

Annual Business Plan

2011/2012



Ontario

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

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1 Context

1.1 Mandate and Strategic Directions of the Erie St. Clair Local Health Integration Network (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 Erie St Clair LHIN's 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 (MOHLTC), communicates the priority areas that will guide Erie St. Clair LHIN activities from Fiscal Years 2010 to 2013 and is the basis for this Annual Business Plan (ABP).

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

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

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 Advisory 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 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 and promote primary care

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 opportunities for sustainability of small community Emergency Departments (EDs)
- A planning exercise, *StrategiCare*; established with the goal of examining the potential for enhanced regional integration of programs in W/E hospitals
- An endeavour to promote the integration of the local W/E 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:

- Improved Access

The Erie St. Clair LHIN:

- Created Long-Term Care (LTC), Complex Continuing Care (CCC) and other bed-based alternatives to sustain acute care services
- Invested widely in meals enhancements to enable elderly to stay home
- Invested in transportation to enable elderly to improve socialization and connections to health care services
- Created an 'End-of-Life Care' Advisory Network

- Improved Quality

- 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
 - W/E hospitals enhanced integration initiatives
 - W/E CHC integration
 - Erie St. Clair LHIN CMHA integration initiative

With regard to current IHSP specific progress, success is being realized in a number of key areas over the 2010-11 period:

- Diabetes – The Erie St. Clair LHIN received funding notification for the Wave 2 Diabetes Team Expansions. The Erie St. Clair LHIN also assisted with the establishment of a new Erie St. Clair LHIN-wide Diabetes Regional Coordination Centre (RCC) with the Ontario Diabetes Strategy. The Diabetes RCC Administrator and support staff have been hired. The Diabetes RCC has established an office at the Windsor Family Health Team site. The Diabetes RCC Administrator is now co-chairing the Erie St. Clair LHIN Diabetes Regional Advisory Network (with Erie St. Clair LHIN staff) and will assume a greater leadership role as implementation progresses.
- ALC / ED / Medicine – In November 2010, Erie St. Clair LHIN staff combined the Alternate Level of Care (ALC) Advisory Network with the Pay for Results-Process Improvement Program (P4R-PIP) Group to form one unified Advisory Network in order to align the work in these two related areas. The Advisory Network first met on November 4, 2010 to discuss progress / performance, share successes and strategize for the next quarter. The Restorative Care Program (begun as a pilot at Leamington District Memorial Hospital) is currently being expanded to other hospitals in the Erie St. Clair region. Reporting for Stocktake continues to consider a wider view (outside of the hospital) to include community efforts that both directly and indirectly impact ED volumes, wait times and ALC flow.
- Mental Health and Addictions (MH&A) – The Tier II / III process is well underway. Confirmation on the funding coming to our LHIN region was finalized in April 2011 to support local service / program development and enhanced bed capacity. A Coordination / Integration Opportunities Assessment Project (involving KPMG and Erie St. Clair LHIN staff) was initiated Erie St. Clair LHIN-wide in November, involving the three CMHAs and other Mental Health providers. The providers in this sector have continued to advance plans and provide options that better align current and future programming with Ministry LHIN Performance Agreement (MLPA) performance expectations.

- Rehabilitation – A working group of the Advisory Network has completed a Business Case to advance a future vision and modeling exercise. This process will determine how to move this sector forward to become more integrated and results-based. This will be reviewed by senior Erie St. Clair LHIN staff in the coming fiscal year. The Community Rehabilitation Resource Team (CRRT) was initiated in W/E in October 2010 and is now established Erie St. Clair LHIN-wide.

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 sub-acute teams (palliative and chronic medical)
4. The investment of LTC beds
5. The development and integration of local CHCs
6. The integration of the local 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 current economic challenges, beginning in 2008 to present, have resulted in a disproportionately high unemployment rate compared to the provincial and national 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. The economic situation continues to result in an increase in the proportion of the population considered low income, potentially increasing pressures on social, MH & A 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. 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: Erie St. Clair facilities are short 25 ED Medical Doctors (MDs), Nurse Practitioners (NPs) are needed to provide off-hour and weekend support, Canadian Triage & Acuity Scale (CTAS) 4/5 patients continue to present at the ED due to lack of primary care. Due to this increase the EDs are experiencing physical space needs, and in some areas; Windsor for example, unexpected and dramatic increases in ALC has increased ED holds and lengthened ED Length of Stay (LOS) for admitted patients. Although, the Erie St. Clair LHIN performed just above provincial targets for ED LOS, there are specific opportunities within the region to decrease both the low acuity and high acuity LOS in hospital EDs.

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. During 2010/11, ALC volumes have increased dramatically in W/E. Causes and impacts include: the closure of Malden Park LTC home for renovation starting February 1, 2011, increase of ALC to approximately 25% in Q3 2010/11, increase in ED holds and cancelled elective surgeries, increase in staff overtime, increase in ED LOS for admitted patients; and, the continued service pressures on CCAC to provide more intensive services.

In December 2010, across the Erie St. Clair LHIN, approximately 17% of acute care beds, 44% of CCC beds and 13% 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 (CHF), chronic obstructive pulmonary disease (COPD) and Diabetes.

Residents in the Erie St. Clair LHIN are also waiting longer for a bed in LTC homes. In Q1 of 2010 / 11, the median time to LTC placement was 71 days, similar to last year's Erie St. Clair LHIN performance of 77 days. Specifically, in Q1 2010/11 Chatham-Kent (C-K), S/L and W/E had the median time to placement averaging 75, 70 and 63 days respectively.

It is becoming clearer that in order to rebalance the system and effectively address the current challenges, community services such as home care, LTC and rehabilitation services need to be prioritized and financed in such a manner that they move ALC patients out of the acute care setting. Recent funding announcements complement this direction. Being able to discharge patients in a timely manner with appropriate supports will increase the availability of acute care beds for patients waiting in the ED to be hospitalized, hence improving overall patient flow.

Finally, with the mounting economic challenges, it is important that the Erie St. Clair LHIN address opportunities to improve access to MH & A services. The system trends are clear both in our hospitals and in the community. In our hospitals, the majority of MH & A ED 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, MH & A 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 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 ED 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 MH & A
6. Addressing the impact of chronic disease
7. Improving system performance by 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 MH & A
- 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
- CCC program standardization planning
- Development of a system-wide clinical services plan
- HHR planning

In June 2010, the MOHLTC and LHINs agreed to a new MLPA with specific performance targets across a number of system indicators. This new direction was instituted to simplify / replace the previous Ministry LHIN Accountability Agreement (MLAA) and focus specifically on the ED and ALC issues. The key performance indicators expected to have the greatest impact (under the MLPA) for 2010-11 are:

- 90th Percentile Wait Times for:
 - Cancer Surgery
 - Cardiac By-Pass
 - Cataract Surgery
 - Hip Replacement
 - Knee Replacement
 - Diagnostic MRI Scan
- % of ALC Days – by LHIN institution
- 90th Percentile ED LOS for Admitted Patients
- 90th Percentile ED LOS for Non-Admitted Complex (CTAS 1-3) Patients
- 90th Percentile ED LOS for Non-Admitted Minor Uncomplicated (CTAS 4-5) Patients
- Repeat Unplanned ED Visits within 30 Days for Mental Health Patients
- Repeat Unplanned ED Visits within 30 Days for Substance Abuse Patients
- 90th Percentile Wait Time for CCAC In-Home Services
- Readmission within 30 Days for Selected Case Mix Groups (CMGs)

Over the summer of 2010, the main Erie St. Clair LHIN Advisory Networks which include ALC, Emergency Department / Medicine, Diabetes, Mental Health & Addictions, and Rehabilitation, met to advance plans to better align their strategic activities and projects with the new MLPA targets. During this period the health service providers were asked to complete a brief survey that attempted to identify the high-end users of the ED for each sector, and hospital in-patients that could be released earlier with appropriate community supports, and finally to advance projects that will have the greatest impact on the new MLPA targets. The following Erie St. Clair LHIN ABP now reflects these changes across all major planning areas.

