

Annual Business Plan 2013/2014



Agenda Item 13.1



Ontario

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

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1 Context

1.1 Mandate and Strategic Directions of the Erie St. Clair Local Health Integration Network (ESC LHIN)

The ESC LHIN's Health Care Vision:

"Better Care, Better Experiences, Better Value."

ESC LHIN's mandate is to create a local health care system that:

- Generates better clinical and functional results, especially for the most vulnerable, fragile patients
- Creates a more coordinated system that provides the right care at the right place and the right time, especially for the most vulnerable, fragile patients
- Boldly transforms the health care system, positioning it to become a highly efficient and effective performance leader

The ESC 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

Strategic Directions:

The ESC LHIN Board Strategic Plan developed a series of directions to guide the LHIN's activities:

Direction #1: Chronic Disease Management (CDM)

Objective: Realign the health care system so that people with chronic diseases receive better regular care, are better able to self-manage their conditions, and are less reliant on emergency and acute care services.

Direction #2: Bold, Focused Leadership

Objective: As leaders of local health care, make courageous decisions that create a more tightly integrated, better aligned, and sustainable system where people receive the best care possible.

Direction #3: Partnerships in Health Promotion

Objective: Create better links between all health promotion and prevention organizations so that people have better access to programs and information that help them live healthier lives.

The ESC LHIN's Integrated Health Service Plan (IHSP 3), supports the ESC LHIN Board local strategic plan, by further advancing directions intended to integrate and improve the clinical and effectiveness outcomes of the local health system. The IHSP 3, which is consistent with the vision and strategic directions of the Ministry of Health and Long-Term Care (MOHLTC), communicates the priority areas that will guide ESC LHIN activities from fiscal years 2013 to 2016 and is the basis for this Annual Business Plan (ABP).

1.2 Overview of the ESC LHIN's Current and Forthcoming Programs / Activities

In the first six years of activity, the ESC LHIN's perception and activities were shaped through the initial strategic directions of the IHSP 1 & 2:

- Chronic disease management
- Reducing dependence on hospital-based services
- Supporting people at home
- Back office/administrative integration
- System navigation
- Health human resources
- Health promotion and illness prevention
- Timely access to appropriate care and services
- Improved outcomes in alternate level of care
- Improved outcomes in emergency department (ED) care
- Improved outcomes in diabetes management (chronic disease management)
- Improved outcomes in mental health and addictions
- Improved outcomes in rehabilitation care and interventions

These directions became the foundation for our examination of funding initiatives, enhancements, fiscal recoveries and service coordination. The ESC 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 six years of operation, the ESC 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, and considering current information from a number of key directional documents released provincially and locally over the past few years, the ESC LHIN's main activity and actions are now being directed toward the following general strategic themes:

- Promoting integration from a patient service perspective
- Managing care transitions (hospital to community)
- Supporting the voluntary integration of programs and services of Windsor Regional Hospital and Hôtel-Dieu Grace Hospital as well as a Stage 1A program and services plan
- Improving efficiency (back office)
- Building system capacity and capability (Health-Based Allocation Model-HBAM effect)
- Promoting and improving health maintenance (chronic disease management)
- Enhancing access to primary care
- Enhancing coordination, transitions, and standardization of care for targeted populations
- Implementing evidence-based practice to drive safety
- Maintaining achievement in access, accountability, and safety ("holding the gains")

To further support the general themes listed above, the ESC LHIN has identified the following four main system dimensions (consistent with previous planning efforts) intended to enable system improvements:

➤ Improved Access

- Invested in transportation to decrease the incidence of social isolation for seniors, and to help them connect to health care services
- Invested in the creation of additional convalescent care beds to help sustain acute care services
- Invested in the creation of additional units for assisted living for seniors
- Invested in the creation of assess and restore beds at Hôtel-Dieu Grace Hospital (HDGH) and Leamington District Memorial Hospital (LDMH), to improve outcomes for alternate level of care (ALC) patients in acute care beds
- Invested in the creation of 60 interim Long-Term Care (LTC) beds in Windsor/Essex

➤ Improved Quality

- Invested in standardized utilization tools
- Invested in the establishment of a psychiatric assessment team in the ED at HDGH to enhance services for psychiatric patients presenting in ED
- Invested in establishing geriatric emergency medicine (GEM) nurses in all hospital EDs
- Invested in end-of-life teams and CDM teams

➤ Cost Effectiveness

- Worked with ESC Community Care Access Centre (CCAC) to ensure that seniors continue to receive the care they need in a cost-effective, sustainable manner
- Made timely funding recoveries and subsequently transferred funds to organizations facing strategic needs and pressures
- Invested in installing Ontario Telemedicine Network (OTN) equipment and telemedicine nurses in all hospitals

➤ Co-ordination/Integration

- Enhanced integration initiatives in Windsor/Essex hospitals
- Integrated Windsor/Essex Community Health Centres (CHCs)
- Integrated Canadian Mental Health Associations (CMHAs) Kent County branch, and Sarnia/Lambton branch
- Invested in the implementation of a coordinated dialysis transportation system in Windsor/Essex

With regard to IHSP progress, success was realized in a number of key areas between 2009-13:

➤ Emergency Department Wait Times:

ESC LHIN continues to monitor ED wait times for all five hospitals for high-acuity admitted patients, high-acuity non-admitted patients, low-acuity patients, physician initial assessment, and time to in-patient bed. This is a key LHIN priority. The pay-for-results (P4R) program is monitored (in collaboration with the ESC LHIN lead and the ED/ALC manager) on a monthly basis, and the goal is to reduce ED wait times and monitor performance and financial accountability through quality process improvement planning, evidence-based practice, and redesign strategies. Frequent site visits are arranged with each P4R hospital in order to monitor progress, address challenges, and align with ESC LHIN strategies and programs required for improved performance. Network forums for all participating P4R hospital Leads and community support services are provided in order to enhance opportunities to share best practices, innovative solutions, and lessons learned. The P4R Network Forums aim to develop a coordinated, consistent, and integrated approach across ESC LHIN.

