Erie St. Clair **LHIN**
RLISS d'Érié St. Clair
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Annual Business Plan

2012/2013

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 the clinical and effectiveness outcomes of the local health system. The IHSP, which is consistent with the above vision and strategic directions of the Ministry of Health and Long-Term Care (MOHLTC), 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, in subsequent years, 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) as well as improving the effectiveness of ED flow
- 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 and achievements 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, and mobile service teams

- 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 was realized in a number of key areas over the 2011 period:

- Diabetes – The Erie St. Clair LHIN assisted with the establishment and implementation of a new Erie St. Clair LHIN-wide Diabetes Regional Coordination Centre (RCC) with the Ontario Diabetes Strategy (ODS). The Diabetes RCC Administrator and staff have been hired and initial work focused on the production of a diabetes action plan and service inventory that was developed by the RCC, Erie St. Clair LHIN and the Diabetes Advisory Network. This plan aligns closely with the LHIN ABP/IHSP and ODS key directions. Priorities for 2011 and going forward are on advancing better methods of data collection that are more performance-based, with the potential of becoming predictive models of future utilization. Improving system access, navigation and coordination through a centralized intake and referral mechanism. Improved screening of high risk populations (associated with ED utilization) and continued focus on self management and preventative strategies of health care management.

- ALC/ED – Throughout 2011, the Erie St. Clair region continued to experience ALC and ED issues including long waits in the ED, higher than average length of stay for admitted patients and high volumes of non-urgent and deferrable visits to the ED. ALC volumes continued to increase dramatically in Windsor/Essex and Sarnia/Lambton. In order to address these issues, the Erie St. Clair LHIN initiated a number of targeted actions including endorsement of the Dr. Walker report and advancing a regional ALC Action Plan. As part of the action plan, the Erie St. Clair LHIN implemented the Home First Project and philosophy which emphasizes the need to help seniors get the care they need and live independently in their own homes longer. The Erie St. Clair LHIN has also had some success in attracting ED physicians to our area (although there is still a need for this service), Nurse Practitioners (NPs) and Physician Assistants to provide off-hour and weekend support. Priorities for 2011 and the coming year will continue to focus on (but not be limited to) increasing bed capacity (e.g. convalescent care), home care, supportive housing, restorative care, transitional care, rehabilitation support, and respite care, all needed to safely move ALC patients out of acute care settings and prevent non-urgent ED visits.

- Mental Health and Addictions (MH&A) – 2011 was very busy for the Mental Health and Addictions area with the completion of some long outstanding projects and launch of a number of exciting new initiatives. In June, the Provincial government released its Ten Year Mental Health and Addictions Strategy entitled '*Open Minds, Healthy Minds*'. This strategy's focus is on children and youth including early identification and support, expanding tele-psychiatry, hiring more community based crisis workers, developing a wait time strategy, and advancing outcome measures for long-term transformation. Also, in June, the Erie St. Clair LHIN Board approved support for an Erie St. Clair LHIN Mental Health Strategic Plan and implementation of community capacity enhancements to be completed by spring 2012.

  In the fall, the Tier II tertiary psychiatric bed transfer from Regional Mental Health Care London (South-West [SW] LHIN) to Windsor Regional Hospital (Erie St. Clair LHIN) concluded with the successful program and funding transfer of 59 beds, three Assertive Community Treatment (ACT) Teams, and the repatriation of 17 patients to their home communities in Windsor/Essex and Chatham-Kent.

In December, the Erie St. Clair LHIN Integrated Behavioral Support Services (BSS) Plan was approved by the MOHLTC. The Erie St. Clair LHIN BSS plan will provide enhanced, integrated and cross-sectoral services to meet the needs of older adults with cognitive impairments due to dementia, mental health issues, addictions, and neurological conditions associated with responsive behaviors.

- Rehabilitation – In 2011 the Erie St. Clair LHIN Board approved support to advance a strategic plan for the future rehabilitation system to be completed by May 2012. This plan will endeavor to improve access to rehab services, facilitate appropriate use of inpatient rehab beds, improve patient flow, and the capacity of patients/families to self-manage across a continuum of care, and finally, coordinate care provision across the acute, primary and community sectors. The strategic plan will focus on three priority areas (supported by current utilization data): orthopedic, stroke, and the medically complex population. The main objective of the Erie St. Clair LHINs work in this area will be to continue to implement and support rehabilitation interventions. These interventions are expected to have positive benefits of lowering hospital length of stay (LOS) (leading to improved patient flow), maintaining or improving a patient's functional independence, and enabling people to live in their homes longer and safer with appropriate supports. Together, these activities will result in lower rates of hospitalization and re-hospitalization following episodes of acute illness, injury or surgery.

Key Planning Activities for the Next Fiscal Year

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

1. A comprehensive examination of the mental health system (Strategic Plan)
2. A comprehensive examination of the rehabilitation system (Strategic Plan)
3. The continued development, refinement and evaluation of sub-acute/community support teams that are population/condition specific (e.g. Chronic Obstructive Pulmonary [COPD] Teams)
4. The investment of community bed capacity, e.g. LTC beds, convalescent care beds
5. The integration of the local CMHAs
6. The continued integration of hospital services
7. Enhancements in primary care and wider primary care strategy
8. A clinical services review (initial discussions/formalization of this project have begun)
9. Maximizing the community impact on care by coordinating hospital services with community providers
10. Strategic alignment of actions that will drive improved health care outcomes for Francophone and Aboriginal communities
11. Improved data collection and impact models that are performance-based

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 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 Erie St. Clair, ED services are available across all five main hospitals and at two rural hospital sites. Like many hospital EDs they are facing a variety of planning issues, for example: Erie St. Clair facilities are short 14 ED medical doctors (MDs), and Canadian Triage & Acuity Scale (CTAS) 4/5 patients continue to present at the ED due to lack of primary care. Due to this increase in patient volumes the EDs are experiencing physical space needs, and in some areas (Windsor for example), unexpected and dramatic increases in ALC has increased ED patient holds and lengthened ED LOS for admitted patients.

Although, the Erie St. Clair region 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 region. During 2011/12, ALC volumes have increased dramatically in W/E and S/L. Causes and impacts include: the closure of Malden Park LTC Home, the move of Bluewater Health (BWH) to a single site, increase of ALC to approximately 13.5% in Q3 2011/12, increase in ED holds and Emergency Medical Services (EMS) off load, increase in ED LOS for admitted patients, and the continued service pressures on CCAC to provide more intensive services. To compound the problem there continues to be ED physician coverage issues.

In Q2 2011/12 across the Erie St. Clair region, approximately 13.1% of acute care beds, 46.4% of CCC beds, and 5.3% of rehabilitation beds were occupied by ALC patients; whereas in Q3 2011 approximately 13.5% of acute care beds, 47.8% of CCC beds, and 5.8% of rehabilitation beds were occupied by ALC patients.

In Q1 of 2011/12, residents continued to wait longer for a bed in a LTC home, the median time to LTC placement was 92 days, higher than 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 87, 67 and 104 days respectively.

It is becoming clear that in order to rebalance the system and effectively address the current challenges (as outlined in this submission), the Erie St. Clair LHIN plans will continue to closely align with recent announcements by the MOHLTC *'Ontario's Action Plan to Transform Health Care'*, specifically to improve overall system navigation, improve health outcomes of the population, prevent/reduce hospital re-admissions, better manage health care spending, provide/support more opportunities for clients (and their families) to participate in their own wellness activities, initiate evidence-based best practices and finally set clear improvement targets.

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 of the IHSP:

- 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 Ministry LHIN Performance Agreement (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 2011 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 2011, the main Erie St. Clair LHIN Advisory Networks and Groups which include ALC Group, Emergency Department Group, Diabetes Advisory Network, Mental Health & Addictions Advisory Network, and Rehabilitation Advisory Network, met to advance plans to better align their strategic activities and projects with the new MLPA targets. During this period the health service providers continued to advance projects and provide advice to the Erie St. Clair LHIN on actions that are expected to 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 (note that the ABP has been expanded – beyond the five key IHSP priority areas, to include End-of-Life Care/Hospice care plans, French language, and Aboriginal health care).