2.1 Emergency Department

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN 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: ➤ Erie St. Clair facilities are short 25 ED MDs – 12.5% of provincial shortage for 5% of Ontario's population ➤ Retention of NPs to provide off-hour and weekend support ➤ High use by CTAS 4/5 patients due to lack of primary care ➤ Challenge of providing care to special needs populations (violent, multi-need clients) ➤ Physical space needs ➤ Unexpected and dramatic increase in ALC in W/E has increased ED holds and lengthened ED LOS for admitted patients ➤ Provision of follow-up / primary care for patients who revisit ED	
Current Status	
Information obtained from Ontario's ED Public Reporting System data indicated the following in Q4 of 2011: • To the end of Q4 2010/11, only 56% of admitted high acuity patients were treated within the eight-hour target. This is 10% below baseline. • For the same period, 93% of high acuity non-admitted patients were treated within the eight-hour target – stable and at baseline. • For the same period, 88% of low acuity non-admitted patients were treated within the four-hour target – stable and at baseline. In Erie St. Clair, the high volumes of non-urgent CTAS 4 and deferrable (CTAS 5) visits to EDs of small hospitals reflect a lack of timely access to primary care services and patient expectations. 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 S/L and 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 use of Health Care Connects 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 LTC homes
- Increased resources to Nurse Lead Outreach Teams (NLOT) to LTC homes
- Increased use of assess / restore and CCAC programs to reduce the demand for LTC homes and ALC
- 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:

- Patients who are “ED Hold”
- 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
- Patients with CTAS levels 4 and 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
- Community supports for Mental Health and substance abuse patients
- Community supports for CHF and COPD patients to prevent ED revisit and inappropriate admissions

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		
	2011-12	2012-13	2013-14
Standardization of GEM RN role for avoidable admissions	90%	10%	-
Expand the ED hours of Nurse Practitioner (NP) / Physician Assistant (PA) coverage for treat and release patients	80%	20%	-
Develop a referral process to primary care initiated by the ED	80%	20%	-
Continue and expand P4R and PIP Strategies in order to reduce wait times in the ED	80%	20%	-
Develop a primary care path for congestive heart failure (CHF) / chronic obstructive pulmonary disease (COPD)	80%	20%	-
Develop mechanisms so that unattached patients (CHF / COPD) are auto-referred to NP	80%	20%	-
Develop strategy for patients with known infectious diseases	60%	40%	-
Develop strategies to better manage the assessment and admission process for Mental Health patients	50%	50%	-
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%
ED MD retention strategy for Erie St. Clair LHIN	100%	-	-

Expected Impacts of Key Action Items

- Reduce ED LOS to target by 10%
- 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 / 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 chronic conditions (e.g. arthritis, asthma, diabetes, hypertension, mood disorder, anxiety disorder) driving up ED volumes
- Inability to recruit and retain ED Physicians
- Limited alternative options to ED in community
- Rural populations access to health care services
- High unemployment rate that is expected to continue

2.2 Alternate Level of Care

TEMPLATE A:

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY

Integrated Health Services Plan Priority:

Alternate Level of Care

IHSP Priority Description:

During 2010/11 ALC volumes have increased dramatically in W/E. Causes and impacts include:

- Closure of Malden Park LTC home to service the Windsor Western Tower renovation starting February 1, 2011
- Increase of ALC to approximately 18% in Q4 2010/11
- Increase in ED holds and cancelled elective surgeries
- Increase in staff overtime
- Increase in ED LOS for admitted patients, particularly in W/E
- Service pressures on CCAC to provide more intensive services

Current Status

In December 2010, across the Erie St. Clair LHIN region, approximately 17% of acute care beds, 44% of CCC beds and 13% 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 - CHF, COPD and Diabetes

Residents in the Erie St. Clair LHIN are waiting longer for a bed in LTC homes. In Q1 of 2010/11, the median time to LTC placement was 71 days, similar to last year's Erie St. Clair LHIN performance of 77 days. Specifically, C-K, S/L and W/E had the median time to placement averaging 75, 70 and 63 days respectively.

Further, patients are occupying ED space because there are no available acute care beds. In November 2010, Ontario hospitals estimated that approximately 16% of acute care beds were occupied by ALC patients, with 63% waiting for LTC (Ontario Hospital Association 2010).

Finally, the crux of the issue, appropriate community services such as home care, LTC and other services including rehabilitation services need to be supported and available in order to safely 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 discharge options (including End-of-Life Care (EOLC))
- Maximize functional conditioning of patients over the age of 60
- Improve ED wait times for admitted patients and reduce ED holds
- Improved time to LTC Home placement for inpatients and community
- Develop a fully implemented Falls Prevention Program in institutions and homes
- 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 Home
- Reduction in acute length of stay for chronic disease populations

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

- ALC patients in CCC and rehabilitation beds
- Geriatric Mental Health clients
- Post-acute (convalescent) 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		
	2011-12	2012-13	2013-14
Build on success of existing Temporary Care Program (TCP) and expand Erie St. Clair LHIN-wide	-	-	-
Review Compliance Branch requirements and co-ordinate with potential rest / retirement homes to ensure patient safety regarding TCP	100%	-	-
Develop key messages / market plan to highlight services offered by each LTC home (video format)	80%	20%	-
Develop and implement restorative care programs at Leamington District Memorial Hospital (LDMH) and Erie St. Clair LHIN-wide	60%	40%	-
Develop a comprehensive Falls Prevention Program Erie St. Clair LHIN-wide	30%	30%	30%
Initiate an education planning group to develop marketing / educational initiatives to mitigate ALC risks	30%	20%	20%
Expand NP program – to cover nursing homes (with goal of preventing ED visits)	20%	20%	20%