In 2012, MOHLTC implemented primary care physician LHIN Lead positions in order to advance primary care services to support timely, accessible, and effective primary care and to prevent unnecessary ED visits. The Erie St. Clair Primary Care Physician LHIN Lead created a Primary Care Council to advise ESC LHIN on improving integration and quality improvement within Erie St. Clair's primary health care system. The Council's first initiative is focused on reducing avoidable ED visits and avoidable hospitalizations for chronic obstructive pulmonary disease (COPD) patients in Chatham-Kent.

➤ Alternate Level of Care:

Erie St. Clair continues to experience an increasing percentage of patients designated ALC, which impairs smooth transitions and improved patient flow. In July 2011, ESC LHIN instituted a coordinated LHIN-wide approach and structure to address the ALC issue across the entire region, to ensure a coordinated systematic approach and process improvement from all health care providers and sectors (e.g., hospitals, CCACs, primary care teams, community support services, the LTC sector, etc.). In September 2011, the Home First program, in partnership with ESC CCAC, was implemented with a LHIN-wide focus on priority populations. The Home First Steering Committee provides oversight to the Home First implementation philosophy, and supports an innovative, systematic, integrated approach to resolving ALC issues within each local geographical area. Further work to improve patient flow is being done through the ESC LHIN Rehabilitation Advisory Network, which recently completed a *Rehabilitation System Strategic Plan for the Erie St. Clair Region* that began to be implemented in January 2013.

➤ Chronic Disease Management:

In June 2012, the ESC LHIN Board of Directors approved its strategic plan. A key goal identified through this process is the need to realign the health care system so that people with chronic diseases receive better regular care, are better able to self-manage their conditions, and are less reliant on emergency and acute care services. Key chronic populations identified included those living with COPD, congestive heart failure (CHF), and complex conditions. Work has begun in the Chatham-Kent and the Sarnia/Lambton region to advance a COPD Integrated Care Path/Model. The main objectives of this work are to: 1) establish accountability to patients by improving access to care and better incorporating the patient experience into planning and care; 2) improve the health of the COPD population; 3) better manage the costs of COPD care, ensuring a sustainable system is available in the longer term; 4) promote innovation through best practice uptake; and 5) continue to build capacity through quality improvement. The COPD Care Path development process has been directly linked to the work of the Primary Care Council, ensuring better access to ongoing primary care and the maintenance of chronic illnesses.

Work is also continuing on the implementation of a *central intake referral form* to facilitate a smoother process for health care providers and patients who need to access diabetes care services. ESC LHIN continues to promote the development and dissemination of key clinical pathways for diabetes care, foot care, and optometry to relevant stakeholders and primary care providers. Quality improvements through the uptake of best practices continue to be a priority focus for this population.

Finally, work on improving patient care for people with CHF will begin in 2013 using the results from the report that was released in August 2012 by the Cardiac Care Network of Ontario, the Heart and Stroke Foundation, and the Ontario Stroke Network, entitled *Shaping the Future of Vascular Health: An Integrated Vascular Health Blueprint for Ontario*.

➤ Mental health and addictions:

Between 2009 and 2012, ESC LHIN approved the transition of 59 specialized mental health beds (tier II) to Windsor Regional Hospital. The tier II funding was finalized in November 2011, and it immediately increased local bed capacity.

A strategic planning process was implemented in fiscal 2012. System redesign and increasing community capacity are the focus of the *Erie St. Clair Mental Health Strategic Plan for Erie St. Clair 2012-2016*, which focuses on adult mental health. Embedded in the plan are future vision statements, plans for increased community mental health service delivery, and performance-based advancement plans to decrease mental health ED repeat visits and re-admissions within 30 days. The plan's development was overseen by an advisory committee comprising consumer–family initiatives, community mental health providers, and tertiary mental health providers. The plan is anticipated to strengthen the role for integrated, community-based mental health services as well as foster better partnerships with primary care providers.

In 2012, ESC LHIN, in partnership with the Ontario Tele-Medicine Network, provided video-conferencing equipment for seven health service providers (HSPs) to enhance services for people with addictions. As part of the Opiate Dependency Strategy, ESC LHIN provided enhanced funds for a Caring Connections Program, which focuses on assisting pregnant and/or parenting women who have an addiction. The program is run in partnership with local child welfare organizations and Ontario Early Years Centres, and focuses on children aged 0–6. The Opiate Dependency Strategy also includes:

- Start-up funds for the new Sarnia/Lambton Withdrawal Management Services
- New therapist position for the Bluewater Methadone Clinic
- New therapist position for the Erie St. Clair Methadone Clinic in Windsor

➤ Key Planning Activities for the Next Fiscal Year (and for the IHSP 3)

Moving forward with the implementation of the directions and tactics identified in IHSP 3, we have incorporated the following key considerations in our work:

Embed quality improvement and learning strategies into our activities

1. Advance strategies related to the collective LHIN system-wide imperatives
2. Continue to implement a consistent and transparent approach to planning, priority setting, and decision-making
3. Continue to identify, advance, and measure performance indicators and targets that support the achievement of provincial and LHIN-level goals and priorities
4. Apply a variety of communication and engagement strategies, to ensure that interested parties have an opportunity to participate in decision-making
5. Align our tactics with the impact of funding reform

In the coming year(s), as we continue to build on previous successes and the efforts already underway, the IHSP 3 four key strategic directions that the ESC LHIN will focus on are:

1. Improved outcomes in alternate level of care
2. Improved outcomes in the emergency department
3. Improved outcomes in chronic disease management
4. Improved outcomes in mental health and addictions

1.3 Assessment of Issues Facing the ESC LHIN

Future Demographics, Projections and Trends:

Erie St. Clair, the southernmost LHIN, comprises Essex County, the Municipality of Chatham-Kent, and Lambton County. It is home to over 640,000 people, or 4.8% of the population of Ontario. During the years 2006–11, the population of Erie St. Clair decreased by 1.6%, while Ontario's population grew by 5.6%.

Erie St. Clair has a growing seniors' population, and is aging faster than the province as a whole, while our younger population, those between 0 and 44 years, is decreasing. In 2011, almost 16% of the population were seniors (aged 65+), an increase from 14% in 2006. Compared to the rest of Ontario, Erie St. Clair has a slightly higher proportion of the population over the age of 60 and a slightly lower proportion of the population between the ages of 30 and 34. These differences in age distribution are most pronounced in the Chatham-Kent and Sarnia/Lambton communities.

