ 25,019,154**

5.4 Aging at Home Funding

Erie St. Clair Local Health Integration Network Aging at Home Fiscal Year 2009/10					
Organization	**Project Title**	**Base Funding**	**One-Time Funding**	**Total Funding**	**Annualized Base**
VON for Canada Ontario Branch Windsor/Essex	Meals for Culturally Diverse (recovery from year 1)		(50,000)	(50,000)	(118,080)
Brain Injury Association	Club Service Program	30,000		30,000	98,080
Lakeshore Community Services	Congregate Dining	20,000		20,000	20,000
CKHA	Psycho-Geriatric Outreach Team	287,887		287,887	383,849
Canadian Mental Health Association Sarnia/Lambton	Psycho-Geriatric Outreach Team	287,887		287,887	383,849
WRH	Expansion of Psycho-Geriatric Resource Consultant Services	119,137		119,137	158,850
WRH	Geriatric Emergency Management	146,250		146,250	195,000
HDGH	Geriatric Emergency Management	146,250		146,250	195,000
LDMH	Geriatric Emergency Management	146,250		146,250	195,000
CKHA	Geriatric Emergency Management	146,250		146,250	195,000
BWH	Geriatric Emergency Management	146,250		146,250	195,000
WRH	Malden Park LTC Interim Beds		1,600,000	1,600,000	
Chippewas of Sarnia	Congregate Dining	15,000		15,000	15,000
Centre of Seniors Windsor	Friendly Visiting/Security Checks	16,500		16,500	22,000
Amherstburg Community Services	Friendly Visiting/Security Checks	10,463		10,463	13,950
Lakeshore Community Services	Friendly Visiting/Security Checks	15,000		15,000	20,000
Lambton Elderly Outreach	Friendly Visiting/Security Checks	15,000		15,000	20,000
South Essex Community Council	Friendly Visiting/Security Checks	15,000		15,000	20,000
VON Chatham-Kent	Friendly Visiting/Security Checks	30,000		30,000	40,000
Family Counseling Centre	Friendly Visiting/Security Checks	15,000		15,000	20,000
Family Service Kent	Home Maintenance and Repair Service	52,500		52,500	70,000
Lakeshore Community Services	Home Maintenance and Repair Service	28,875		28,875	38,500
Centre for Seniors	Home Maintenance and Repair Service	31,500		31,500	42,000
South Essex Community Council	Home Maintenance and Repair Service	52,500		52,500	70,000
Lambton Elderly Outreach	Home Maintenance and Repair Service	52,500		52,500	70,000
Grand Bend CHC	Home Maintenance and Repair Service	52,500		52,500	70,000
Walpole Island	Home Maintenance and Repair Service	27,975		27,975	37,300
Alzheimer Society of Windsor/Essex	Caregiver Education & Support Program	15,000		15,000	20,000
Alzheimer Society of Windsor/Essex	In-home Respite Service	24,000		24,000	32,000
Chippewas of Kettle & Stoney Point	Day Programs	61,500		61,500	82,000
Brain Injury Association	Acquired Brain Injury Day Program	68,698		68,698	91,597
Leamington Mennonite Home	Emergency Response		45,000	45,000	
Erie St. Clair CCAC	Roho Cushions		24,300	24,300	
Canadian National Institute for the Blind - Windsor	Daily Life Skills Programs	90,830		90,830	90,830
Alzheimer Society of Sarnia/Lambton	Mobility Monitors		5,000	5,000	
Citizen Advocacy	Transitional Care Planning for LTC	49,313		49,313	65,750
Family Service Kent	Transitional Care Planning for LTC	49,313		49,313	65,750
Lambton Elderly Outreach	Transitional Care Planning for LTC	49,313		49,313	65,750
Chippewas of Kettle & Stoney Point	Assisted Living	154,000		154,000	154,000
North Lambton CHC (paymaster for Chippewas of Kettle)	Assisted Living	140,000		140,000	140,000
Erie St. Clair CCAC	End of Life (Chatham-Kent)	588,750		588,750	785,000
LDMH	Interim Complex Continuing Care Beds		900,000	900,000	-
CKHA	Chronic Pain		180,000	180,000	-
Sandwich CHC/Lakeshore	Rehab Team	738,910		738,910	785,000
BWH	Interimediate CCC Beds		75,670	75,670	
TOTAL Approved for 2009/10		**$ 3,936,101**	**$ 2,779,970**	**$ 6,716,071**	**$ 4,847,975**