Expected Impacts of Key Action Items

- Increase percentage of patients returning to pre-hospital environment by 5%
- Decrease the percentage of patients placed in LTC homes post acute by 5%
- Ensure 100% 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 for Windsor
- Shortage of appropriate LTC Home beds to accommodate patients' needs
- Need 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 versus reactive / crisis management)
- Systemic data collection processes are needed 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
- Not enough resources to support extra training and staffing resources for LTC homes to better manage "hard to place populations" (behavioral, aggressive, wandering, Mental Health issues)
- Inability to identify and apply best practices in discharge planning across the Erie St. Clair LHIN area
- Need to develop a single coordination mechanism for ALC patients and to establish an integrated wait list management structure
- Growing elderly (aging) population
- Need 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 region 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 CCAC, four of the diabetes providers are based out of CHCs, while four are based in hospitals. Paediatric care for children and youth with diabetes 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: • Need a 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, Chiropractor, Recreational Specialists • Treating special needs populations (e.g. Aboriginals, people with a Mental Illness, those with Developmental Disabilities, those with Visual and Hearing Impairments) • Increasing medication costs • Salary variations across programs between hospitals and community • Need 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 2010, approximately 10.7% (54,659 residents) of Erie St. Clair residents 18+ had a diagnosis of Diabetes, which is higher than the Province of Ontario average of 10.3% or 1,044,622 people (2009 Baseline Diabetes Dataset Initiative – MOHLTC). During 2007/08, there were approximately 740 acute hospital visits (12% higher than the province) and 1,800 ED visits (22% higher 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: • Need 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 • Need for better lifestyle choices • Need 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 Erie St. Clair LHIN sub-regions
- Improved system navigation within Erie St. Clair 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 utilization 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
- Those with Pre-diabetes at risk of developing 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 ODS that will improve access to prevention programs and team-based care.

Action Plans / Interventions			
Action Plans / Interventions:	% Completion by Year		
	2011-12	2012-13	2013-14
Establish new Diabetes Education Program Team(s) across the Erie St. Clair LHIN (Wave 1)	100%	-	-
Establish new Diabetes Education Program Team (s) across the Erie St. Clair LHIN (Wave 2)	100%	-	-
Begin to initiate Regional Coordination Centre (RCC) for Diabetes in Windsor (to serve the entire Erie St. Clair LHIN)	80%	20%	-
Advance performance targets and metrics for the Diabetes sector	80%	20%	-
Initiate Self-Management Program Erie St. Clair LHIN-wide	50%	50%	-
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 Erie St. Clair LHIN	20%	20%	20%
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%
Establish timelines and plan for divestment of DEP to community from hospital (C-K)	20%	80%	-
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?			
- Timely new service expansion - Need for a 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) and Family Physicians - Access - Distribution of Diabetes Teams - Accessibility to clinic (i.e. parking fees, registration process at Ambulatory Care can be barriers) - Not enough HHR supports (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 (MH & A)	
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, MH&A 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 MH&A 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 MH & A • 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 the MH&A sectors and between hospital and community services	

Current Status

The MOHLTC and local communities have been planning for the reform of the MH&A systems for over 10 years.

Re-occurring themes and issues include:

- 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
- The need 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 comprehensive service delivery model for MH&A Services along with a supporting policy framework
- Meaningful participation of consumer / survivors and their families in the reform process
- Ontario's diverse population must be addressed during the reform process
- Change management plan-process
- Improved education, training, and public awareness in this sector

Further, the Erie St. Clair LHIN region has been extremely hard hit in the economic downturn. MH&A 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 MH&A 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
- 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, MH&A 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
- Reduce ED repeat visits
- 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 LTC homes
- 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 (MH&A) clients
- Early intervention clients (newly identified youth with psychotic disorders / Mental Illness)
- Transitional Aged Youth - those moving from the children's Mental Health sector into the adult system
- 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
- Adults requiring Withdrawal Management Services

Consistency with Government Priorities:

The above goals are consistent with the government's commitment to strengthen MH&A 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		
	2011-12	2012-13	2013-14
Mental Health			
Initiate Tier II and Tier III Planning Process and Structures	75%	25%	-
Continue to advance the 'integrated assessment project' Erie St. Clair LHIN-wide	70%	30%	-
Advance performance targets and metrics for Mental Health sector	70%	20%	10%
Initiate an 'employment task force' (in W/E) and develop a strategy to resolve issues in this area	30%	40%	20%
Increase community education and promotion of Community Crisis Services	20%	20%	20%
Plan and initiate alternatives to hospitalization	10%	10%	10%
Expand Tele-Crisis Services Erie St. Clair LHIN-wide	10%	10%	20%
Enhance community service capacity for priority areas: early intervention, Crisis services, psycho-geriatric teams, mobile outreach, Program of Assertive Community Treatment (PACT) Team capacity, etc.	10%	10%	20%
Enhance and re-engineer crisis follow-up	10%	10%	30%
Establish a community-based mood disorders program; provide information and education about the service to primary care providers, ED Physicians / staff, other key referral sources	-	10%	10%
Addictions (Adults with Addictions):			
Align addiction plans with MLPA targets	100%	-	-
Expand existing day treatment program (S/L)	10%	10%	10%
Establish Withdrawal Management Services for each Erie St. Clair LHIN sub-region	10%	30%	30%
Expand addiction medicine services at ambulation clinics; 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 addiction medicine program for gender responsive services (W/E)	10%	10%	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 ED repeat visits by 15%
- 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
- Adherence to treatment plan: increase in completion of outpatient treatment by 20%
- Reduced Inpatient gero-psychiatry admission by 5-10%
- Eliminate the PACT 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 referrals 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 improve access to service

What are the risks / barriers to successful implementation?

- Increasing demand for services (capacity) in the community for the mentally ill and those with addictions
- Access to primary care for this population
- Ongoing delay in divestment of Tier II (bedded) and Tier III (non-bedded) services from Regional Mental Health
- Funding issues in both sectors
- 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 and suicide rates
- Continued separate planning, funding and service delivery silos between MH & A
- Need for 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 functional decline. Often rehabilitation is provided by an interdisciplinary team which may include: Nurses (RN and RPNs), Physiotherapists (PTs), Occupational Therapists (OTs), Speech-Language Pathologists, Social Workers and Dietitians, Pharmacists, Psychologists, Psychiatrists, Geriatricians. Services are provided 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. Many conditions, although they improve, tend to remain chronic requiring specialized community re-integration, and adaptations to care and the environmental residential setting. In the Erie St Clair LHIN, a comprehensive range of inpatient and outpatient rehabilitation services is available to children and adults who experience debilitating illness or injury, e.g. cardiac rehab, complex care, complex injury, geriatric rehab, LTC, neurological including stroke, 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 publicly-funded physical therapy services (affecting the overall supply of Physical Therapists (PTs) and Occupational Therapists (OTs). A recent report (2007) by the Canadian Institute Health Initiatives 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	
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. assess-restore 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 activation 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 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, Muscular Dystrophy)
- Complex disability patients (stroke, Acquired Brain Injury)
- Individuals with chronic respiratory diseases, lung disease: COPD
- Individuals with heart failure and myocardial infarction: post-coronary rehabilitation
- 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		
	2011-12	2012-13	2013-14
Expand in-hospital assess-restore program(s) to W/E then Erie St. Clair LHIN-wide	60%	40%	-
Advance performance targets and metrics for Rehab sector	60%	10%	10%
Advance a Community Rehabilitation Resource Team (in W/E) and then Erie St. Clair LHIN-wide	60%	20%	20%
Advance Transitional Stroke program Erie St. Clair LHIN-wide (focus on S/L to start)	75%	25%	-
Complete assessment of allied health care needs in Erie St. Clair LHIN region (with consideration of rehab within assessment)	40%	10%	10%
Advance a Hip Fracture program / strategy Erie St. Clair LHIN-wide	30%	30%	30%
Initiate 'future visioning exercise' to determine the future state for Rehab in Erie St. Clair	10%	90%	-
Review CCC and determine best future use for this bed resource	10%	50%	40%
Expand Day Rehab Services Erie St. Clair 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%
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 reducing reliance on CCC or LTC homes • Increase patients discharged from rehabilitation to home by 10% • Decrease the total LOS (acute plus rehabilitation) by two days for top 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 – need for more formal coordination • Reduction of current services in-hospital (including rehabilitation services) • 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, Respiratory Therapist (RT)) • Need for organizations to work together to resolve 'system' issues • Lack of subsidized supportive residential alternatives other than LTC • Limited alternative options to ED in community • 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			