Of the total Erie St. Clair population, 17.0% live in Chatham-Kent, 62.5% in Essex County and the remaining 20.5% in Lambton County. Compared to the province as a whole, Erie St. Clair has a larger rural population (5.4% larger). Population density is also considerably higher in Erie St. Clair (approximately 70 more people per square kilometer) than in the province.

At the county level, the population has declined by 4.2% in Chatham-Kent, 1.6% in Lambton, and 1.2% in Essex. Between 2011 and 2016, the population is expected to experience slow growth and increase by only 3,686 residents (0.6%); by 2021, it is forecast to increase by 1.6%. During the same period, it is projected that the population of Ontario will grow by 13%.

Of the total Erie St. Clair population, 3.3% identify as Francophone (e.g. claim French as their mother tongue), which is slightly lower than for the province as a whole. The Francophone population is also much older than the general population: seniors represent 24% of this group, in comparison with 16% in the general population. Education and revenue levels are also lower than for the general population. Out-migration of Francophone youths is of particular concern to the community.

The proportion of the population identifying itself as Aboriginal in Erie St. Clair has increased slightly since 2006, and is now 0.4% higher than for the province as a whole. The largest numbers of Aboriginal people — 43% — live within Windsor/Essex; 39% live in Sarnia/Lambton, and 18% in Chatham-Kent, with the majority living off-reserve in Ontario.

Economic Challenges:

The current economic challenges, which began in 2008, have resulted in a disproportionately high unemployment rate in Erie St. Clair compared to the rest of the province. This high rate may be exacerbated by the fact that the population of Erie St. Clair has lower levels of education than the province as a whole. Approximately half of the population (54.9%) has completed post-secondary education, while 15.5% of the population does not have a certificate, degree, or diploma. Levels of education are highest in Sarnia/Lambton and lowest in Chatham-Kent.

From 2006 to 2011, the unemployment rate in Erie St. Clair decreased slightly, to 7.5%, which is higher than the 6.4% unemployment rate for the rest of Ontario. Unemployment was highest in Essex (7.9%) and lowest in Sarnia/Lambton (6.5%). After the dramatic changes that occurred in the Canadian economy between 2009 and 2011, however, the employment situation in Erie St. Clair shifted. In 2011, the unemployment rate in Windsor/Essex decreased slightly, to 9.3%, which was higher than the provincial average of 7.8%. The localized unemployment rate in the Municipality of Chatham-Kent (8.8%) is higher than the provincial average.

Overall, the economic challenges of the past few years have had a disproportionate impact on the Erie St. Clair region. It is anticipated that the economic and employment situation will result in an increased need and demand for social services and mental health and addiction services within Erie St. Clair. In summary, ESC LHIN has significant concerns about the pending impact of the economic situation on the demand for services and performance implications within the local health care system.

Health Status and Chronic Conditions:

The residents of Erie St. Clair perceive that they are healthier than they actually are. Residents in this region have a lower life expectancy rate, a higher age-standardized mortality rate, and a higher potential years-of-life-lost rate compared to rates for the province.

Poor health practices correlate with an increased risk of chronic disease, mortality, and disability. Relative to the rest of the province, residents of Erie St. Clair report higher rates of smoking, alcohol consumption, and obesity, and lower rates of physical activity and healthy eating. These factors place the residents of Erie St. Clair at a higher risk for developing chronic conditions, especially diabetes.

Health status information indicates that life expectancy among males and females in Erie St. Clair is lower than life expectancy for Ontarians overall. Since 2006, female life expectancy at birth increased by 0.6 years for Erie St. Clair and 0.9 years for Ontario. During the same period, male life expectancy at birth in Erie St. Clair increased by 1.0 years. Between 2006 and 2011, male life expectancy in Erie St. Clair increased at a higher rate than female life expectancy.

Chronic conditions place a high burden on the health care system and reduce the quality of life for those who have one or more of these conditions. Forty-one per cent of Erie St. Clair residents (aged 12+) have a chronic condition and 17% have multiple conditions. The prevalence of multiple chronic conditions increases dramatically with age: more than half of Erie St. Clair residents aged 65+ have two or more chronic conditions. Chronic conditions account for 6 of 10 deaths, 1 of 4 acute hospital admissions, and 3 of 10 acute hospital days for Erie St. Clair residents.

Compared to Ontario, Erie St. Clair had higher rates of the following chronic conditions (in order from highest to lowest) in 2009: arthritis, hypertension, diabetes, asthma, heart disease, and COPD. For all age groups, arthritis and hypertension are the most common of the selected chronic conditions. As well, Erie St. Clair residents over the age of 65 have the highest occurrence rates for all of the selected conditions (except asthma) compared to Ontario.

Assessment of Service Utilization:

The point of access for most medical care is through a primary care physician. The majority of Erie St. Clair residents have a regular primary care physician (90.9%), with 82.8% having had at least one contact with a physician in the past year. The Ministry of Health and Long-Term Care's Health Care Connect (HCC) program — which helps Ontarians who don't have a family doctor, find one — began in February 2009. Between February 2009 and April 2012, 10,660 Erie St. Clair residents registered with the program, and 94% of them have been referred to a primary care provider through HCC.

In the Erie St. Clair region, there are a total of 87 health service providers, including:

- Community Care Access Centre
- Community Health Centres
- Community Support Services
- Hospitals
- Long-Term Care Homes
- Mental Health and Addictions

A significant number of ministry-funded services do not fall under the LHIN mandate, including most physician services, ambulance services, public health, drug benefits, laboratories, and independent health facilities.

Across the Erie St. Clair region, opportunities exist to improve both access to and appropriate utilization of EDs. Emergency department services are available across all hospitals in Erie St. Clair. As with many hospital EDs, Erie St. Clair's EDs are facing a variety of operational issues. For example, the facilities need more NPs and physicians in order to maintain current levels of service.

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

ESC LHIN's focus over the next three years is to continue transformation and integration efforts aimed at providing the right services to meet expected demand, increased collaboration, stakeholder engagement in the decision making-process, and improved overall efficiency in the use of health care resources.