2.1 Emergency Department

TEMPLATE A: **PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY** **Emergency Department**
Integrated Health Services Priority:
Emergency Department
IHSP Priority Description:
In the Erie St. Clair region, ED services are available across all five main hospitals and at two rural hospital sites. Like many hospital EDs, they are facing a variety of planning issues. Currently, in the Erie St. Clair region: • There is a need for 14 Emergency Department Physicians, this being an improvement from the previous reported ABP need of 25 vacancies. This change has taken place in the past 1 ½ to 2 years While there has been a marked increased in the number of ED physicians staffing the region's emergency departments, this observation could change based on the current physician demographic. According to the OPHRDC (Ontario Physician Human Resources Data Centre – self reported data) there are 57 physicians who are staffing Erie St. Clair EDs and of those 57, 10 (or 18%) are over the age of 55 years, with 16 (or 28%) are over the age of 50 years. Challenges Include: • Recruitment and retention of NPs and Physician Assistants to provide off-hour and weekend support • High use by CTAS 4/5 patients due to lack of access to 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 and S/L has increased ED holds and lengthened ED LOS for admitted patients • Erie St. Clair continues to experience increased percentage of patients designated Alternative Level of Care (ALC) contributing to transition and patient flow at 13.5%, with W/E at 12.2%, S/L at 12.9%. ALC experienced in CK and LDMH remains below the 9% target of 7.5 and 6.9 respectively. • Provision of follow-up / primary care for patients who revisit ED

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY
Emergency Department (cont'd)

Current Status

Information obtained from Ontario's ED Public Reporting System data indicated the following in November 2011:

- Nine out of 10 ED patients in the Erie St Clair region spend at most 7.3 hours at the Emergency Department. Erie St Clair LHIN ranks 4th among the LHINs and shares 6% of the total reported volume of the province
- The ED LOS for admitted patients (24.6 hours) is 18.7 hours longer than non-admitted patients (6 hours). 11% of the total ED visits are admitted compared to the Province of (31.1 hours) for admitted patients for November 2011
- Shortest ED LOS is at Charlotte Eleanor Englehart Hospital site BWH (3.3 hours) while the longest ED LOS is at Hôtel-Dieu Grace Hospital Windsor(10.2 hours)
- 57% of total ED visits are CTAS I - III patients with an ED LOS of 9.2 hours
- In November 2011, 56% of admitted high acuity patients were treated within the 8 hour target. This is 12% below baseline. This is 1% change from last reporting period
- For the same period, 89% of high acuity non-admitted patients were treated within the 8 hour target – 1% above the baseline
- For the same period, 90% of low acuity non-admitted patients were treated within the 4 hour target – 2% below the baseline

In Erie St. Clair, patients experiencing complex conditions/requiring more time for diagnosis, treatment or hospital bed admission spent 9.5 hours in the ED from the time they registered to the time they leave. W/E and S/L are experiencing increase ED volumes and EMS off-load delays. W/E continues to experience higher patient acuity and ED holds. Patients with minor or uncomplicated conditions requiring less time for diagnosis, treatment or observation spent 4.3 hours within the ED from the time they register to the time their visit is complete.

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 of the ED. 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 region - overall in C/K 61%, S/L 37% and W/E is 6.1% of ED visits could have been managed elsewhere.

Erie St. Clair LHIN in collaboration with Erie St. Clair Community Care Access Centre has an emphasis on Home First as a philosophy across the region in an effort to help seniors get the appropriate care and live independently in their homes. Home First aims to reduce inappropriate ED visits, reducing wait times, and increasing function and mobility allowing seniors to remain supported safely in their home. Home First is based on the premise that with appropriate community services and supports, seniors in Erie St. Clair will do better recuperating at home to maintain mobility and independence as well as avoid hospital infections that pose serious threat to frail seniors often presenting in the hospital system.

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Emergency Department

Goal (s)

ED Overall Goals:

- Increased patient flow from ED registration to inpatient admission and appropriate discharge
- Prioritization of the Home First philosophy across the Erie St. Clair region to support patients in the community with the appropriate services
- Reduced ED visits and re-admission for chronic disease management patients
- Stream-lined Mental Health Services that are seamless between community providers and hospital
- Explore impact of ED P4R program on ED LOS and patient utilization
- Improved access to primary care for episodic care and ongoing care
- Improved access to primary care/NP assessments in LTC homes
- Increased resources to Nurse Lead Outreach Teams (NLOT) to LTC homes, convalescent and Assess and Restore Programs
- Enhance home care services and initiative for seniors to avoid unnecessary ED visits, ED and hospital admissions, and support timely discharge for seniors
- Increased use of assisted living, resettlement, convalescent care, assess / restore, and CCAC programs to reduce the demand for LTC homes and ALC
- Determine appropriate care pathway for patients with known community-acquired infections

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

- Seniors to avoid unnecessary ED admissions and support timely discharge from the ED/hospital
- Patients who are “ED Hold”
- Mental Health and substance abuse patients
- Patients living in LTCH’s supported by the Nurse Practitioner Outreach Team
- Patients requiring respite care
- 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 higher acuity CTAS level 3 not requiring admission
- 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 CHF and COPD patients and other chronic diseases 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.

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Emergency Department (cont'd)

ED Action Plans / Interventions

Action Plans / Interventions:	% Completion by Year		
	2011-12	2012-13	2013-14
Expand the ED hours of Nurse Practitioner (NP) / Physician Assistant (PA) coverage for treat and release patients	90%	10%	-
Develop a referral process to primary care initiated by the ED and CCAC	80%	20%	-
Continue and expand Pay for Results (P4R) and Process Improvement Program (PIP) Strategies in order to reduce wait times in the ED	80%	20%	-
Develop mechanisms so that unattached patients (Congestive Heart Failure [CHF] / COPD) are auto-referred to NP for follow up	80%	20%	-
Explore research opportunities related to a predictive model approach for P4R program in Erie St. Clair	30%	70%	
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 customer service strategy for patients waiting in the ED	33%	33%	33%
Develop a primary care path for CHF/COPD S/L and transferrable across Erie St. Clair region	30%	70%	-
Review ED MD recruitment and retention strategy for the Erie St. Clair region	20%	80%	-

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 10%
- 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 20%
- Improve patient discharge screening risk assessment completion to 100%
- Increase discharge follow-up for CHF / COPD patients by 50%

TEMPLATE A: **PART 2: GOALS and ACTION PLANS** **Emergency Department (cont'd)**
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** **Alternate Level of Care**
Integrated Health Services Plan Priority:
Alternate Level of Care
IHSP Priority Description:
During 2010/11 ALC volumes have increased dramatically in W/E & S/L. Causes: • Closure of Malden Park LTC Home to service the Windsor Western Tower renovation • The move of BWH/SL to a single site completed July 2011 Impact: • Increase of ALC to approximately 13.5% in Q3 2011/12 • Increase in ED holds and EMS off-Load for W/E and S/L. • Increase in ED LOS for admitted patients, particularly W/E and S/L • Increase in staff overtime/sick time • Service pressures on CCAC and Community Support Services to provide more intensive services • Required improved service coordination for specialized populations (End of Life, Mental Health & Substance Abuse, Geriatric Outreach, GEMS's, rehabilitation, respite, palliative care • Urgency for Home First Erie St. Clair LHIN-wide

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY
Alternate Level of Care (cont'd)

Current Status

In Q2 2011/12 across the Erie St. Clair region, approximately 13.1% of acute care beds, 46.4% of CCC beds and 5.3% of rehabilitation beds were occupied by ALC patients. Whereas in Q3 2011/12 approximately 13.5% of acute care beds, 47.8% of CCC beds and 5.8% 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 region were associated with three conditions - CHF, COPD and diabetes.

Residents in the Erie St. Clair region are waiting longer for a bed in LTC homes. In Q4 of 2010/11, the median time to LTC placement was 92 days, higher than 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 87, 67 and 104 days respectively.

Further, patients are occupying ED space because there are no available acute care beds. To compare, in November 2011, Ontario hospitals estimated that approximately 16% of acute care beds were occupied by ALC patients, with 63% waiting for LTC (Ontario Hospital Association 2010). Erie St. Clair continues to experience increased percentage of patients designated ALC impacting smooth transitions and patient flow. Overall Erie St. Clair LHIN continues to increase in ALC rates as of Q3 2011/12 W/E and S/L are 3.2% and 3.9% higher than the provincial target where as C/K is at 7.5% (1.5% below the provincial target).

Erie St. Clair LHIN has endorsed Dr. Walker's report addressing ALC and has implemented Home First philosophy and support care initiatives LHIN-wide emphasizing an effort to help seniors get the appropriate care and live independently in their homes. Locally, Home First is based on the premise that with appropriate community services and support seniors in Erie St. Clair will do better recuperating at home to maintain mobility and independence as well as avoid hospital infections that pose serious threat frail seniors often presenting in the ED.

Finally, community services such as home care, supportive housing, restorative type care programming, transitional care, long-term care, and other services such as assisted living, rehabilitation, palliative care services, respite care, and prevention strategies are considered to safely move ALC patients out of the acute care setting. In turn, this improved patient flow 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
Alternate Level of Care

Goal(s)

ALC Overall Goals:

- Primary care providers enabling care for seniors - a priority to include early identification of risk of frailty and proactive management of multiple challenges
- Advance an integrated and coordinated continuum of care through additional and sustained resources to Community Care Access Centres (CCACs), community support services, and assisted living arrangements
- Support the advancement of Senior Friendly Care principles in acute care hospitals
- Support restorative, transitional, and respite care programs in the LTC sector while maintaining permanent placement for those with more complex needs
- Increase community knowledge of hospital access implications and impact of ALC patients on emergent care processes
- Enhance services in the Home First sector across the Erie. St. Clair region to provide patients and families with what they need to go home, make decisions and live safely as independently as possible
- Improve access to acute care capacity (medical, surgical and critical care) through process improvement, bed utilization, discharge planning processes
- Ensure appropriate community care and discharge options (including End-of-Life Care (EOLC, palliative, rehabilitation, geriatric response)
- Maximize functional conditioning of patients over the age of 60
- Improve ED wait times for admitted and non-admitted patients and reduce ED holds
- Reduce acute length of stay for chronic disease populations and readmission rates, improve time to LTC Home placement for inpatients and community residents
- Implement a sustainable Falls Prevention Program in institutions and homes
- Create effective standardized educational programs for seniors with respect to services, supports and self management programs available to assist them in either: a) staying at home, b) transitioning to Rest/Retirement Home or c) to a LTC Home
- Support the LTC sector to better service patients with challenging behaviors and high intensity of care needs