2.6 End-of-Life Care / Hospice Palliative Care

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY
Integrated Health Services Plan Priority:
End-of-Life Care (EOLC) / Hospice Palliative Care (HPC)
IHSP Priority Description:
The overarching priority is to create a formalized system of HPC Service delivery in each of the three counties in Erie St. Clair, rather than a collection of disconnected services. HPC is needed for all disease categories, (including chronic diseases), and is required in all care settings where patients die. HPC has been shown to: • Improve patient and caregiver quality of life • Save money for the health care system (when patients are cared for in the appropriately setting) Despite the demonstrated benefits of HPC programs there are still far too many: • Needlessly unpleasant deaths • Procedures conducted on patients at the EOL which neither prolong nor improve life • Inappropriate admissions to acute care • Patients dying in inappropriate locations e.g. of the patients who died of cancer, the % that died in acute care hospital in Erie St. Clair is higher than the provincial average (55.7% vs. 52.1%) • Unnecessary visits to the ED e.g. % of lung cancer patients who visited the ED in the last 2 weeks of life is higher than the provincial average (48.1% vs. 45.8%) The need for HPC is increasing. It is projected that in the Erie St. Clair region in 2011/2012 over 3000 people (and their families) will require a specialized program of palliative care, with many more requiring primary care palliative care services. The Erie St. Clair region shows significant trends, such as aging population, rates of cancer, and residents' behaviours, such as smoking and lack of exercise, which indicate an even greater need for palliative care than is the case across the province (e.g. higher lung and bronchus cancer incidence rates, colon and rectum cancer incidence rates, chronic diseases). Previously efforts related to enhancing HPC service delivery in Erie St. Clair have been sector specific / program specific. A cross sector, system-level approach is now required.
Current Status
Recent progress has been made to advance system development in Erie St. Clair, with pockets of palliative care excellence emerging. However, gaps persist and integration is incomplete, including: • Key care settings and services lacking in specific catchment areas (e.g. Bereavement Programs for complex grief management in two counties; residential hospice in one county) • Palliative Care Programs are established in fewer than 40% of care settings where patients die • Specific integration essentials are needed in each county (e.g. cross sector access to documentation) • More trained HPC professionals are needed (e.g. using a simple population based calculation and comparison with Toronto Central LHIN, Erie St. Clair has 67% fewer palliative care Physicians for patients in this community) • Improved system-level accountability, evaluation, monitoring and reporting is needed (e.g. monitoring, evaluation and reporting at a program specific and / or facility specific level has been enhanced, however, this has not been rolled up into a system level evaluation framework or process) • Provincial / federal policy / guidelines / funding issues continue to impact service delivery at the local Erie St. Clair LHIN level

TEMPLATE A:
PART 2: GOALS and ACTION PLANS

Goal (s)

EOLC / HPC Overall Goals:

- To ensure a full continuum of HPC care settings and services is available in each county
- To increase the number of HPC programs within care settings where patients die
- To improve integration across sectors through common regional processes, structures, education and personnel that connect the sectors
- To increase the number of specialist level HPC experts and to improve primary care providers' knowledge, skills and confidence in reducing the severity and distress associated with end-of-life symptoms
- To enhance the current cross sector accountability mechanism for HPC in Erie St. Clair. (This accountability mechanism will include cross sector / system level planning, evaluation and reporting)
- To identify provincial and federal policy / funding / guideline issues that impact HPC service delivery and work towards improved integration

The action plans will focus on the following priority populations for EOLC / HPC:

Any patient with any diagnosis who is *deemed to require palliative care services in:

- Community settings as well as LTC Home and CCC and Residential Hospice settings with priority given to:
 - Pre-empting or managing crisis situations that would otherwise lead to emergency department visits and / or hospital admissions
 - Enhancing care provision and patient family experience
- Acute care settings with priority given to:
 - Facilitating earlier and clearer prognostication of patient outcomes
 - Helping reduce the provision of aggressive, expensive medical treatments which neither prolong or improve life
 - Providing more timely symptom response for tertiary level HPC crisis intervention thereby facilitating earlier discharge and decreased ALC days
 - Enhancing care provision and patient family experience

➤ Additional priority populations within these care settings include:

- "Orphan" patients – no primary care provider
- Seniors
- First Nations people
- Rural or geographically isolated people
- Minority ethnic populations
- Frequently readmitted chronic disease patients who are nearing end of life or for whom advance care planning needs to be completed

*Note: Criteria used in Erie St. Clair for determining the need for palliative care services includes using the following questions:

1. *Would you be surprised if this client died in the next 6 months? (If the answer is "no" - ask question 2)*
2. *Does the client have unmet symptoms and / or support needs? (If the answer is "yes" some type of palliative care assistance may be required)*

Consistency with Government Priorities:

The above goals are consistent with the government's priorities to enhance care in the community (reduce wait times), and to reduce inappropriate acute care hospital utilization (admissions, ALC days, ED visits etc.).

Action Plans / Interventions			
Action Plans / Interventions	Target - % completed by year		
	2011-12	2012-13	2013-14
Advance a full continuum of care settings and services for EOLC / HPC in all 3 counties – specific focus on addition of Bereavement Services and Residential Hospice.	40%	30%	30%
Support building and integration of HPC programs in all care settings where patients die – specific focus on community (education and Palliative Care Consultation Team) and other care settings (education).	30%	20%	20%
Continue with integration activities and projects – specific focus on Education Blueprint / Strategy and Communication Strategy (refer to specific strategy documents for details). This includes education in First Nations and other culturally diverse populations and emphasis on enhancing best practice in all care settings.	40%	30%	30%
Enhance human resources for HPC by: advancing the use of team based care, providing education to primary care providers, recruiting specialist level HPC providers etc.	20%	20%	20%
Strengthen system-level accountabilities – including the EOLC Erie St. Clair LHIN Advisory Network role in system level: data collection, evaluation, outcomes and overall performance of the HPC system.	45%	45%	45%
Participate in development of provincial / federal level policy / guidelines / strategies. Develop mitigating strategies to work around current imposed limitations.	40%	40%	20%