Building on the general strategic directions of the Erie St Clair LHIN Strategic Plan (Page 1 and 2 of this document), the IHSP 3 targeted outcomes for 2013–16 are:

1. Improved outcomes in alternate level of care

Rationale:

Too often, people remain in hospital when an alternate level of care (ALC) is available and would serve them better; for instance, at home or in long-term care, where services can be better tailored to their needs. This negatively affects both patient flow and patient experience while driving up overall health care costs. The ALC rate for 2011-12 (fourth quarter) was 12.82%, above ESC LHIN's target rate of 12%. Erie St. Clair continues to have the highest proportion of ALC patients discharged to complex continuing care (CCC).

The top three patient types for ALC days across the Erie St. Clair region are dementia, ischemic event of central nervous system, and heart failure without coronary angiogram.

2. Improved outcomes in the emergency department

Rationale:

In ESC LHIN (and in Ontario generally), hospital EDs continue to be the default portal through which many consumers gain access to health care. The resulting ED congestion is an indicator of overall health system performance, telling us how effectively our primary health care, community care, mental health, and hospital programs are working together to serve patients.

3. Improved outcomes in chronic disease management

Rationale:

Chronic health conditions are rapidly increasing the overall burden of disease in the Erie St. Clair region. Compared to the province, the Erie St. Clair population has higher rates of occurrence for arthritis, asthma, diabetes, hypertension, mood disorder, COPD, and heart disease. Of these conditions, the largest proportions of ED visits are associated with arthritis, heart disease, and COPD.

4. Improved outcomes in mental health and addictions

Rationale:

Mental health and addictions are traditionally underserved areas, and consequently have a significant impact on EDs, acute settings, and community resources. In the region's EDs, for example, 77% of the mental health and addictions visits are associated with the following diagnoses: neuroses, stress-related and somatoform disorders, mood disorders, and mental and behavioural disorders due to psychoactive substance use.

After identifying our overall strategic priorities, we initiated a more focused approach targeting "priority populations" (e.g. those most in need, and high users of the health care system), and identifying "hot spots" — defined geographic areas indicating patterns of evidence of higher utilization, or inappropriate utilization of health care resources (because other options for care do not exist).

Through community engagement, stakeholders were also engaged to provide input on how to better address health care needs. The result is a list of priority tactics/projects (refer to next section of this plan) that will be started within the next 12 to 36 months; the aim is to produce results that better address the following ESC LHIN key performance measures:

- Percentage of ALC days reductions
- ED length of stay (LOS) non-admitted complex (Canadian Triage and Acuity Scale [CTAS] 1–3) reductions
- Improve time to in patient bed for admitted high acuity wait time
- ED LOS non-admitted minor (CTAS 4–5) reductions
- Wait time (WT) for CCAC in-home services reductions
- Repeat unplanned ED visits within 30 days for mental health and addictions reductions
- Readmissions within 30 days for selected case mix groups (CMGs)

Other support areas identified in the next section include: End of Life Care, French Language Health Care, 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 ED 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 increase in the number of ED Physicians staffing the region's EDs, 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%) over the age of 50 years. Challenges Include: • Recruitment and retention of ED trained physicians, Nurse Practitioners (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 Windsor/Essex and Sarnia/Lambton has increased ED holds and lengthened ED LOS for admitted patients • Erie St. Clair continues to experience increased percentage of patients designated ALC - 15.3 % contributing to transition and patient flow at 13.5%, with Windsor/Essex at 12.2%, Sarnia/Lambton at 12.9%. ALC experienced in Chatham-Kent and Leamington District Memorial Hospital (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 Emergency Department (cont'd)
Current Status
In ESC LHIN (and in Ontario generally), hospital EDs continue to be the default portal through which many consumers gain access to health care. The resulting ED congestion is an indicator of overall health system performance, telling us how effectively our primary health care, community care, mental health, and hospital programs are working together to serve patients. • Nine out of 10 people with complex conditions requiring more time for diagnosis, treatment, or admission to a hospital bed spent up to 23.8 hours in the ED. This is well above the provincial access target of eight hours. • Nine out of 10 people with minor or uncomplicated conditions requiring less time for diagnosis, treatment, and observation spent up to 3.9 hours in the ED, which is slightly below the provincial access target of four hours. In Erie St. Clair, continued high volumes of non-urgent (CTAS 4) and deferrable (CTAS 5) visits to EDs of hospitals reflect a lack of timely access to primary care services. For instance, the top conditions associated with ED visits that could be managed elsewhere (e.g., visits for conditions that could be treated in alternative primary care settings) are upper respiratory infections, bladder infections, ear infections, and eye infections. In Sarnia/Lambton and Chatham-Kent, the rate of ED visits that could be managed elsewhere is more than double the overall rate across the Erie St. Clair region.
<u>ED Planning Objectives Considered</u> • Reduction in avoidable re-hospitalization for key diagnosis • Improved transitions and care coordination at the interfaces between care settings • Enhancing coaching, education, and support for patient self-management • Streamlined mental health services between community providers and the hospital • Enhanced use of Health Care Connect for unattached patients to existing primary care providers • Improved primary care access aligned with Primary Care Strategy • Enhanced adequate after-hours/weekend/holiday coverage by primary care practitioners • Improved access to primary care for episodic care, and follow-up and ongoing care • Improved access to primary care assessments in LTC homes • Increased effectiveness of Nurse Lead Outreach Teams (NLOT) to LTC homes, targeting high ED users across the Erie St. Clair region • Increased use of transitional care, assess and restore, and CCAC programs to reduce the demand for LTC homes (and ALC) supporting the Home First philosophy • Improved patient flow from ED registration to inpatient admitted bed • Reduced ED visits and re-admission for chronic disease management patients