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

- ALC patients in acute, CCC and rehabilitation beds
- Geriatric Mental Health clients
- ED and post-acute (convalescent) clients
- Patients with dementia and behavioral problems
- Lower income patients and those impacted by the social determinants of health
- 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 supported by CCAC and assisted living

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Alternate Level of Care (cont'd)

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
Develop and implement restorative care programs at Leamington District Memorial Hospital (LDMH) and Erie St. Clair LHIN-wide	100%		-
Develop key messages/market plan to highlight services offered by each LTC home (video format)	80%	20%	-
Initiate and develop Home First geographic Implementation Teams to support ALC and Home First goals and objectives LHIN-wide	50%	50%	
Develop and implement transitional care programming Erie St. Clair LHIN-wide	50%	50%	
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 and communicate the role of Home First in Erie St. Clair	30%	20%	20%
Enhance short-term bed capacity to improve ALC patient flow and offer alternatives to hospital admission/placement	20%	80%	
Improve patient flow by building community capacity, re-purposing empty LTC beds and creating reactivation programs	20%	80%	
Support a robust discharging planning process with Home First as the primary goal	20%	40%	20%
Expand NP outreach program, behavioral supports, psycho-geriatric fostering – to cover nursing homes (with goal of preventing ED visits and enhanced community services)	20%	40%	20%

Expected Impacts of Key Action Items

- Maintain percentage of ALC in hospital at or below MLAA negotiated target of 9%
- Increase percentage of patients returning to pre-hospital environment by 20%
- Decrease the percentage of patients placed in LTC homes post acute and waiting in community by 10%
- Decrease the percentage of CCAC client admission to hospital by 10%
- For 100% of patients in acute care prior to an ALC designation, CCAC to consider all community options for Home First
- Ensure 100% of all appropriate patients on target units receive ambulation to avoid de-conditioning
- Improved patient and family satisfaction by 5%
- 5% reduction of falls within acute and LTC homes.
- Reduce average length of stay (ALOS) by 7% on all units providing targeted patient ambulation interventions
- 10% reduction for seniors seen in the ED related to falls.
- 5% reeducation in readmission rates for frail elderly with chronic conditions

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Alternate Level of Care (cont'd)

What are the Risks / Barriers to Successful Implementation?

- Delay in new LTC Home beds construction schedule for Windsor
- Lack of primary care access and follow up to seniors
- Shortage of appropriate LTC Home beds to accommodate patients' needs
- Need to ensure seamless transitions for patients (in a timely manner) to the most appropriate care setting with Home First philosophy
- Lack of accurate knowledge and understanding related to a central model of system navigation, perception and expectation
- Lack of disease management strategies for persons with a chronic illness aimed at reducing hospital admissions for these groups – CHF, COPD, dementia
- Inability of home care to shift the focus toward preventing hospital admissions rather than the current focus on facilitating hospital discharges (more proactive verses reactive / crisis management)
- Systemic data collection processes 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
- Scarce 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 region
- 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
Diabetes Care

Integrated Health Services Priority:

Diabetes Care

IHSP Priority Description:

In total, Erie St. Clair 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 Community Health Centres (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:

- A need for a consistent approach to diabetes management by Physicians and professionals
- Limited access to and coordination between Specialists and Family Physicians
- Access to social work and/or Psychologist, Dietitian, Chiropodist, and 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 for those with diabetes
- Salary variations across programs between hospitals and community sectors
- A need for more education/standard knowledge of diabetes across primary care providers and for clients
- A need for a greater emphasis on prevention and self-management strategies
- Current physical space limitations at sites
- A need for improved coordination across the diabetes sector/other teams in the community (Family Health Teams, CHCs etc.)
- A need for earlier intervention and prevention strategies
- A need for more support for persons with advanced diabetes and multiple co-morbidities
- More attention on the social complexities of diabetes associated problems/determinants of health

Current Status

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

In October, 2011, approximately 10.2% (51,632) of Erie St. Clair residents 18+ had a diagnosis of diabetes, which is higher than the Province of Ontario average of 9.4% or 989,212 people (2011 Ontario Diabetes Key Performance Measures, Ministry of Health, Health Analytics Branch). Based on the Health Analytics Report on Diabetes (ODS key performance measures), in 2010/11, the Erie St. Clair LHIN rate of Emergency Visits per 100,000 for Hypo and Hyperglycemia on an age-adjusted basis was approximately 20% higher than the Province (1,272 versus 1,063).

Looking ahead at population health trends, Erie St. Clair residents will likely continue to be at a high risk for developing Diabetes and other associated chronic conditions. Supporting evidence identifies the Erie St. Clair region as highest in the province currently (62.1% compared to provincial average of 53%) for percentage of Ontarians age 18+ that are overweight or obese (2011 Ontario Diabetes Key Performance Measures, Ministry of Health, Health Analytics Branch).

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Diabetes Care (cont'd)

Current Status

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.

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

- A need for better information technology to monitor and track patient care on best practices
- Lack of patient education and self-management programming
- Cost, especially for the working poor who cannot afford medications
- A need for better lifestyle choices
- Higher obesity rates in children
- A need for timely access to primary care

A need for a better rural transportation network

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Diabetes

Goal (s)

Diabetes Care Overall Goals:

- Advance predictive models of diabetes ED utilization
- Reduce avoidable ED visits for diabetes
- Centralized Intake for newly diagnosed patients
- Improve inter-professional collaboration and evidence-based practice for diabetes interventions
- Improve/stream-line coordination across service providers within Erie St. Clair sub-regions
- Improve system navigation within Erie St. Clair sub regions
- Improve, share and standardize education programming for professionals (e.g. best-practice, on-going, professional development, knowledge exchange)
- Expand existing care capacity (primary care specifically)
- Optimize wait times for diabetes services
- Improved referral processes and/or development of clinical pathways leading to more timely and appropriate access to care
- Increased use of clinical practice guidelines by health care practitioners
- Improved screening of identified higher risk populations
- Improved performance tracking and health outcomes for those with diabetes
- More opportunities for knowledge transfer and skill development among health care providers

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Diabetes (cont'd)

Goal (s)

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 and/or at risk of developing diabetes
- Women with gestational diabetes
- Individuals who suffer from mental illness and diabetes
- First Nations people with diabetes
- Francophone population with diabetes
- Ethnic population who have diabetes
- Rural or geographically isolated people with diabetes who experience transportation challenges
- Pediatric individuals with diabetes

Complex patients with multiple co-morbidities

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 a Regional Coordination Centre (RCC) for diabetes in Windsor (to serve the entire Erie St. Clair region)	90%	10%	-
Advance a System Wide Diabetes Clinical Care Path for Erie St Clair	80%	20%	-
Establish performance targets and metrics for the diabetes sector – score care format	80%	20%	-
Advance a central intake-referral process/format for the diabetes sector	60%	30%	10%
Establish a 1-800-Diabetes access telephone number Erie St. Clair LHIN-wide	40%	30%	30%
Initiate a Self-Management Program Erie St. Clair LHIN-wide	40%	30%	30%
Develop a Strategic Plan for the future diabetes system in the Erie St. Clair region	10%	90%	-
Evaluate the effectiveness of new Diabetes Education Teams in the Erie St. Clair region	10%	70%	20%

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Diabetes (cont'd)

Expected Impacts of Key Action Items

- Expanded Diabetes Education Teams to serve 100-200 new clients in the first year (teams expected to serve up to 1000 clients within three years – evaluate this in 2012-13)
- 90% of patients with diabetes having a foot exam completed annually
- 80% of patients with diabetes having their eye exam completed every 1-2 years
- 80% of diabetes clients having their A1C test completed yearly
- 80% of diabetes clients reporting satisfaction with Diabetes Education Program (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 for those with Diabetes
- Approximately 1-2% reduction in LOS for those hospitalized with Diabetes-related complications
- RCC to provide education sessions on diabetes services to 100% of health care providers in the region
- Improved confidence of 50% of LTC Homes in their ability to provide and support best practices for diabetes care management Erie St. Clair LHIN-wide
- Improved documentation processes (diabetes care related) within 50% of LTC Homes Erie St. Clair LHIN-wide

What are the Risks / Barriers to Successful Implementation?