Expected Impacts of Key Action Items
- Expanded PCCT ➤ To all three counties to serve an additional 550 new community-based clients - Reduced avoidable ED visits, avoidable admissions and ALC days ➤ Avoidance of ED visits / admissions in 70% of PCCT clients who might have otherwise visited the ED - Increased options in care settings for dying patients and increased prevalence of concordance between client preference and place of death ➤ At least 60% of PCCT clients will achieve concordance between preference and place of death - Increased percentage of non-hospital deaths ➤ At least 50% of PCCT clients will die in non-hospital locations - Improved patient flow ➤ At least 75% of stakeholders will report an improvement in patient flow as a result of the action plans / interventions - Enhanced Palliative Care Programs within acute care settings facilitating earlier identification and treatment of patients requiring palliative care thereby: ➤ Reducing the numbers of procedures (which neither prolong nor improve life) conducted on patients at the end of life ➤ Reducing length of stay

- Enhanced Palliative Care Programs in all settings where patients die so that within three years at least 70% of these care settings have a definable and viable HPC Program for their clients
- 10% increase in number of providers who receive training in HPC
- Increased use of informal care givers by 10% to support the current volunteer complement through Share the Care™ training
- Enhanced system level accountability for Hospice Palliative Care service delivery with publication of first Erie St. Clair HPC system-level report card in 2011/2012
- Increased access to comprehensive, quality HPC Services across the Erie St. Clair region
- Improved symptom management and quality of life for patient and family / care providers resulting in improved patient / family and provider satisfaction with EOLC and quality of dying
- Decreased likelihood of major depression, poor health and premature death for family members / caregivers
- Creation of a sustainable, innovative regional model of care and accountability that synergistically leverages current provider systems and strengths and is robust and flexible enough to be maintained in the event of changes in personnel, changes in priorities etc.

What are the risks / barriers to successful implementation?

- Public (and health care provider) misconception that palliative care means abandoning hope and just “doing nothing”, resulting in delayed referrals and continued acute care approach
- Sector specific priorities that may not support a system-wide approach to Palliative Care Service Delivery.
- Recruitment issues – Specialist level Palliative Care Physicians, NP as well as other team members
- Improve data collection methodologies to allow HPC evaluation at a system level (e.g. National Ambulatory Care Reporting System (NACRS) to capture increased use of ED by patients who require palliative care)
- Few resources in LTC homes to support increased staffing requirements that may be needed to handle complex palliative care needs
- Need to clarify policy directions regarding the role of residential hospices within the HPC system

2.7 French Language Services

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY	
Integrated Health Services Priority:	
French Language Services (FLS)	
IHSP Priority Description:	
The Erie St. Clair LHIN Francophone population counts approximately 22,000 people (based on the inclusive definition of Francophone). • Generally older than the general population ➢ Average age is 48 in comparison to 39 in the general population ➢ 52% is aged 50 and over in comparison to 33% in the general population • Increasing number of French-speaking immigrants, especially in the Windsor area ➢ Many come from African war-torn countries • Chronic diseases rates are higher among the Francophone population in comparison to the general population. For example: ➢ high blood pressure = 22.2% (Francophone population) vs 17.3% (general population) ➢ heart disease = 8.3% vs 5.2% ➢ diabetes = 9.7% vs 6.3% The Francophone population is dispersed across the Erie St. Clair LHIN with pockets along the main watercourses, therefore creating limited critical mass opportunities.	
Current Status	
The Erie St. Clair LHIN needs to improve current data about the Francophone population and health services available in French. The Erie St. Clair LHIN does know however, that access to and accessibility of health services in French remains limited in the in the region despite the identification and / or designation of 34 health care providers for the delivery of services in French. French-speaking seniors need a French-speaking environment inside a LTC facility in their last years of life in order to maintain their quality of life. The French Language Services Coordinator is now in place at the Erie St. Clair LHIN to assist with the planning and monitoring of services in French. The newly announced (December 2010) French Language Health Planning Entity is expected to be functional at the beginning of the 2011-2012. The role of the entity will be to advise the Erie St. Clair LHIN on methods of engaging the Francophone community, on its needs and priorities, and on strategies to improve integration, access to and accessibility of health services in French. This will lead to changes in the action plans with the identification of other priorities and needs. The Erie St. Clair LHIN French Language Services Committee remains an important link between the Francophone community and the Erie St. Clair LHIN, and will continue to provide feedback into the Erie St. Clair LHIN's work.	

TEMPLATE A:
PART 2: GOALS and ACTION PLANS

Goal (s)

FLS Overall Goals:

- Ensure strong and meaningful engagement with the Francophone community
- Improve data collection on the nature of Francophone population
- Understand and strengthen existing structures
- Develop a comprehensive French Language Health Services Plan
- Improve patient experience
- Increase accessibility of LTC and community support services for Francophone seniors
- Investigate use of EDs by Francophone population

The action plans will focus on the following priority populations:

- Francophone population as a whole
- Francophone seniors
- Francophones living with chronic diseases and / or mental health conditions

Consistency with Government Priorities:

The above goals are consistent with the government's priority to improve access to and accessibility of health services in French to the Francophone population across the province.

Action Plans / Interventions

Action Plans / Interventions:	% Completion by Year		
	2011-12	2012-13	2013-14
Develop a communication strategy to reach the Francophone community	-	60%	40%
Review data currently collected, identify gaps, and develop a data collection protocol regarding FLS and Francophones	-	70%	30%
Have identified HSPs to complete a FLS Implementation Plan	20%	80%	-
Review and / or develop Erie St. Clair LHIN policies regarding FLS	-	80%	20%
Prepare an inventory of FLS healthcare professionals	60%	30%	10%
Analyze data and draft a FLS plan for the Erie St. Clair LHIN	-	60%	40%
Develop and deliver education sessions and materials to increase knowledge and awareness of providers and their staff about Francophones and FLS needs	-	60%	40%
Work with the Diabetes Regional Coordination Centre to identify and develop actions specific to Francophones living with diabetes	10%	40%	40%
Advance an inventory of available community support services in French for seniors	-	100%	-
Investigate opportunities to develop programs to address gaps in community support services available in French for seniors	-	10%	30%
Create a LTC French-speaking pod (36 beds) for Francophone seniors in a LTC Facility	-	20%	20%

Expected Impacts of Key Action Items
• Increased awareness of available services in French by the Francophone population • More reliable data on the Francophone population • Up-to-date picture of the status of FLS and FLS capacity in Erie St. Clair • Increased providers' and staff awareness of requirements regarding FLS • Increased integration of FLS into day-to-day business of providers • Increased responsiveness of providers to the needs of the Francophone population • Improved patient satisfaction • Reduced ALC use
What are the risks / barriers to successful implementation?
• Inability to advance 'innovative thinking' on the development of services specific to Francophones • Lack of human and financial resources needed to meet goals