TEMPLATE A: PART 2: GOALS and ACTION PLANS Emergency Department (cont'd)
Goal (s)
<u>ED Overall Goals:</u> • Improve core discharge planning/policies and transition processes from hospital to community through standardization • Initiate an early-warning, high-risk identification process for potential repeat ED users • Continue to develop recruitment and retention initiatives for the ED • Evaluate the Home First initiative and readjust per revised plan • Improve leadership and interfaces between care settings: – Hospital – Nurse Practitioner Lead Outreach Team – Primary care – Community support services (CSS) • Utilize decision support team to identify high users of the ED who have diabetes • Increase the number of Aboriginal people with a primary care provider • Continue to initiate education collaborative in hospice palliative care, with an emphasis on best practice uptake in all care settings • Initiate a virtual team to improve access to end-of-life specialists The action plans will focus on the following priority populations within the ED: • High users of the ED • High-risk seniors aged 65+ • Individuals with multiple chronic diseases • Mental health and addiction users of ED services • Aboriginal people not attached to a primary care provider • Individuals and/or families living with a progressive, life-limiting illness
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)			
Action Plans / Interventions			
Action Plans / Interventions:	% Completion by Year		
	2012-13	2013-14	2014-15
Expand the ED hours of Nurse Practitioner (NP) / Physician Assistant (PA) coverage for treat and release patients	30%	30%	30%
Develop a referral process and primary care path for COPD/ Congestive Heart Failure [CHF] initiated by the ED and CCAC	80%	20%	-
Continue and expand Pay for Results Program (P4R) and Process Improvement Program (PIP) strategies to reduce wait times in the ED	30%	30%	30%
Develop mechanisms so that unattached patients (CHF / COPD) are auto- referred to NP or primary care (PC) provider for follow up and self -management	30%	30%	30%
Explore research opportunities related to a predictive model approach within Erie St. Clair to support patient flow and efficiencies for admitted patients	50%	50%	-
Support health promotion best practices related to influenza prevention practices in acute care and LTC sectors diseases.	50%	50%	-
Develop strategies to support improved admission and discharge policies and processes to enhance smooth transitions of care.	50%	50%	-
Develop strategies to support mental health & addiction health service provision	50%	50%	-
Develop improved communications, customer service and patient satisfaction strategies for patients waiting in the ED	50%	50%	-
Explore opportunities to support ED diversion strategies with HSP's (emergency medical services [EMS], PC, CCAC) with LTC homes in the Erie St. Clair region	50%	50%	-
Review ED MD recruitment and retention strategies and coverage for Erie St. Clair region	50%	50%	-
Expected Impacts of Key Action Items			
• Reduce ED visits ESC LHIN-wide from 1,247 to 944 within three years for individuals with COPD aged 35+ (rate per 100,000 population) • Reduce ED visits ESC LHIN-wide from 456 to 362 within three years for individuals with CHF aged 35+ (rate per 100,000 population) • Reduce 30-day repeat visits to the ED by 5 % within three years for people with mental illness and addictions • Divert 10 % of current inappropriate hospital mental health visits to the community sector • Reduce avoidable ED visits for people with diabetes by 2 % within three years • Reduce avoidable palliative care visits to the ED to reach 10th percentile of provincial performance • Increase the percentage of Aboriginal people attached to a family physician/primary care provider in a culturally safe primary care setting by 20 % CHF: reduce emergency visits per 100,000 population ESC LHIN-wide (for those aged 35+) from 456 to 362 in three years • Achieve 90th-percentile CCAC wait time in home services			

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 • Continued challenges experienced by ALC • Continued higher than provincial rates of chronic conditions (e.g. arthritis, asthma, diabetes, hypertension, mood disorder, anxiety disorder) driving up ED visits • Inability to recruit and retain ED Physicians without threat of ED closure in some sites For each risk/barrier describe the plan to mitigate risk. • Aligning and engaging ESC Primary Care Council goals and objectives to improve access to a primary care provider and/or NP in the Erie St. Clair region • Develop and support improved smooth transitions and health service delivery models for those individuals with COPD/CHF, MH ED revisits, and substance abuse • Develop standardized discharge policies and processes in collaboration with acute care and CCAC to support transitions of care for an improved patient care experience What are some of the key enablers that us to achieve our goal? • Standardized approach to health promotion, CDM, prevention and self-management strategies that support best practices and knowledge translation through the Erie St. Clair region. • Continue building Behavioural Supports Ontario (BSO) capacity within the ESC LHIN for ED, acute and LTC homes • Develop a current and future state ED coverage inventory to ensure safe and quality care provision in addition to a physician recruitment and retention plan

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:	
Too often, people remain in hospital when an alternate level of care (ALC) is available and would serve them better — for instance, at home or in long-term care, where services can be better tailored to their needs. This negatively affects both patient flow and patient experience while driving up overall health care costs. The ALC rate for 2011–12 (fourth quarter) was 12.82 % with an increasing ALC rate trend for 2012-13(second quarter) 15.88% above ESC LHIN's target rate of 12 %. Erie St. Clair continues to have the highest proportion of ALC patients discharged to complex continuing care (CCC). The top three patient types for ALC days across the Erie St. Clair region are dementia, ischemic event of central nervous system, and heart failure without coronary angiogram.	
Current Status:	
<u>ALC Planning Objectives Considered</u> <u>Planning Objectives Considered</u> • Improved outcomes for ALC patients through dissemination and integration of evidence-based practice, integration, and partnership for selected diagnosis • Improved transitions of care, discharge processes, and follow-up for selected diagnosis • Increased community knowledge of hospital access implications and impact of ALC patients on emergent care processes • Reduce hospital utilization incidence rate for identified high-risk users • Reduce hospital and inappropriate Community Care Access Centre (CCAC) utilization • Avoidable admissions and re-admissions on selected case mix groups (CMGs) who become ALC • Implementation of Ontario's Seniors Strategy • Increase capacity of Nurse Practitioner Led Outreach Team to support LTC homes and appropriate ED aversion opportunities. • Alignment with the integrated vascular model and chronic disease management (CDM) • Improved access to acute care capacity (medical, surgical, and critical care) through process improvement • Ensuring appropriate community care and discharge options (including end-of-life care) • Maximize functional conditioning of patients over the age of 60 • Improved time to LTC home placement for hospital inpatients and community • Improved outcomes of implemented falls prevention program in institutions and homes • Creation of effective standardized educational programs for seniors with respect to services, supports, and programs available to assist them in either a) staying at home, b) transitioning to a rest/retirement home, or c) transitioning to a LTC home • Reduction in acute length of stay (LOS) for chronic disease populations, and subsequent transfer of a greater proportion of care to community services or restorative care services, 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 (cont'd)**

Goals:

ALC Overall Goals:

Initiate Rehabilitation System Strategic Plan for the Erie St. Clair region:

- Identify and implement best practices for top three rehabilitation clinical conditions
- Facilitate appropriate use of inpatient rehabilitation beds
- Ensure adequate access to outpatient and community rehabilitation services
- Increase assisted-living capacity/beds ESC LHIN-wide
- Continue to implement ESC LHIN-wide falls prevention initiative
- Support the development of residential hospice services in Chatham-Kent and Leamington
- Enhance the primary care role in managing end-of-life patients
- Support Leamington District Memorial Hospital Seniors Centre of Excellence Strategy
- Transform 2 % of all LTC beds into convalescent care beds
- Initiate early warning risk assessment tool (the LACE index — length of stay, acuity, comorbidity, and emergency department visits within six months)

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

- ALC patients with diagnosis whose acute stay would be shortened if they received intensive rehabilitation services
- High-risk frail seniors aged 65+
- Potential assisted-living patients currently in CCC, assess and restore, and/or convalescent beds
- Individuals and/or families living with a progressive, life-limiting illness
- Frequently readmitted CDM and behavioral patients

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		
	2012-13	2013-14	2014-15
Develop and increase capacity for restorative care/transitional care programs e.g. convalescent care programming ESC LHIN-wide	70%	30%	-
Develop key messages/market plan to highlight services offered by each LTC home (video format)	100%	-	-
Initiate and develop Home First geographic Implementation Teams to support ALC and Home First goals and objectives ESC LHIN-wide	100%	-	-
Redesign Home First to support geographical as transitional care sites on key trends, barriers and challenges to improve transitions of care	10%	60%	30%
Develop a comprehensive Falls Prevention Program ESC LHIN-wide	60%	40%	-
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	100%	-	-
Improve patient flow by building community capacity, enhance short-term bed capacity to improve ALC patient flow and offer alternatives to hospital admission/placement	100%	-	-
Support a robust discharging planning process with Home First as the primary goal	50%	50%	-
Support BSO Collaborative and Resident First strategy to support mental health patients and individuals with behaviours and transitions of care	60%	40%	
Expand NP outreach program, behavioral supports, psycho-geriatric fostering – to cover nursing homes (with goal of preventing ED visits and enhanced community services)	60%	40%	-
Expected Impacts of Key Action Items			
• Reduce acute ALC to 12 % ESC LHIN-wide • Reduce the need for hospital acute services (inpatient discharges) within the next three years to meet the provincial discharge rate of 100 % • Meet the target of 7,250 new patient days (equal to 20 beds) for assisted living in Windsor/Essex • Meet the target of 7,250 new patient days (equal to 20 beds) for assisted living in Chatham-Kent and Sarnia/Lambton • Reduce hospitalizations due to falls from 12 to 11.2 (rate per 1,000) for those aged 65+ within three years • Maintain ALC throughout ratio at or above provincial target (e.g. greater than one) • 5% re-education 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 long-term care home beds construction schedule for Windsor/Essex- need for 260 + 250 additional. • Need to ensure seamless transitions for patients (in a timely manner) to the most appropriate care setting with Home First philosophy • Inability to identify and apply best practices in discharge planning across the Erie St. Clair region • Growing elderly (aging) population with higher acuity needs • 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 For each risk/barrier describe the plan to mitigate risk. • Continued challenges experienced by ALC pressures and designations and RIA assessments completed within the acute care sector without transitions of care opportunities. • Long-term care home education, supports, and resources for high intensity needs for BSO, end-of-life care, best practices, advance care planning (ACP) to appropriately support ED aversion to include long and short stay client experience. What are some of the key enablers that us to achieve our goal? • Improve primary care access and follow up to seniors • Appropriate allocation or redistribution of resources to adequately support equitable access and health service models for high risk populations and seniors- Health Links, mental health and addictions, and rehabilitation • Explore and develop primary care access opportunities in prevention and self-management for CDM, mental health and addictions and seniors. • Transitional Care programming • Expansion of nurse led outreach team NLOT program ESC LHIN-wide.

2.3 Chronic Disease Management

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY PRIORITY: Chronic Disease Management	
Integrated Health Services Priority:	
Chronic Disease Management	
IHSP Priority Description:	
Chronic health conditions are rapidly increasing the overall burden of disease in the Erie St. Clair region. Compared to the province, the Erie St. Clair population has higher rates of occurrence for arthritis, asthma, diabetes, hypertension, mood disorder, chronic obstructive pulmonary disease (COPD), and heart disease. Of these conditions, the largest proportions of ED visits are associated with arthritis, heart disease, and COPD. • Lack of information technology to monitor and track patient care to best practices • Lack of patient education and self-management programming • Need for better lifestyle choices • Need for timely access to primary care <u>Chronic Disease Management Planning Objectives Considered</u> • Improved/streamlined coordination across service providers (Care Path/integrated model development) within Erie St. Clair region for three main foci: COPD, CHF, and diabetes • Simplified (single point of access/centralized intake) for the COPD, CHF, and diabetes services system • Increased uptake of best practice for COPD, CHF, diabetes care ESC LHIN-wide • Improved system-level reporting on performance management for chronic conditions • Improved system navigation within Erie St. Clair region for those with chronic diseases • Improved, shared, and standardized education programming (e.g., best practice, ongoing professional development) • Expand existing care capacity (primary care specifically) dedicated to CDM • Determine overall need for rehab supports for individuals with a chronic disease • Optimized wait times for key COPD, CHF, and diabetes services • Improved inter-professional collaboration and evidence-based practice for CDM interventions • Improved and timely access to specialized consultations • Increased utilization of ancillary health care practitioners within existing clinical practice guidelines • Improved (earlier) screening of identified higher-risk populations (COPD, CHF, diabetes)	