- Timely new service expansion
- Need for a consistent approach to diabetes management by Physicians and professionals (not all on the same page)
- Access/availability of Specialists and Family Physicians
- Access - distribution of diabetes teams
- Accessibility to clinics (i.e. parking fees, registration process at Ambulatory Care can be barriers)
- Not enough HHR supports (full time opportunities, 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/care paths for people with diabetes
- Confusing booking/referral processes within the Diabetes sector
- Not enough focus on social determinants of health

2.4 Mental Health and Addictions

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Mental Health and Addictions

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, peer support, occupational therapy and supportive housing. Services include a range of activities and objectives from mental health promotion and prevention to the treatment of acute psychiatric disorders and on-going intensive, case management and rehabilitation for persons with severe and persistent psychiatric conditions. Addiction services include assessment and referral, day or evening programs, withdrawal management services, residential treatment programs, counseling, public awareness and prevention regarding substance misuse and problem gambling. In Erie St. Clair, MH&A services are provided within hospital and across the community sector. Providers are facing a variety of issues related to service delivery:

- Funding sustainability and stabilization
- Wage harmonization between sectors e.g. hospital to community
- Recruitment and retention/staffing
- Stigma issues
- Shortage of Physicians and Psychiatrists
- Access issues and prolonged wait times for certain services (e.g. residential treatment for addictions, CMHA case management, withdrawal management)
- Capital/space issues across a number of organizations
- Need for improved access to primary care
- Need for reliable, standardized and timely data to measure outcomes
- Lack of ED care linkages to community services
- Continued separation in client care (silos) within the MH&A sectors, i.e. hospital and community services
- Need for seamless linkages between Schedule One discharges and community based longer term care
- Lack of specialized housing services for clinically complex conditions e.g. dual diagnosis, older adults with responsive behaviors (not eligible or denied LTC admission)
- Need for greater uptake and coordination between hospital and community using Tele-Medicine (OTN) technology including standardized Tele-Crisis Protocols, Care Paths and OTN clinic days to facilitate care closer to home (rural access issues)
- The up-down nature of client needs indicates a need for better reassessment–follow up processes
- Need for greater integration to provide seamless care for older adults with responsive behaviors residing in the community, and LTC Homes and individuals transitioning from acute care or Schedule One Facilities back into the community
- Need for more formalized coordination through service protocols between the Ministry of Children and Youth Services (MCYS) and LHIN funded providers to address the needs of transitional aged youth including young adults experiencing a first psychosis or other mental health/addiction crisis
- Inconsistency of service provision across communities
- Lack of alternatives in the community needed to prevent ED visits (especially after hours)

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Mental Health and Addictions (cont'd)

Current Status

In June, 2011 the Provincial government released its "Ten Year Mental Health and Addictions Strategy entitled '*Open Minds, Healthy Minds'*. This strategy initial focus is on children and youth with a three year funding commitment of $257 Million. Key service areas include: early identification and support, expanding tele-psychiatry, hiring more community based crisis workers, developing a wait time strategy and advancing outcome measures for long-term transformation.
In the fall of 2011, the Tier II tertiary psychiatric bed transfer from Regional Mental Health Care London (South-West LHIN) to Windsor Regional Hospital (Erie St. Clair LHIN) concluded with the successful program and funding transfer of 59 beds, 3 ACT Teams and the repatriation of 17 patients to their home communities in Windsor/Essex and Chatham-Kent. An additional, six beds via post construction operating plan process will be added in 2012.

Despite the release of the Provincial Strategy and the successful divestment of Tier II, issues remain for the adult MH&A sectors. Providers have repeatedly stressed that going forward, the Erie St. Clair LHIN must focus on implementing Tier III reform or addressing community capacity needs.

In June 2011, the Erie St. Clair LHIN Board of Directors approved support for an Erie St. Clair LHIN Mental Health Strategic Plan and Implementation of Community Capacity Enhancements to be completed by spring 2012. The project scope includes individuals with a moderate mental illness, the seriously mentally ill, eating disorders and concurrent disorders. The primary aim is to identify and redesign clinical service levels for Tertiary, Schedule One including out-patient programs and community mental health services.
The addiction sector is recognized as having unique and long standing issues that warrants its own strategic plan. The Erie St. Clair LHIN will leverage successful processes and lessons learned from the mental health planning exercise and use this to advance an Addiction Sectors Strategic Plan (for summer 2012).
With regard to current trends and conditions, the Erie St. Clair region continues to be negatively impacted by the global economic downturn. As a result, MH&A clients continue to present in crisis at the ED and for admission to acute care.

- Erie St. Clair LHIN ranks 7th in the LHIN system for ED mental health repeat visits (within 30 days) with the highest volumes occurring at HDGH followed by CKHA Chatham site, WRH and BWH Sarnia site.
- On a year over year basis, data shows that the following mental health diagnostic categories consistently present in the ED: neuroses, anxiety, stress related and somatoform disorders, followed by mood disorders, schizophrenia and other psychotic conditions and behavioral issues amongst children and adolescents. In the acute setting, 77% of active cases are associated with mood disorders, schizophrenia and other psychotic disorders.
- Erie St. Clair ranks 3rd highest in Ontario (2010-11) for repeat ED visits (within 30 days) related to substance use. For individuals seeking addiction treatment services the top three substances identified by Connex Ontario are: alcohol, cocaine and narcotics/opiates. The highest repeat ED substance use visits (within 30 days) occurred at HDGH with 317 visits or 26.2% followed by BWH Sarnia site 72 visits or 15.6%, CKHA Chatham site, 61 visits or 21.3%, WRH 57 visits or 16.3%. Smaller community hospital repeat rates are Sydenham site 21 visits or 18.3% and LDMH 17 visits or 19.5% (Petrolia site volumes are less <5 cell count). The total repeat substance use ED visit rate (within 30 days) for Erie St. Clair LHIN in the last fiscal year was 27.3% with a target of 12%.

Current promising practices, related to repeat ED mental health visits (within 30 days) include LHIN funding to integrate a CMHA Case Manager based in the ED at HDGH with a sole mandate of service provision and placement for repeat ED mental health clients. It is noteworthy that in the last fiscal year, HDGH had the highest repeat visits (within 30 days) with 896 visits or 23.1% compared to CKHA Chatham site, 150 repeat visits or 15.2%; Windsor Regional Hospital 144 repeat visits or 17%, Bluewater Health Sarnia site, 141 repeat visits or 12%.

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Mental Health and Addictions (cont'd)

Current Status

Smaller community hospitals repeat mental health ED visits (within 30 days) for last fiscal year are: LDMH 38 repeat visits or 15.4%, Sydenham site 41 repeat visits or 16.2% and Petrolia site with 6 repeat visits at 5%. Overall, the Erie St. Clair LHIN ED mental health repeat visit rate (within 30 days) in the last fiscal year was 18.5% compared to the Erie St. Clair LHIN target of 12%.

Another promising initiative includes the development of a W/E MH&A Cross Sector Committee that successfully reviewed and addressed the needs of fifty hard to service clients in one year's time. This collaborative process will be streamlined further by the Erie St. Clair LHIN to include representation from Community Health Centres and direct linkages to community services. During 2011, the Erie St. Clair LHIN approached all CHCs regarding their willingness to participate as a key member on a similar county specific, committee by providing primary care where needed, and counseling supports for ED Repeat MH&Add clients that "fit" their respective CHC population groups. Across the Erie St. Clair LHIN, CHCs expressed overwhelming support and a keen willingness to participate. The Erie St. Clair LHIN will further streamline the existing cross sector committee in W/E and develop new committees for C-K and S/L in 2012.

At the closure of 2011 all Schedule One Facilities reported inclusion of CMHA staff during the discharge planning process. This positive LHIN wide collaboration will be tracked as per client metric outcomes related to Schedule One readmission within 30 days.

Anecdotal information identifies that suicides have increased particularly for adolescents and young adults. In the fall of 2011 the Erie St. Clair LHIN provided funding enhancements to address wait lists, human resource limitations and public awareness needs as it relates to Early Intervention, First Episode Psychosis Programs. This investment includes using a lead agency approach towards standardizing clinical practices and public awareness endeavors. It is noteworthy, that in May 2011 the MOHLTC released "Provincial Standards" for the Early Intervention, First Episode Psychosis Program. Standards include defining the eligibility criterion as aged 14 to 35 experiencing a first psychosis. This age criterion crosses into the Ministry of Children & Youth Services (MCYS) mandate for provision of mental health services. Therefore, a formal, coordinated and integrated approach between Erie St. Clair LHIN and MCYS regional office is required in 2012.
In the later part of 2011, the Erie St. Clair LHIN received approval from the MOHLTC to implement a Tele Medicine initiative by placing a total of six new FTE MH & Addiction RNs situated at five EDs and one RN at WRH Child & Adolescent Crisis Centre. Key objectives for this 2012 project include:

- Provision of standardized OTN & crisis intervention training for six RNs
- Develop, implement and monitoring of Tele- Crisis Protocols as it relates to ED MH & Add clients
- Establishing OTN MH & Add Clinic Days (LHIN wide) to address rural access issues

In December 2011, the Erie St. Clair LHIN Integrated Behavioral Support Services (BSS) plan was approved by the MOHLTC. The Erie St. Clair LHIN BSS plan will provide enhanced, integrated and cross sectorial services to meet the needs of older adults with cognitive impairments due to dementia, mental health issues, addictions and neurological conditions associated with responsive behaviors. The target population includes caregivers and older adults with responsive behaviors who reside in the community, Long Term Care Homes and individuals transitioning from the emergency department, acute care admissions, Schedule One or Tertiary Psychiatric Facilities back to their home or to LTC Home (new LTC placement or existing resident). Responsive behaviors may include agitation, physical resistance to care, relentless exit seeking and wandering. This $2.4 Million investment is intended to address quality of life by keeping older adults in their homes as long as possible by providing enhanced support to caregivers and clinical interventions. Additional aims include:

- Reducing ALC and ED visits
- Increasing skills and LTC Homes ability to care for this increasingly complex population group

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Mental Health & Addictions

Goal (s)

Mental Health Overall Goals:

- Reduce ED repeat visits (within 30 days) by 6.5% to achieve the 12% Erie St. Clair LHIN target by March 31, 2013
- Reduce repeat (within 30 days) admissions to Schedule One Facilities
- Implement the Erie St. Clair LHIN BSS model for older adults with responsive behaviors with the primary aims of decreasing ALC, preventing or delaying admission to hospital or LTC placement.
- Decrease ED repeat visits for young adults experiencing their first psychosis episode (base line data is not available)
- Implement a coordinated and integrated Tele-Medicine MH&A initiative for acute and community based MH&A providers including provision of care closer to home via OTN Clinic Days
- Evaluate effectiveness of ED CMHA Case Managers and consider expansion based on population needs
- Increase awareness (public and family physicians) regarding the Early Intervention, First Episode Psychosis Program. Establish service protocols with MCYS funded providers as it relates to clients transitioning from the child/adolescent mental health sector to the adult LHIN mental health funded sector e.g. transitional aged youth and first episode clients
- Establish cross sector committees to align with the "service placement" ED CMHA mandate (repeat ED mental health clients may have either a moderate or severe mental illness)
- Completion of the 2012 Erie St. Clair LHIN Mental Health Strategic Plan including targeted investments and/or integration as per forthcoming recommendations
- Address the current service inequities, access and coordination issues for eating disordered clients in the Erie St. Clair region. This goal is included in the above Mental Health Strategic Plan scope
- Ensure that there is specialized psychiatric commitment (leadership) in the planning and delivery of services in the Erie St. Clair region

The action plans will focus on the following mental health priority population groups:

- Early intervention, first episode psychosis clients
- Transitional aged youth - those moving from the MCYS funded children's mental health sector into the LHIN funded adult mental health system (16+)
- Mental health repeat ED clients within 30 days (including clients without a primary care providers)
- Older adults with cognitive impairments due to dementia, mental health issues, addictions and other neurological conditions associated with responsive behaviors and their caregivers. Responsive behaviors may include physical/verbal aggression when receiving care, agitation and relentless exit seeking
- Crisis population presenting in the ED
- Repeat (within 30 days) Schedule One admissions
- Dual diagnosis population and complex mental health cases

Addictions Overall Goals:

- In the summer 2012, implement an Addiction Sectors Strategic Plan that focuses on access, capacity, integration and innovative approaches to harm reduction, relapse prevention and addiction care

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Mental Health & Addictions (cont'd)

Consistency with Government Priorities:

The above goals are consistent with the government's commitment to strengthen MH&A services in the province including:

- New program standards and LHIN funding enhancements for the early intervention first episode psychosis population
- Formalize service coordination with MCYS funded providers as it relates to transitional aged youth
- Increase access and coordinating eating disorders services with primary care, community and acute mental health and addiction services
- Provide care closer to home through Tele-Medicine OTN nursing resources / OTN Clinic Days
- Reduce repeat ED mental health visits (within 30 days)
- Enhance services for older adults with responsive behaviors with the primary aim of reducing ALC and ED visits for this population group

Action Plans / Interventions

Action Plans / Interventions:	% Completion by Year		
	2011-12	2012-13	2013-14
Mental Health			
Increase community education and promotion of early intervention first episode psychosis. Ensure that the early intervention and extended psychosis programs in Erie St. Clair meet Provincial Program Standards	10%	80%	10%
Implement the Erie St. Clair BSS Model for older adults with responsive behaviors and their caregivers	10%	80%	10%
Implement Tele-Crisis Services and OTN Clinic Days Erie St. Clair LHIN-wide	10%	80%	10%
Establish cross sector committees and CMHA ED Case Managers in all three counties	10%	80%	10%
Implement the Mental Health Strategic Plan	-	80%	20%
Continue to advance the 'Integrated Assessment Record' Erie St. Clair LHIN-wide	30%	70%	-
Implement Ontario Common Assessment of Need (OCAN) assessments for ACT clients Erie St. Clair LHIN-wide and compare clinical levels of need/risk to CMHA intensive case management clients	10%	70%	20%

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Mental Health & Addictions (cont'd)

Addictions			
Develop protocols and care paths between the Erie St. Clair LHIN funded Chronic Pain Program and Addiction Assessment & Referral services (Erie St. Clair LHIN-wide)	10%	90%	-
Evaluate the Addiction System Navigator role for replication in C-K and S/L.	10%	80%	10%
Initiate the Addictions Strategic Plan 2012	-	70%	30%
Continue withdrawal management service partnership work in respective communities	20%	50%	30%
Initiate data tracking methodology for concurrent disordered first episode psychosis clients	-	50%	50%
Additional objectives (yet to be determined) are dependent upon the Addiction Strategic Plan outcomes & recommendations	-	-	-

Expected Impacts of Key Action Items

Mental Health:

- Reduce ED repeat visits by 6.5% to achieve Erie St. Clair LHIN target of 12%
- Reduce Schedule One readmission (baseline required) by 10%.
- Reduce repeat ED visits by 15% for individuals identified as first episode psychosis 2012/2013
- Ensure that 100% of admitted inpatient psychiatric patients have access to a community plan/services upon discharge January 2013
- Increase Tele-Medicine mental health consults Erie St. Clair LHIN-wide from 61% (last fiscal year) to 75% by March 31, 2013
- Upon full implementation of the BSS Model, reduce inpatient Schedule One admission by 10% for older adults with behavioral issues by March 31, 2013.

Addictions:

- Implement Addictions Strategic Plan and subsequent recommendations 2013/ 2014

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
- 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 health human resources staff (Physicians and Psychiatrists)
- Continuing high unemployment rate contributing to ED MH&A repeat visits
- Continued separate planning, funding and service delivery silos between MH&A
- Continued stigma
- Lack of 24/7 community-based MH&A services
- Continued economic issues/risks

2.5 Rehabilitation Care

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Rehabilitation Care

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 (NP, RN and RPNs), Physiotherapists (PTs), Occupational Therapists (OTs), Speech-Language Pathologists, Social Workers, Dietitians, Pharmacists, Psychologists, Physiatrists, and 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 region, a comprehensive range of inpatient and outpatient rehabilitation services are 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 supporting them to attain the highest quality life possible. 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 regain independence and return to work or home.

Studies have further shown that inpatient rehabilitation can reduce inpatient LOS and improve or maintain mobility and function 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.

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Rehabilitation Care (cont'd)

Current Status

Within the Erie St. Clair region, 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 functional independence and enabling people to live in their homes longer and safer with appropriate supports resulting in lower rates of hospitalization and re-hospitalization following episodes of acute illness, injury or surgery.

Data Review

Rehab capacity, at the beginning of 2010/11 was approximately 117 beds per 100,000 65+ population in Sarnia/Lambton and Chatham-Kent, while Windsor/Essex was at 89 beds per 100,000 65+. Since that time, Assess Restore beds in Leamington District Memorial Hospital and HDGH have been developed with further expansion planned in Q4 2011/12.

A scan of the Rehab data for 2010/11 indicates that 80% of the rehab visits fall under four categories, namely orthopedic (376 or 34%), stroke (315 or 28%), medically complex (175 or 16%) and debility (34 or 3%). These categories are consistent with the province and represent 76% of the Ontario volumes. A lower proportion of rehab care is provided to orthopedic joint replacement surgeries in Erie St. Clair (34%) versus the province (39%). This is appropriate because the recommended practice for the majority of those persons is to receive rehabilitation services in the community. This also allows higher numbers of rehab admissions for stroke (28%) in Erie St. Clair versus the province (18%). This is appropriate due to a higher incidence of stroke in Erie St. Clair; most likely related to higher levels of risk factors (smoking, obesity, inactivity).

Orthopedic

117 (31%) of rehab orthopedic cases are related to fractures of the lower extremity, similar to the provincial proportion (31%). There is wide variation to these proportions across hospitals in Erie St. Clair (15% at WRH and 49% at BWH). The goal would be to increase the proportion of these cases to approximately 50% of orthopedic volumes.

Other orthopedic (98 or 26%) and replacement of lower extremity (160 or 43%) represent categories requiring further analysis to better understand what volumes can be safely deferred to lower levels of care. The goal is to create orthopedic rehab capacity for fractures and the implementation of the Hip Fracture Best Practice Model which will save acute days and improve patient outcomes in terms of function and percent returning home.

The Erie St. Clair region is lower than the Ontario benchmark for replacements going to rehab, which is consistent with the provincial goal to decrease elective surgeries going to inpatient rehab (Ontario currently at 51%). Work is ongoing to continue to improve on targeted variances.

Indicators

Fractures

The average onset days in Ontario for fractures to rehab is 17 days with the best quartile at 12 days. CKHA has the lowest onset days in Erie St. Clair at 10 days, with BWH at 13 days. WRH is the highest at 48 days. Ontario functional score at admission is 76, which is similar to CKHA at 75. BWH and WRH FIM at admission is lower at 66 indicated slightly more debility on admission. LOS in the province is 27 days with the lowest quartile at 20 days, similar to CKHA. BWH and WRH are at 30 days.

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY
Rehabilitation Care (cont'd)

Current Status

Other Orthopedic

The Erie St. Clair region average admission FIM is approximately 80, similar to Ontario at 82. The Ontario onset of care days average at 35 days, this being higher than BWH (26 days) and CKHA (24 days) but lower than WRH at 49 days. Average length of stay in hospital is 27 days in Ontario with the lowest quartile at 18 days. Erie St. Clair comparatively at BWH and CKHA is lower than the average at 24 and 21 days, while WRH is higher at 38 days.

Replacement of Lower Extremity

Ontario has higher volumes of elective surgeries receiving rehab for this category thus comparisons of the Erie St. Clair region to this population in the province is difficult. Preliminary identification within the Erie St. Clair LHIN data has shown to have fractures and arthritis associated with these cases making them more debilitated as evidenced by the FIM admission score in the province being higher (86) than the Erie St. Clair region (72) and % returning to home (87% versus 57%). Admission of joint replacement cases to inpatient rehabilitation is appropriately lower than the province, including those cases with greater complexity and comorbidity.