3 Erie St. Clair LHIN Operations and Staffing Templates

3.1 Erie St. Clair LHIN Operations Spending Plan

LHIN Operations (\$)	2009/10 Actuals	2010/11 Actuals	2011/12 Plan	2011/12 Outlook	2012/13 Outlook
Salaries and Wages	2,462,994	2,578,900	2,553,400	2,634,400	2,711,300
Employee Benefits					
HOOPP	201,003	213,700	248,200	255,600	263,300
Other Benefits	289,379	297,600	244,900	252,200	259,800
Total Employee Benefits	490,382	511,300	493,100	507,800	523,100
Transportation and Communication					
Staff Travel	93,118	88,900	90,200	90,200	90,200
Governance Travel	28,121	21,300	20,300	20,300	20,300
Communications	60,243	54,800	45,000	45,000	45,000
Others	-				
Total Transportation and Communication	181,482	165,000	155,500	155,500	155,500
Services					
Accommodation	219,341	188,300	213,800	220,200	220,200
Community Engagement	43,336	68,800	110,000	110,000	110,000
Consulting Fees	249,133	148,600	100,500	145,000	75,000
Governance Per Diems	118,525	114,300	105,300	105,300	105,300
LSSO Shared Costs	362,714	409,500	610,000	428,300	441,100
Other Meeting Expenses	46,069	36,800	57,500	57,500	57,500
Other Governance Costs	99,690	45,800	35,300	35,300	35,300
Staff Development	26,917	114,100	38,500	38,500	38,500
Other Services	-	-	-	-	-
Total Services	1,165,725	1,126,200	1,270,900	1,140,100	1,082,900
Supplies and Equipment					
IT Equipment	-				
Office Supplies & Purchased Equipment	87,643	105,000	86,000	121,100	86,100
Other S & E					
Total Supplies and Equipment	87,643	105,000	86,000	121,100	86,100
Capital Expenditures	-				
LHIN Operations: Total Planned Expense	4,388,226	4,486,400	4,558,900	4,558,900	4,558,900
Annual Funding Target	4,388,226	4,486,400	4,558,900	4,558,900	4,558,900
Operating Surplus (Shortfall)	-	-	-	-	-

3.2 Erie St. Clair LHIN Staffing Plan

Template C: Erie St. Clair 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
Director, Corporate Services / Controller	1	1	1	1	1
Community Engagement	2	2	2	2	2
Health System Design Manager	4	3	3	3	3
Health System Manager	3	3	3	3	3
Data	2	2	2	2	1
Funding and 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 Communications Plan

Outcomes	To communicate the purpose, direction and initiatives captured in the ABP and gain commitment on the plan internally from Erie St. Clair LHIN staff, and externally from funded HSPs			
Key Messages	➤ The Erie St. Clair LHIN's ABP is the strategic plan of our LHIN for the next year. It includes the priorities and strategic directions of the IHSP, outlines how we plan to address these priorities and improve our health care system in coming fiscal year of 2011-2012 ➤ The ABP helps communicates the public what and how the Erie St. Clair LHIN will address the needs of the community ➤ The Erie St. Clair LHIN ABP is approved by our LHIN Board of Directors and the MOHLTC			
Tactic	Audience	Strategy	Engagement	Timelines
Draft sent to Board for review	1. Erie St. Clair LHIN Board	To inform Board as to the contents of the ABP	Inform / Educate	January 2011
Develop key messages	1. HSP 2. Media 3. Public	To communicate effectively and consistently about the purpose of the ABP	Inform / Educate	January 2011
Develop and communicate a Corporate Communication Plan	1. Public 2. HSP 3. Stakeholders Erie St. Clair LHIN Staff	To incorporate the initiatives captured in the ABP and other organizational priorities into a Corporate Communications Plan	Inform / Educate	April 2011
Develop and communicate an Annual Community Engagement Plan	1. Public 2. HSP 3. Stakeholders Erie St. Clair LHIN Staff	To incorporate the initiatives captured in the ABP and other organizational priorities into Annual Community Engagement Plan	Inform / Educate	April 2011
Discuss and approve ABP draft at open Board meeting	1. Erie St. Clair LHIN Board 2. Media 3. Public	To discuss and gain approval in an open and transparent manner	Involve	June 2011
Board meeting highlights	1. HSP 2. Media 3. MPPs 4. MOHLTC	To communicate approval of draft ABP (Note: Post to web)	Inform / Educate	June 2011
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 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	June 2011
Facebook update to fans	1. Stakeholders	Post update on Facebook site to communicate purpose of ABP, highlights and timelines	Inform / Educate	June 2011
Include in LHINfo Minute update	1. Elected Officials	To continue to keep elected officials informed of Erie St. Clair LHIN initiatives	Inform / Educate	June 2011

Communication and Community Engagement Tactics and Vehicles:

The Erie St. Clair LHIN uses a number of integrated communication tactics and tools to inform and engage its stakeholders. These tools and tactics are captured in the Communication and Community Engagement Tactical Plan.

An emphasis will be placed on the Erie St. Clair LHIN website as a comprehensive and interactive resource to find more information.

Communications tools include, but are not limited to:

- Media Releases
- Media Conferences
- Public Service Announcements (PSA's)
- Letters to the Editors
- Editorial Boards
- Email Campaigns
- Email Taglines / Signatures
- Web Alerts (via Erie St. Clair LHIN website)
- Website
- Online Collaborative
- Social Media (Facebook, Twitter, YouTube)
- Video / Podcasting
- Video Blog
- 3rd Party Publications (e.g. Health Service Provider's Newsletters)
- Presentations / Public meetings
- Video and Teleconferences / Webinars
- Annual Report
- Publications (e.g. Brochures, Reports, etc.)
- Board Meetings
- Board Meeting Highlights
- Online Board Meeting Packages
- Community Engagement Activities
- Direct Mail
- Advertising

Communications Strategy and Goals

As stated in the Corporate Communication Plan: April 2011 – March 2012, the communication strategy for the coming year will be focused in the following ways:

Strategy Statement:

Proactive, Informative, People-focused

Strategic Direction:

Use proactive communication as the prioritized method for delivering the Erie St. Clair LHIN Corporate Communications and Community Engagement plans. Informative communications will focus on the “Access to Care” messaging, ESC LHIN value statements, and local initiatives and successes. People-focused communications will bring to light patient / consumer experiences, crafted with clarity and relevancy, and respect both official languages.

Strategic Objectives:

Primary - Increase access to health care

Access to health care will be increased by producing educational and engaging communications that improve navigation of the health care system and public understanding of local health care services.

Secondary - Promote the value of LHINs

Communicating the value of LHINs will be achieved through proactive communication with a focus on demonstrating LHIN investments and results that improve the health outcomes of local residents.

Goals:

1. Produce proactive communication strategies and materials that support Pan-LHIN and provincial projects; Erie St. Clair LHIN projects and community engagement plans and other major initiatives.

For example – Annual General Meeting, Media calendar, LHINfo Minute, news releases, media events, communications plans, communication and marketing materials

2. To create people-centered communications in a manner that uses common language, demonstrates relevancy to the audience, and highlights the patient / consumer experiences and testimonials.

For example - news releases, social media postings, LHINfo minutes

3. Further enhance community conversations, with and amongst all stakeholders, by utilizing informed two-way dialogue.

For example - “join the discussion” campaign, enhanced Facebook postings, community based presentations and events, Erie St. Clair LHIN Compliments and Concerns Process, online feedback, Open Mic

4. Partner with HSPs / stakeholders on joint communication initiatives in order to present a system view, make the most efficient use of resources, and as a means of sharing information with common audiences.