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES
PRIORITY Chronic Disease Management (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 Chronic Disease Management (cont'd)			
Goal (s)			
<u>Chronic Disease Management Overall Goals:</u> • Advance ESC LHIN-wide standardized COPD Care Path • Initiate CHF Care Path development (beginning in Windsor/Essex) • Advance an ED and hospital discharge protocol for COPD • Implement a centralized intake process ESC LHIN-wide for diabetes based on Windsor/Essex model (beginning in Chatham-Kent) • Advance an ESC LHIN-wide care path for diabetes • Advance/link with more culturally based models of care The action plans will focus on the following priority populations for people in need of chronic disease management care: • Individuals with COPD • Individuals with CHF • Individuals who have suffered a stroke • Individuals with complications/high needs due to diabetes • Individuals with complications due to digestive disorders • Aboriginal people with a chronic disease and co-morbidities • Individuals and/or families living with a progressive, life-limiting illness • Francophone seniors with a chronic disease and co-morbidities			
Consistency with Government Priorities:			
The above goals are consistent with MOHLTC directions for chronic disease management			
Action Plans / Interventions			
Action Plans / Interventions:	% Completion by Year		
	2012-13	2013-14	2014-15
Establish a COPD Integrated care path/model starting in Chatham-Kent and expanding ESC LHIN-wide by 2013	50%	50%	
To improve overall system accountability and reporting implement an Electronic Assessment Tool for COPD in Chatham-Kent and expanding ESC LHIN-wide by 2014	50%	50%	
Advance protocols to managed COPD care transition points on the care path (e.g. discharge, end of life, flow from CCAC to the rapid response teams)	50%	50%	
Advance an Integrated care path for diabetes starting in Windsor/Essex and then LHIN wide by 2014	50%	50%	
Advance a crisis management – after hours strategy hours model of care and reflect this element on all CDM	50%	50%	
Advance a CHF Integrated care path starting in Windsor/Essex and then LHIN wide by 2014	50%	50%	
Improve linkages with primary care through the care paths	50%	50%	
Advance performance measures and targets for all priority areas by 2014 (COPD, diabetes and CHF)	60%	40%	

TEMPLATE A: PART 2: GOALS and ACTION PLANS Chronic Disease Management (cont'd)
Expected Impacts of Key Action Items
• Reduce 30-day re-admissions from 24.5 % to 12 % within three years for individuals with COPD aged 35+ • Reduce 30-day re-admissions from 18.8 % to 12 % within three years for individuals with CHF aged 35+ • Reduce admissions from 322 to 280 within three years for individuals with CHF aged 35+ (rate per 100,000 population) • Reduce admissions from 417 to 330 within three years for individuals with COPD aged 35+ (rate per 100,000 population) • Reduce high blood pressure within the Erie St. Clair population from 19.7 % to 17.7 % within three years • Reduce the daily or occasional smoking rate within three years from 22.2 % to 18.9 % • Achieve a 2 % reduction in ED diabetes visits • Achieve a 2 % reduction in LOS for hospitalized diabetes related complications • Place 90 % of complicated COPD, CHF, and diabetes patients on a multidisciplinary Care Path
What are the Risks / Barriers to Successful Implementation?
• Inability to quantify accountability measures in the health care system • People not adopting better lifestyle changes • Inability to acquire timely access to primary care • Lack of education opportunities and self-management support options • Continued lack of standardized community care paths (COPD, CHF, diabetes) • Inability to effectively track results and impact of programs on patient outcomes • Poorly defined linkages with primary care for ongoing maintenance and prevention • Continued reliance on hospital (EDs) for health care service after hours For each risk/barrier describe the plan to mitigate risk. • Develop standard integrated care paths for high end users of the health care system in Erie St Clair (COPD, CHF, diabetes) • To improve overall accountability and tracking performance, implement an electronic assessment tool intended to measure results of care path standardization • Focus more on health promotion, education and self-management strategies as a response to longer term health care overall improvement) • Operationalize linkages with primary care through care path and protocol development • As part of the integrated care path advance models of after hour care and crisis management within community settings

TEMPLATE A: PART 2: GOALS and ACTION PLANS Chronic Disease Management (cont'd)
What are the Risks / Barriers to Successful Implementation? (cont'd)
What are some of the key enablers that us to achieve our goal? • Training and signed service agreements for the use of an electronic assessment tool • ESC LHIN support for planning and establishing structures in the community (working groups) to design and operational integrated care paths • Identification of best practices and agreement from provides on uptake of these ESC LHIN-wide • Ability to accurately measure and report on health system performance • Agreement from health care providers on performance targets and measures at the onset of the implementation process

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	
IHSP Priority Description:	
Mental health and addictions are traditionally underserved areas, and consequently have a significant impact on EDs, acute settings, and community resources. In the region's EDs, for example, 77% of the mental health and addictions visits are associated with the following diagnoses: neuroses, stress-related and somatoform disorders, mood disorders, and mental and behavioural disorders due to psychoactive substance use. After identifying our overall strategic priorities, we initiated a more focused approach targeting "priority populations" (e.g. those most in need, and high users of the health care system), and identifying "hot spots" — defined geographic areas indicating patterns of evidence of higher utilization or inappropriate utilization of health care resources (because other options for care do not exist). Through community engagement, stakeholders were engaged to provide input on how to better address health care needs. The result is a list of priority tactics/projects that will be started within the next 12 to 36 months; the aim is to produce results that better address the following ESC LHIN key performance measures: • In the ED, 77% of mental health and addictions visits are associated with the following four diagnoses: neuroses, stress-related and somatoform disorders, mood disorders, and mental and behavioural disorders due to psychoactive substance use • In the acute setting, 77% of active cases are associated with mood disorders and schizophrenia, as well as other psychotic disorders • In the acute care setting and schedule one older adults with responsive behaviors are documented as having high ALC rates due to refusals by LTC homes to accept the resident back. • In the community, increases in new admissions indicate a growing need for problem-gambling and substance-abuse programs. For individuals seeking substance-abuse treatment services, the top three substances identified are alcohol, cocaine, and narcotics/opiates • Finally, anecdotal information identifies that suicides and abuse events are increasing in the localized severe economic downturn • Mental health and addictions is a growing issue that requires a comprehensive, measured, and action-oriented approach.	