Stroke

The incidence of stroke is higher in Erie St. Clair (1.9 per 1,000) than the province (1.47). While the proportion of acute stroke patients discharged to inpatient rehabilitation (34.9%) is also higher than the provincial average (30.7%), the goal is for 40.7% of all persons experiencing stroke to access rehabilitation. In reviewing rehabilitation admissions for stroke clients, it is helpful to consider stroke severity. The Erie St. Clair region admits a higher proportion of more severe strokes (Rehabilitation. Patient Groups [RPG] 1100 and 1110 40% Erie St. Clair versus 32% in Ontario); indicating good access to care for these persons.

For admissions of milder stroke to inpatient rehabilitation, the Erie St. Clair region is slightly higher than the province (at 13% and 8% versus Ontario 12% and 6%, respectively), admitting 66 of these milder stroke cases (33 at WRH, 23 at CKHA and 10 at BWH). The hospital LOS for these cases is 23 days in Ontario, with similar LOS in Erie St. Clair (CKHA is lowest at 15 days, BWH at 20, WRH 23). These individuals could potentially be treated safely in an alternate, non-inpatient setting if access to such programs were to be improved.

Indicators

After onset of stroke, once medically stable, the severe to moderate stroke cases (RPG 1100-1140) requiring rehab go to rehab within 29 days in Ontario; the lowest quartile being 13 days. Erie St. Clair hospitals vary from 11 onset days at CKHA, 22 at BWH and 32 at WRH. Some of this variation is due to the requirement for greater medical stability at an offsite program (WRH) as well as access to rehab capacity. There is an opportunity to improve flow with greater access. Length of stay opportunities also exist for this group as the best quartile is 28 days in Ontario. CKHA currently is at the 28 day target with BWH and WRH at 32 and 42 days LOS, respectively.

Medically Complex

This category includes a diverse group of clients and health conditions. The higher proportions of the most debilitated medically complex RPG 3100 at 60% of the total cases in Erie St. Clair versus the province at 37% reiterates the complexity of our Erie St. Clair region's population receiving rehab, due to higher rates of chronic disease. 71% at BWH of medically complex fall under this category, while CKHA and WRH are 55-56%.

Indicators

FIM scores at admission are between 76-77 for Erie St. Clair while the province is higher at 83. LOS is highest at WRH at 31 days, 26 days at BWH and 18 at CKHA compared to Ontario LOS of 27. Ontario's lowest quartile is at 20 days LOS. The greatest FIM improvement is seen at BWH with an increase of 27, The highest proportion going home is at CKHA at 72%, with BWH at 59% and WRH at 68%. Ontario is at 68% of patients going home with the highest quartile at 76%.

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Rehabilitation Care

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
- Reduce ALC in CCC beds
- To improve activation for the complex inpatient geriatric population with low intensity long duration rehabilitation services
- Provide access to a pulmonary and cardiac rehabilitation
- 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 community alternatives to hospitalization (e.g. assisted living, mobile 24 hour community supports, community rehabilitation teams)
- Develop and implement health promotion, prevention and protection strategies

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

- Individuals with hip fracture and other orthopedic conditions including arthritis and total joint replacement
- Individuals with stroke and other complex neurological disabilities
- Geriatric populations including frail individuals over the age of 65 with reduced mobility, balance, endurance, strength and weight loss, evidence of depression, dementia, delirium, and/or incontinence
- Individuals with other medically complex conditions such as chronic respiratory diseases, lung disease: COPD, diabetes, heart failure and myocardial infarction

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.

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Rehabilitation Care (cont'd)

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 and C-K then to S/L (note these have been initiated in W/E and C-K)	60%	40%	-
Implement Community Rehabilitation Resource Teams Erie St. Clair LHIN-wide (note these have been implemented in W/E and C-K – focused on COPD)	60%	40%	-
Implement a Transitional Stroke Program Erie St. Clair LHIN-wide starting with S/L (note initiated in S/L and C-K)	60%	40%	-
Implement a Hip Fracture Program / Strategy Erie St. Clair LHIN-wide (note initiated in S/L and C-K)	60%	40%	-
Complete 'visioning exercise' to determine the future state for rehab in Erie St. Clair	50%	50%	-
Advance performance targets and metrics for rehabilitation sector	20%	40%	40%
Complete assessment of allied health care needs in the Erie St. Clair region	10%	90%	-
Institute an automatic e-referral system for the rehab sector (resource matching and referral project)	10%	20%	20%
Enhance Pulmonary Rehab Program Services (C-K)	10%	60%	30%
Review CCC and determine best future use for this bed resource (to be covered in Rehab Strategic Plan)	0%	-	-
Expand day rehab services Erie St. Clair LHIN-wide (to be covered in Rehab Strategic Plan)	0%	-	-

Expected Impacts of Key Action Items

- 5% reduction in LOS for selected chronic conditions (conservable days)
- Improve overall FIM efficiency scores by 10%
- Improve perceived pain/quality of life ratings by 10%
- 90% of clients report good to excellent satisfaction ratings with community rehabilitation intervention team
- Increase discharge disposition to home by 5%
- Decrease the total LOS (acute plus rehabilitation) by two days for top Case Mix Group (CMG) and Rehabilitation Patient Group (RPG) (e.g. stoke and hip fracture)

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Rehabilitation Care (cont'd)

What are the Risks / Barriers to Successful Implementation?

- Continued fragmentation across the rehabilitation sector – need for more formal coordination, communication and collaboration
- Reduction of current services in-hospital (including rehabilitation services)
- Growing elderly population – resulting in increased reliance on caregivers (sandwich generation)
- 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
- Lack of in-home support generally
- 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
End-of-Life Care / Hospice Palliative Care

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 Hospice Palliative Care (HPC) service delivery in Erie St. Clair. HPC is needed for all disease categories (including chronic diseases), and is required in all care settings where persons die.

HPC has been shown to:

- Improve quality of life for persons with life limiting illness and their caregivers,
- Improve resource utilization.

Despite the demonstrated benefits of palliative care there are still far too many:

- Needlessly unpleasant deaths
- Procedures conducted on persons at the end of life which may neither prolong nor improve life.
- Avoidable admissions to acute care
- Lengths of stay in hospital that are too long in Erie St. Clair
    - 12.4% of ALC is palliative in nature
- Persons dying in inappropriate locations in Erie St. Clair
    - ➢ 58% of acute care palliative care patients died in acute care, 42% were discharged home or to other locations

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY
End-of-Life Care / Hospice Palliative Care (cont'd)

IHSP Priority Description:

- Unnecessary visits to the ED
  - Percentage of lung cancer patients who visited the emergency department in the last 2 weeks of life is worse in Erie St. Clair (48.4% in Erie St. Clair vs. 45.9% in the province as a whole)
- Referrals to palliative care that are too late or not at all
  - In Erie St. Clair of the 2104 deaths in hospital only 57.4% had a palliative designation (Z51.5) associated with the record

The need for HPC is increasing. It is projected that each year in the Erie St. Clair region over 3000 people (and their families) will require a specialized program of palliative care, with up to 5000 patients and families 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 rates, colon and rectum cancer, and rates of life threatening 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 being pursued.

Current Status

Recently, major progress has been made to advance HPC system development in Erie St. Clair, with pockets of palliative care promising practice emerging. The Palliative Care Consultation Team (PCCT), the Education Collaborative and the Residential Hospice Programs (Sarnia and Windsor) are of particular note. Additionally the Regional Cancer Program is revitalizing its Palliative Care Program. Several hospitals as well as LTC Homes are enhancing their palliative care initiatives. Hotel Dieu Grace Hospital facilitated the participation of key members of its "virtual" HPC team to attend the "Palliative Care in Acute Care" Education Day supported by the Education Collaborative. The Windsor Essex Hospice and St. Joseph's Hospice in Sarnia are now partnering with the PCCT and the CCAC to further advance integrated HPC. A study on residential hospice feasibility for Chatham-Kent has been supported by the Erie St. Clair LHIN.

Improvements in system level outcomes are evident. The most recent cancer quality index shows improvement in almost all palliative related indicators.

The Erie St. Clair LHIN, Erie St. Clair End of Life Care Advisory Network and the Palliative Pain and Symptom Management Program serving Erie St. Clair have endorsed and helped facilitate many of these improvements. Additional funding from the Erie St. Clair LHIN has been critical.

At a provincial level, recent work has been initiated through a palliative care engagement strategy led by the MOHLTC, LHINs and the Quality Hospice Palliative Care Coalition of Ontario. Program plans in Erie St. Clair are aligned with this work.