For example - joint funding announcements, Pan-LHIN Community Engagement Guidelines, Health Care Connect

Note: Individual communications plans will be developed for projects and initiatives captured in the ABP 2010/11 as well other organizational priorities

Community Engagement

Community Engagement takes many forms and occurs throughout the year in both a general way and in a project specific approach. The following is a sample of community engagement initiatives that the Erie St. Clair LHIN will be undertaking in 2011-2012:

- ALC engagement opportunities focusing on the input from seniors and caregivers
- Continued interface with the Erie St. Clair LHIN Health Professional Advisory Committee
- Continuation of the Erie St. Clair LHIN Advisory Networks Seniors' initiatives such as Home First, Falls Prevention, Aging at Home and a Seniors' Services Guide
- Continuing to promote Health Care Connect
- Creation of a Citizens Advisory Network to provide a formal mechanism for public input
- Fostering Erie St. Clair LHIN – HSP partnerships to enhance collaborative Community Engagement efforts
- Implementation of Pan-LHIN Community Engagement Guidelines
- Improved online Compliments and Concerns process
- Increased community participation at open Board meetings through the education sessions
- Delegation process and the Open Mic opportunity
- Join the discussion - Facebook, a means to increase dialogue with, and amongst, the community
- Utilizing the Erie St. Clair LHIN Speakers Bureau to reach out to the community

Priority Population / Programs

Communication and Community Engagement initiatives impact many populations and sectors within the Erie St. Clair LHIN region during the year, however, during 2011/12 the Erie St. Clair LHIN will focus its resources to engage the following populations primarily, and consider other engagement opportunities pending resource availability and project specific needs. The following target populations have been identified based on Local Health System Integration Act, 2006 obligations, priority projects, and communities of interest / practice that are essential to the achievement of planning outcomes.

- Aboriginal community
- Elected officials, Aboriginal and community leaders
- Francophone community
- General public
- HSPs
- Physicians
- Seniors

5 In-Year Funding Allocation

Throughout the course of the fiscal year, additional in-year funding grants are provided to the LHINs 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

Erie St. Clair			
Local Health Integration Network			2010/11 Funding
			Total 2010-11
			\$ 2,527,772
Project Title	Service Provider Name	Project Description	
Windsor Allergy Asthma Education Centre	Windsor Regional Hospital	Continuity of training program	20,000
Hospice Van Renovation	Hospice of Windsor	Replacement of aging vans	35,000
Alzheimer PT Social Worker	Alzheimer Society W/E	FT Social worker	45,000
CMHA Addiction Counselling	CMHA W/E	Salvation Army Program	80,000
APPD Respite Program	APPD	Family Support	80,000
Centre for Seniors - Wheelchair Van	Centre for Seniors	New wheelchair van - not one currently	57,000
Alzheimer Comp Review	Alzheimer Society W/E	Support for SW and ESC LHIN Societies to conduct review	20,000
Malden Park - Temp (Conversion) Beds	Erie St. Clair CCAC	provide 12 hour per day PSW, one nursing visit per day, equipment rentals and supplies for equivalent of 20 patients during the time of Malden park transition	787,000
W/E Hospitals Labour Relations	Windsor Regional Hospital	Labour relations integration	60,000
Malden Park - Start-up Conversion Bed costs	Windsor Regional Hospital	This funding provides a maximum of \$100,000 for equipment and furnishings, support for a management contract and patient liaison costs for safe patient transfer, additional nursing costs and managerial certification costs	350,000
NP Transition Hosp/Community	Hotel Dieu Grace	Nurse Practitioner	90,000
Primary Health Care Task Group Decision Making Tool	Grand Bend CHC	DMT - PMHCTG	50,000
Wellness Program	Windsor Regional Hospital	Wellness Program for Extended Psychosis	100,000
Nursing Unit Preparation	Hotel Dieu Grace	preparation as needed for the Nursing Unit	150,000
Interventional Angiography	Hotel Dieu Grace	program for cardiac patients	300,000
Congregate Dining	Windsor-Essex CHC	new program funding	22,000
Operations Supplies	Family Counselling Centre	Necessary Equipment replacement	2,200
Arthroplasty Services	Hotel Dieu Grace	Hip and Knee surgery services	190,000
Resettlement Program	Hotel Dieu Grace	Supplementary Support Services alongside CCAC	80,000
MOW Integration	St. Andrew's Residence	MOW Integration within Chatham-Kent Municipality	9,572
Total Allocated Urgent Priorities Fund			\$ 2,527,772

5.2 Erie St. Clair LHIN Funding: In-Year Revenues

ERIE ST. CLAIR LOCAL HEALTH INTEGRATION NETWORK					
Draft Statement of Financial Activities					
For The Year Ended March 31, 2011					
	Prior Year YTD 2009/2010	Actual YTD 2010/2011	Budget YTD 2010/2011	Variance	
				\$	%
Revenue					
Transfer Payments	4,288,226	4,386,383	4,295,080	91,303	2.1%
ED/ALC Funding	100,000	100,000	-	100,000	
Diabetes Funding	25,000	3,750	-	3,750	
AHTF Funding	126,500	-	-	-	
French Language Services	36,942	148,227	35,558	112,669	
Capital Revenue	230,825	44,573	50,000	(5,427)	(10.9%)
Critical Care Lead	-	51,000	-	51,000	
eHealth	600,000	1,287,000	-	1,287,000	
ED Lead	75,000	75,000	-	75,000	
	5,482,493	6,095,933	4,380,638	1,715,295	39.2% 1
Expenses					
Salaries	2,327,994	2,388,914	2,336,840	52,074	2.2%
Contract Salaries & Benefits	189,500	185,000	60,900	124,100	203.8% 2
Benefits	440,882	466,264	453,210	13,054	2.9%
Subtotal (Salaries & Benefits)	2,958,376	3,040,178	2,850,950	189,228	6.6%
Governance	246,336	181,377	280,830	(99,453)	(35.4%) 3
Travel	93,118	88,882	109,040	(20,158)	(18.5%) 4
Consulting Services	277,231	148,601	159,260	(10,659)	(6.7%)
Communications/Forums	43,336	68,825	60,000	8,825	14.7% 5
Supplies/Equipment/Maintenance	140,241	200,901	156,000	44,901	28.8% 6
Subtotal (Other Business Expenses)	800,262	688,586	765,130	(76,544)	(10.0%)
Accommodations	135,124	196,001	109,000	87,001	79.8% 7
Lease Expense	144,460	152,085	160,000	(7,915)	(4.9%)
Common Services - LSSO	362,714	359,495	360,000	(505)	(0.1%)
LHIN Collaborative	12,286	50,028	50,000	28	0.1%
Amortization Expense	230,825	44,573	50,000	(5,427)	(10.9%) 8
AHTF Expenses	126,500	-	-	-	
French Language Services	36,942	148,237	35,558	112,679	
Diabetes	-	3,750	-	3,750	
Critical Care Lead	-	51,000	-	51,000	
eHealth	600,004	1,287,000	-	1,287,000	
ED Lead	75,000	75,000	-	75,000	
Total Operating Expenses	5,482,493	6,095,933	4,380,638	1,715,295	39.2%
Net Income (Loss)	-	-	(0)	0	
Draft Statement of Financial Position					
Cash	481,524	849,512			
Prepays	12,054	-			
Accounts receivable - MOHLTC	3,299,486	2,381,019			
Accounts receivable	5,000	65,126			
FINANCIAL ASSETS	3,798,064	3,295,657			
Accounts payable and accrued liabilities	448,107	854,497			
Due to MOHLTC	14,913	55,755			
Due to HSPs	3,299,486	2,381,019			
Due to LSSO	-	4,386			
Deferred Revenue	35,558	-			
Deferred capital contributions	64,604	67,490			
LIABILITIES	3,862,668	3,363,147			
NET DEBT	(64,604)	(67,490)			
Capital assets	64,604	67,490			
ACCUMULATED SURPLUS (DEFICIT)	-	-			
		-			
Forecast Notes:					
1 - Funding announcements expected (post Budget approval)					
2 - additional contract staff related to project funding, sick leave coverage, additional administrative support, and in-house design					
3 - Governance expenses much lower than expected for current fiscal year (turnover in members and lower number of meetings)					
4 - Reduced travel expenses for the year					
5 - HCC Events, Conference					
6 - additional training for staff (IH), LEAN, Coaching					
7 - accommodation expenses increase for the year (op. costs for building, voice and data expense increasing), new equipment <\$70k and so					
8 - amortization on new equipment purchased in 2010/2011 (switches, printer)					