Despite significant progress gaps persist and integration is incomplete, including:

- Key care settings and services lacking in specific catchment areas (e.g. residential hospice in Chatham-Kent)
- Palliative Care Programs are established in fewer than 40% of care settings where patients die
- Specific integration essentials and evidence of cross sector and professional collaboration are missing in each county (e.g. cross sector access to documentation, cross sector clinical rounds etc.)
- More trained HPC professionals and volunteers are needed
- 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 is being 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
End-of-Life Care / Hospice Palliative Care

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/collaboration across sectors through common regional processes, structures, education and personnel that connect the sectors
- To increase the number of specialist level HPC experts across all care settings and to improve formal and informal care providers' knowledge, skills and confidence in reducing the severity and distress associated with end-of-life symptoms
- To develop and implement a framework for cross sector HPC accountability in Erie St. Clair. (this accountability mechanism will include cross sector/system level planning, evaluation, tracking and reporting)
- To implement provincial and federal policy/funding/guideline enhancements that positively impact HPC service delivery and work towards improved integration
- To facilitate earlier and clearer prognostication and definition of client goals in all settings
- To promote utilization of best practice medicine to reduce the provision of aggressive, expensive medical treatments which may neither prolong or improve life
- To advance an ethical framework for end of life treatment

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

- Persons with a diagnosis deemed to require palliative care services in all care settings (persons own home, residential hospice, long term care homes, acute care, complex continuing care, and community/outpatient settings)
  - Pre-empting or managing crisis situations in the setting where they occur to prevent emergency department visits, hospital admissions and/or prolonged lengths of stay.
  - Enhancing care provision and patient/family experience
  - Providing more timely symptom response for tertiary level HPC crisis intervention thereby facilitating earlier discharge and decreased ALC days

- Additional priority populations within the above care settings include:
  - First Nations people
  - Frequently readmitted chronic disease persons who are nearing end of life or for whom advance care planning needs to be completed

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 acute care hospital utilization (admissions, ALC days, ED visits etc.). At a provincial level recent work has been initiated through a palliative care engagement strategy led by the MOHLTC, LHINs and the Quality Hospice Palliative Care Coalition of Ontario. Program plans in Erie St. Clair are aligned with this work.

TEMPLATE A: **PART 2: GOALS and ACTION PLANS** **End-of-Life Care / Hospice Palliative Care (cont'd)**			
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 Erie St. Clair LHIN wide – specific focus on addition of: 1) Bereavement Services – enhancement of one on one professional care for addressing complicated grief situations 2) Residential Hospice in C-K – complete feasibility study and identify next steps.	30%	40%	30%
Support building of HPC programs in all care settings where persons die – specific focus on: 1) Education –all care settings 2) Identifying key program elements, facilitating implementation and tracking progress of program creation - all care settings 3) Continuing to enhance community based access to expert HPC (champion improvements identified via Provincial Integrated Client Care Project) - PCCT and linkages among services/sectors	25%	30%	20%
Continue with integration and collaboration activities - specific focus on: 1) Education Collaborative (this includes education in First Nations and other culturally diverse populations and emphasis on enhancing best practice in all care settings) 2) Communication strategy 3) Creation of "virtual" team linking across sectors	20%	40%	30%
Continue building human resources capacity for HPC by: 1) Advancing the use of team based care 2) Providing education to formal and informal care providers (including family physicians and specialist level HPC providers) 3) Providing a Palliative Medicine Residency program	20%	20%	20%
Strengthen system-level accountabilities starting with: Improved data collection, evaluation, outcomes and overall performance of the HPC system	10%	60%	20%
Participate in the implementation of provincial/federal level policy / guidelines/strategies. Develop mitigating strategies to work around current imposed limitations (e.g. physician billing).	10%	60%	20%

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
End-of-Life Care / Hospice Palliative Care (cont'd)

Expected Impacts of Key Action Items

- Reduced avoidable ED visits, avoidable admissions and ALC days
  - Indicator - avoidance of ED visits / admissions in 70% of PCCT clients who might have otherwise visited the ED
  - Indicator – increase of 10% in use of bereavement services funded via PCCT
- Increased options in care settings for dying patients and increased prevalence of concordance between client preference and place of death
  - Indicator - at least 60% of PCCT clients will achieve concordance between preference and place of death
- Increased percentage of non-hospital deaths
  - Indicator - at least 50% of PCCT clients will die in non-hospital locations
- Increased percentage of timely referrals to palliative care
  - Indicator - an increase of at least 5% in the percent of deaths in hospital that show a palliative care designation (currently 57.4%)
- Enhanced Palliative Care Programs in all settings where patients die
  - Indicator - within three years at least 70% of these care settings have a definable and viable HPC Program for their clients. These programs will include program evaluation (tracking and quality measures of care).
  - Indicator – Foundational palliative care education offered in 2012-2013 in 3 acute care hospitals, over the next 3
- Improved capacity to provide palliative care in Erie St. Clair First Nation communities
  - Indicator:- Provide 1 -2 hospice palliative care education opportunities, per year for the next 3 years, to First Nation formal and informal care providers (as requested by FN partners),
- Strengthened long term, population based outcomes in HPC
  - Indicator - continued positive outcomes in all palliative care/end of life care indicators as published by the Cancer Quality Council of Ontario (meet and/or exceed the provincial average)

Ultimately the expected impact of the action items summarized in this document is to provide quality care for patients and families thereby reducing caregiver and symptom burden within a sustainable system of health care service delivery.

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
- Need for improved 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 persons who require palliative care)
- Few resources in LTC homes to support increased staffing requirements that may be needed to handle complex palliative care needs (especially for midnight and evening shifts)
- Need to clarify policy directions regarding the role of residential hospices within the HPC system
- Physician billing codes related to HPC are confusing and may prevent referral to specialist level providers.

2.7 French Language Services

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY
French Language Services (cont'd)

Integrated Health Services Priority:

French Language Services (FLS)

IHSP Priority Description:

The Erie St. Clair Francophone population is approximately 22,000 people (based on the inclusive definition of Francophone).

- They are mainly 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:
  - 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 region 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 30 health care providers for the delivery of services in French.

The French Language Health Planning Entity is now established. An initial 'Joint Action Plan' was developed for 2011-2012 by the Entity with Erie St. Clair and South-West LHIN involvement. All of the partners have agreed to work on three (3) key objectives and to focus on three (3) priority populations.

3 key objectives:

- Roles and responsibilities of all partners
- Access to and accessibility of services in French
- Communication and community engagement

3 priority populations:

- Seniors and adults with complex needs
- People with mental health and addiction issues
- People with chronic diseases

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
French Language Services

Goal (s)

French Language Services 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 the patient experience
- Increase accessibility of LTC and community support services for Francophone seniors
- Investigate use of EDs by the 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
Have identified health service providers complete their FLS Implementation Plan	90%	10%	-
Determine the health profile of the Francophone population	50%	50%	-
Prepare an inventory of FLS healthcare professionals	40%	40%	20%
Work with the Diabetes Regional Coordination Centre (RCC) to identify and develop actions specific to Francophone's living with diabetes	20%	40%	40%
Review and/or develop Erie St. Clair LHIN policies regarding FLS	-	100%	-
Advance an inventory of available community support services in French for seniors	-	80%	20%
Review data currently collected, identify gaps, and develop a data collection protocol regarding FLS and Francophones	-	70%	30%
Analyze data and Erie St. Clair LHIN to draft a FLS plan for the Erie St. Clair LHIN region	-	60%	40%
Develop and deliver education sessions/materials to providers intended to increase knowledge and awareness about Francophone's and FLS needs	-	60%	40%
Develop a communication strategy to reach the Francophone community	-	40%	60%
Implement the principles of '*active offer'* of services in French	-	30%	50%
Investigate the need for a LTC French-speaking pod for Francophone seniors in a LTC Home (WE-CK)	-	20%	20%
Investigate opportunities to develop programs to address gaps in community support services available in French for seniors	-	10%	30%

TEMPLATE A: **PART 2: GOALS and ACTION PLANS** **French Language Services**
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 information on FLS capacity and utilization in Erie St. Clair • Increased providers' and staff awareness of requirements regarding FLS • Increased integration of FLS into the day-to-day business of health care providers • Increased responsiveness of providers to the needs of the Francophone population • Improved patient satisfaction • More uptake from the Francophone population with chronic disease self-management programs • Reduced ALC use by the Francophone population
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

2.8 Aboriginal Health Care

TEMPLATE A: **PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY** **Aboriginal Health Care**
Integrated Health Services Priority:
Aboriginal Health Care
IHSP Priority Description:
<u>Population</u> The total population of Aboriginal people identifying as Aboriginal and living within the Erie St. Clair region is approximately 14,895. However, the number of people indicating Aboriginal Ancestry is 26,125. (Census 2006). It is important to note this difference within colonized populations when considering the impact on health and health planning. Therefore, depending on geographic location (C-K and W/E) Aboriginal people are between 2.4% and 4.2% of the total population. ➢ 9,440 registered First Nations (FN) ➢ 4, 215 Métis ➢ 20 Inuit ➢ Over 60% of the Aboriginal population live off reserve in Ontario Overall the Aboriginal population is younger with a high growth rate than the population of Ontario. **<u>Chronic Disease</u>** Nationally, prevalence rates of diabetes is 17.2% among First Nations individuals living on-reserve, 10.3% living off-reserve and 7.3% among Métis compared to 5.0% in the non-Aboriginal population. Overall Aboriginal people have 3-7 times higher rates of diabetes than the general population. Complications of diabetes are also more frequent in the Aboriginal population, as well as premature death and dying.

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY
Aboriginal Health Care (cont'd)

IHSP Priority Description:

- Compared to the general Canadian population, First Nation adults have a higher frequency of arthritis/rheumatism, high blood pressure, diabetes, asthma, heart disease, cataracts, chronic bronchitis and cancer
- One in four FN adults has arthritis/rheumatism
- One in five FN adults has high blood pressure
- 85% of First Nations seniors reported having one or more chronic conditions. Two thirds of First Nations seniors reported having two or more chronic conditions.

Mental Health

Though Aboriginal people are more likely to reach out for professional help, rates of depression, suicidal ideation, attempted suicide and completed suicide are still considerably higher than the general population. Drug and alcohol use is lowering in the adult population but addictions continue to be higher than in the general population.

Health Data & Planning

- There are generally, health information deficits for the Aboriginal population in Ontario
- Population health information for the urban and Métis population is practically non-existent
- Currently, health service providers (HSPs) reporting to the Erie St. Clair LHIN are not responsible to specifically track Aboriginal clients
- The LHINs have limited knowledge and access to existing Aboriginal health data
- The role of LHINs and Local Aboriginal Health Committees (LAHC) for health planning, in relation to Aboriginal Health Planning Authorities, MOHLTC and Health Canada is unclear
- Mechanisms for LHINs, MOHLTC, Health Canada and Aboriginal communities/health leadership to strategically plan health and need to be developed

Race and Gender Inequity

Aboriginal people deal with systemic racism and access barriers on a regular basis. There are striking differences between Aboriginal people's health and the general population. The population is also dealing with the intergenerational trauma of residential schools, assimilation policies and indifference.

- First Nations females were more likely to report barriers when accessing health care, compared to First Nations males (60.4% vs. 51.6%)
- There is significant urban Aboriginal poverty and child hunger in Ontario
- There are over 500 Aboriginal women missing in Canada
- More Aboriginal children are in formalized care today than during the residential school era and this trend continues to rise.

Engagement

- The Erie St. Clair LHIN meets on a quarterly basis with an established Local Aboriginal Health Committee representing each of the First Nations within the area and at least one urban Aboriginal community (Windsor)

There is little to no engagement with the Métis community (Windsor) within the Erie St. Clair region and the Friendship Centre of Sarnia Lambton (Urban Aboriginal community)

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY
Aboriginal Health Care (cont'd)

Current Status

- A part-time Aboriginal Health Lead is currently on staff at the Erie St. Clair LHIN, a shared position with the South West LHIN
- The Lead, LHIN management and the LHIN Aboriginal Committees regularly explore opportunities for cross LHIN engagement; planning and activity and have agreed on joint mental health and addictions strategy development
- The current priorities of the Erie St. Clair LHIN in relation to the Aboriginal communities as articulated by the LAHC are: diabetes and mental health
- There is a shortage of primary health care to Walpole Island and Delaware Nation (Moravian of the Thames Band) residents and is also a priority
- The level of access to health care within urban Aboriginal communities (Windsor, Sarnia, Chatham) is unclear
- There are high levels of LHIN staff, management, Board and local health service provider interest to address Aboriginal health issues
- Health planning for this sector is fragmented. There is no regular planning with Aboriginal health planning authorities, federal and other provincial government departments involved in the planning and/or delivery of health care to Aboriginal people

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Aboriginal Health Care

Goal (s)

Aboriginal Health Care Goals:

The overall goal is to better the health status of the Aboriginal population by improving access to provincially funded health services, sensitizing HSPs to the unique needs of the Aboriginal population they serve, support the creation of culturally relevant services and integration of provincial, federal and local services where possible. Support goals intended to directly impact the Aboriginal population are to:

- Reduce rates of diabetes and complications related to diabetes and secondary chronic conditions
- Improve integration of mental health and addictions services and access to culturally relevant crisis intervention, mental health and addictions services including traditional healing
- Improve intergovernmental relations as it relates to communications, coordination of services and health planning where possible
- Participate in health data and service integration strategies/projects
- Increase engagement with urban Aboriginal and Métis populations
- Present options for joint Erie St. Clair and South West LHINs management of the Aboriginal portfolio
- Participate in the Provincial LHIN Aboriginal Leads Network

The action plans will focus on the following priority populations:

- First Nations on reserve
- Métis communities (Windsor)
- Urban Aboriginal communities (Windsor, Chatham, Sarnia)

TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Aboriginal Health Care (cont'd)

Consistency with Government Priorities:

The above goals are consistent with the government's priority to improve access to and accessibility of health services for the Aboriginal population across the province. It is also consistent with the current key provincial and federal identified integration goals as it relates to First Nations.

- Mental Health and Addictions
- Health Data Management
- Chronic Disease
- Public Health

Action Plans / Interventions

Action Plans / Interventions:	% Completion by Year		
	2011-12	2012-13	2013-14
Liaise and facilitate relationship development between the Diabetes RCC and Aboriginal service providers and Aboriginal specific diabetes strategies	Ongoing	Ongoing	Ongoing
Develop a Mental Health and Addictions Integration and Health Data Management Proposal in collaboration with First Nations involved in the Erie St. Clair and South West LHINs Aboriginal Committees to the newly announced three year federal Health System Integration Fund (HSIF)	100%		
Draft options for improved management of the Aboriginal portfolio within the Erie St. Clair LHIN for S/L	70%	30%	
Develop joint Erie St. Clair /South West LHINs Aboriginal specific regional Mental Health and Addictions Strategy	50%	50%	
Work with Chatham Kent CHC, Walpole Island FN and Moravian Town FN as well as other primary care partners to implement relevant primary care services	40%	40%	20%
Pursue formal engagement with Urban Aboriginal communities and Métis Communities to determine health priorities, barriers to access and strategies	20%	80%	
Examine options for palliative/end of life care projects within the Erie St. Clair LHIN preparing for future Federal Aboriginal investments	10%	45%	45%
Create relevant wildly important goals (WIGS) for the Aboriginal Portfolio	10%	90%	

Expected Impacts of Key Action Items

- Decreased fragmented service structures for Aboriginal mental health and addictions
- Increased primary care services to First Nations
- Improved coordination of services and continuity of care in MH&A and diabetes for Aboriginals
- More reliable data on the Aboriginal population
- Improved staff and HSP information about Métis and urban Aboriginal people's health needs
- An up-to-date picture of the status of Aboriginal Health Care capacity in Erie St. Clair
- Improved intergovernmental communications and relations
- Improved patient satisfaction
- Reduced ALC and ED use by the Aboriginal population

TEMPLATE A: **PART 2: GOALS and ACTION PLANS** **Aboriginal Health Care (cont'd)**
What are the risks / barriers to successful implementation?
• Significant Lack of human and financial resources needed to meet planning goals • Limited intergovernmental focus on integrating Aboriginal health planning and restructuring Aboriginal health resources within the MOHLTC to align with LHINs • Continued jurisdictional wrangling

3 Erie St. Clair LHIN Operations and Staffing Templates

3.1 Erie St. Clair LHIN Operations Spending Plan

LHIN Operations Sub-Category ($)	2011/2012 Forecast	2012/2013 Allocation	2013/2014 Planned Expenses	2014/2015 Planned Expense
Salaries and Wages	2,441,200	2,514,400	2,589,800	2,607,500
Employee Benefits				
HOOPP	208,700	215,000	221,500	228,100
Other Benefits	250,000	257,500	265,200	267,200
Total Employee Benefits	***458,700***	***472,500***	***486,700***	***495,300***
Transportation and Communication				
Staff Travel	89,000	85,000	90,000	91,000
Governance Travel	20,000	20,000	21,000	23,000
Communications	51,000	40,000	40,000	40,000
Other Benefits	10,000	-	-	-
Total Transportation and Communication	***170,000***	***145,000***	***151,000***	***154,000***
Services				
Accomodation	148,000	165,000	165,000	170,000
Advertising	1,500	2,000	5,000	5,000
Banking	-		-	
Community Engagement	50,000	50,000	60,000	60,000
Consulting Fees	130,000	165,000	165,000	125,500
Equipment Rentals	15,200	12,000	12,000	12,200
Governance Per Diems	98,000	85,000	85,000	90,000
LSSO Shared Costs	596,300	511,200	410,000	410,000
Other Meeting Expenses	41,500	42,000	40,000	40,000
Other Governance Costs	15,500	17,600	25,000	25,000
Printing & Translation	5,700	5,500	5,000	5,000
Staff Development	57,600	57,000	50,000	50,000
Total Services	***1,159,300***	***1,112,300***	***1,022,000***	***992,700***
Supplies and Equipment				
IT Equipment	45,000	35,000	35,000	35,000
Office Supplies & Purchased Equipment	65,000	60,000	54,700	54,700
Total Supplies and Equipment	***110,000***	***95,000***	***89,700***	***89,700***
LHIN Operations: Total Planned Expense	4,339,200	4,339,200	4,339,200	4,339,200
Annual Funding Target			4,339,173	4,339,173
Variance			27	27

3.2 Erie St. Clair LHIN Staffing Plan

Template C: Erie St. Clair LHIN Staffing Plan (Full-Time Equivalents)

Position Title	2011/2012 Actuals as of Mar 31.11	2012/2013 Forecast FTEs	2013/2014 Forecast FTEs	2014/2015 Forecast FTEs
CEO	1	1	1	1
Senior Directors	2	2	2	2
Director, Corporate Services / Controller	1	1	1	1
Community Engagement	2	2	2	2
Health System Design Manager	3	3	3	3
Health System Manager	3	3	3	3
Data	2.5	2.5	2.5	2.5
Funding and Allocation	2	2	2	2
Administrative Functions	7.5	7.5	7.5	6.5
Program Assistant	5	5	5	5
Total FTEs	29	29	29	28

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, Erie St. Clair 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 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