5.3 Health Service Provider In-Year Allocations

Erie St. Clair Local Health Integration Network Community Sector Incremental Stabilization Funding (excludes CCAC) Fiscal Year 2010/11	
Sector	Base Funding Increase
Acquired Brain Injury	\$ 27,865
Assisted Living	104,967
Addictions	155,484
Community Mental Health	543,388
Community Health Centre	305,500
Community Support Services	299,235
Total Stabilization Increase for 2010/11	\$ 1,436,439
<i>Note: Represents 2% increase over 2009/10 Base Funding</i>	

Erie St. Clair Local Health Integration Network Community Care Access Centre Funding Adjustments' Fiscal Year 2010/11				
Organization	Initiative	Base Funding	One-Time Funding	Total Funding
CCAC	Provincial Program	\$59,000		\$59,000
CCAC	Stabilization / Expansion	2,644,850		2,644,850
CCAC	Service Maximums Incremental	1,913,700		1,913,700
CCAC	Wait Time Strategy (TJR)		\$765,000	765,000
CCAC	Aging at Home		787,000	787,000
CCAC	Care Connectors		170,100	170,100
CCAC	Palliative Care	500,000		500,000
Total Funding Adjustments		\$5,117,550	\$1,722,100	\$6,839,650

Fiscal Year 2010/11				
Organization	Initiative	Base Funding	One-Time Funding	Total Funding
Hospital	Funding Formula Addition	\$8,806,800		\$8,806,800
Hospital	Small Hospital Subsidy	119,300		119,300
Hospital (WRH; BWH)	Post Construction Operating Plan	11,289,900	\$339,500	11,629,400
Hospital (WRH)	Operating Pressures	2,108,300		2,108,300
Hospital (H&K; Cataract; MRI; CT)	Wait Time Strategy		7,693,600	7,693,600
Hospital (Paed Surgery; General Surgery)	Wait Time Strategy		772,700	772,700
Hospital	WTS ER Pay for Results		4,717,100	4,717,100
Hospital (HDGH)	Nurse Led Outreach Team		250,000	250,000
Hospital	Aging at Home	1,070,000	2,873,970	3,943,970
Hospital	Provincial Programs	420,300	121,000	541,300
Hospital	Critical Care Nurse Training		146,900	146,900
Hospital	Hospital Infrastructure Renewal Fund		2,025,299	2,025,299
Hospital	Nurse Practitioners	1,476,000		1,476,000
Total Funding Adjustments		\$25,290,600	\$18,940,069	\$44,230,669

5.4 Aging at Home Year 3 Allocation

Organization	Project Title	Base Funding	One-Time Funding	Total Funding	Annualized Base
WRH	ALC Dedicated Interim LTC beds at MP		1,600,000	1,600,000	
Leamington Mennonite Home	Emergency Response		45,000	45,000	
WE CHC	Response Team for Seniors	392,508		392,508	392,508
CK CHC	Response Team for Seniors	169,164		169,164	169,164
GB CHC	Response Team for Seniors	169,164		169,164	169,164
NL CHC	Response Team for Seniors	169,164		169,164	169,164
CMHA SL	Psycho Geriatric Expansion	40,000		40,000	40,000
CKHA	Psycho Geriatric Expansion	40,000		40,000	40,000
WRH	Psycho Geriatric Expansion	170,000		170,000	170,000
WE CHC	Falls Prevention Program	269,794		269,794	269,794
GB CHC	Falls Prevention Program	32,551		32,551	32,551
NL CHC	Falls Prevention Program	32,552		32,552	32,552
CK CHC	Falls Prevention Program	65,103		65,103	65,103
Alzheimer Society of Chatham-Kent	First Link Program	150,000		150,000	150,000
Alzheimer Society of Windsor-Essex	First Link Program	75,000		75,000	75,000
Alzheimer Society of Sarnia-Lambton	First Link Program	75,000		75,000	75,000
Lakeshore Community Services	Dialysis Transportation Services	200,000	100,000	300,000	200,000
BWH	Ambulation Team	177,036		177,036	177,036
CKHA	Ambulation Team	177,036		177,036	177,036
HDGH	Ambulation Team	291,854		291,854	291,854
WRH	Ambulation Team	291,854		291,854	291,854
LDMH	Ambulation Team	62,220		62,220	62,220
BWH	Slow Stream Rehab		450,000	450,000	-
CKHA	Slow Stream Rehab		450,000	450,000	-
NL CHC	Rehab Team	290,000		290,000	290,000
CK CHC	Rehab Team	290,000		290,000	290,000
Alzheimer Society of Sarnia-Lambton	Caregiver Support & Respite	90,000		90,000	90,000
WRH	GEM Expansion from Yr 2	14,000		14,000	14,000
HDGH	GEM Expansion from Yr 2	14,000		14,000	14,000
LDMH	GEM Expansion from Yr 2	14,000		14,000	14,000
CKHA	GEM Expansion from Yr 2	14,000		14,000	14,000
BWH	GEM Expansion from Yr 2	14,000		14,000	14,000
CCAC	Palliative Care Team	500,000		500,000	500,000
APPD	Supportive Housing for Frail Seniors	-	200,000	200,000	
WE CHC	Rehab Team (From Year 2)	(200,000)		(200,000)	(200,000)
GB CHC	Rehab Team	200,000		200,000	200,000
CKCHC	Expansion of Response Team for Seniors		16,000	16,000	
GB CHC	Expansion of Response Team for Seniors		4,000	4,000	
NL CHC	Expansion of Response Team for Seniors		4,000	4,000	
WE CHC	Expansion of Response Team for Seniors		4,000	4,000	
CKHA	Complex Continuing Care Beds		273,970	273,970	
CKHA	Palliative Care Beds Implementation		100,000	100,000	
Allegro Residences	Interim Long-Term Care Beds WE		1,474,165	1,474,165	1,474,165
				-	-
				-	-
TOTAL Approved for YEAR 3		\$4,290,000	\$4,721,135	\$9,011,135	\$5,764,165