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES Mental Health and Addictions (cont'd)
Current Status:
<u>Mental Health Planning Objectives Considered</u> • Develop community-based alternatives to ED use • Reduce ED repeat visits (within 30 days) • Reduce re-admissions (within 30 days) to inpatient mental health services • Provide community-based care to elderly adults with mental health and/or responsive behaviours to prevent or delay admission to hospital or placement in an LTC home • Provide appropriate services for people with mental illness (moderate or serious), to maintain them in the community of their choice of residence • Improve multi-disciplinary communication through integrated information systems • Increase stabilized housing programs and similar options for all priority populations • Strengthen relationships between mental health and addictions providers and primary care providers, as it relates to “shared care models” <u>Addictions Planning Objectives Considered</u> • Increased access to withdrawal management services • Reduced reliance on primary care, ED, and inpatient services for withdrawal management and addiction services • Increased capacity (service volumes) and reduced wait times (referral to service initiation) of outpatient services for opiate-dependent adults, youth, and seniors • Improved integration and delivery models of services in order to appropriately meet patient needs across their lifespan (youth, adult, and senior) • Ensure that a continuum of addiction services are available for opiate-dependent individuals within Erie St. Clair

TEMPLATE A: PART 2: GOALS and ACTION PLANS Mental Health and Addictions (cont'd)
Goals
<u>Mental Health & Addictions Overall Goals:</u> • Implement <i>Mental Health Strategic Plan</i> – Multi Year Prioritization Framework - Connect frequent users of the ED with community supports in Chatham-Kent and Sarnia/Lambton - Establish an Inner City Mental Health Model in Windsor/Essex to redirect frequent users of the ED to community supports - Implement Next Day Bookings and Wait Time Strategy for mental health and addiction population - Leverage new opiate resources as a primary link to ED for repeat ED visits for substance misuse specific to opiates. - Implement the redesign of the ESC LHIN Mental Health & Addiction Network umbrella structure with six leadership tables. Each leadership table is responsible for concrete deliverables. - Develop a virtual network of providers to serve the Francophone population • Establish ED tracking protocols for opiate-dependent patients needing withdrawal-management services ESC LHIN-wide • Open withdrawal-management services in Sarnia/Lambton in 2013 • Continue to monitor the uptake of the addicted pregnant women initiative (ESC LHIN-wide). • Continue to implement Behavioural Supports Ontario (BSO) initiative The action plans will focus on the following priority populations for mental health & addictions: • High users of the ED (1 % of the population) • Repeat users of the ED for mental health and addictions • Aboriginal people with mental health and addictions • Opiate-dependent patients • Individuals in need of withdrawal-management services • Older adults with responsive behaviours • Youth with mental health crisis (suicidal ideation / early psychosis) • Determine the need for specialized behavioral units • Re purpose existing group homes to align with the Mental Health Strategic Plan • Francophone patients with mental health issues
Consistency with Government Priorities:
The above goals are consistent with the government's commitment to strengthen mental health & addictions services in the province including.

TEMPLATE A: PART 2: GOALS and ACTION PLANS Mental Health & Addictions (cont'd)			
Action Plans / Interventions			
Action Plans / Interventions:	% Completion by Year		
	2012-13	2013-14	2014-15
Mental Health			
Increase community education and promotion of early intervention first episode psychosis and ensure these programs meet Provincial standards	90%	10%	
Implement the Erie St. Clair BSS Model for older adults with responsive behaviors and their caregivers	70%	10%	20%
Implement Tele-Crisis Services and OTN Clinic Days ESC LHIN-wide	90%	10%	
Redesign the Mental Health & Addiction Network by establishing cross sector committees and CMHA ED Case Managers in all three counties	70%	10%	20%
Implement the Mental Health Strategic Plan	10%	70%	20%
Advance shared protocol between mental health and primary care for next day bookings	50%	50%	
Continue to advance the 'electronic booking service' ESC LHIN-wide	100%	-	
Implement Ontario Common Assessment of Need for assertive community treatment clients ESC LHIN-wide and compare clinical levels of need/risk to Canadian Mental Health Association intensive case management clients	80%	20%	
Addictions			
Develop protocols and care paths between the ESC LHIN funded Chronic Pain Program and Addiction Assessment and Referral services (ESC LHIN-wide)	100%		-
Evaluate the Addiction System Navigator role for replication in Chatham-Kent and Sarnia/Lambton	10%	80%	10%
Initiate the Addictions Strategic Plan 2012		80%	20%
Continue withdrawal management service partnership work in respective communities	70%	20%	10%
Initiate data tracking methodology for concurrent disordered first episode psychosis clients	10%	50%	40%

TEMPLATE A: PART 2: GOALS and ACTION PLANS Mental Health & Addictions (cont'd)	
Expected Impacts of Key Action Items	
• Decrease the number of high users of the ED who have a mental illness and who are not attached to community-based mental health services at a rate of five to eight clients per quarter • Decrease the number of repeat ED visits by 10 % within three years • Reduce ALC days by 5 % for people with specialized behavioural needs • Place 50 % of persistent, complicated mental health clients on a community plan prior to discharge • Reduce inpatient gero-psych admissions by 10 % • Reduce the wait time for withdrawal management and addiction medicine services by five days • Reduce wait times for community based mental health & addiction services by 50% • Increase successful residential treatment and compliance rates increase by 20 %	
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 needs to be improved • 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 mental health & addictions repeat visits • Continued separate planning, funding and service delivery silos between mental health & addictions • Continued stigma • Lack of 24/7 community-based mental health & addictions services • Continued economic issues/risks For each risk/barrier describe the plan to mitigate risk. • Implement spring 2013 ESC LHIN-wide 24/7 next day electronic bookings for people with mental health and addiction crisis needs. • Reduction in wait times for crisis services is embedded into providers Multi-Sectoral Service Accountability Agreement (MSAA) • Redesign of ESC LHIN Mental Health & Addiction Network as an “umbrella structure” – incorporation of 6 leadership tables for example– Mental Health and Primary Care, Inter Hospital and Community Integration Lead Table, and Psychiatry Lead Table. Lead Tables are responsible for developing and implementing standardized suicide screening tools, integrated care paths and mitigating treatment options for high users *re admissions and / or ED visits with 30 days. • Primary Care and Mental Health Lead Table will develop “shared care” protocols and link with the next day bookings strategy. Strategy utilizes Tele Med Nurses and existing mental health and addiction resources ESC LHIN-wide.	

TEMPLATE A: PART 2: GOALS and ACTION PLANS Mental Health & Addictions (cont'd)
What are the risks / barriers to successful implementation? (cont'd)
For each risk/barrier describe the plan to mitigate risk (cont'd) • Mental Health Strategic Plan evolves into a multi-year implementation plan and prioritizes the 67 opportunities accordingly. • Align the Inner City Model with COAST Team and the Super Jail as per Release from Custody resources. • Addiction Strategy Plan begins summer of 2013 What are some of the key enablers that us to achieve our goal? • Electronic next day bookings (anticipated outcome) and wait time strategy will result in significant reduction in community wait times for mental health and addiction services (ESC LHIN-wide) • Tele Med equipment and nursing resources ESC LHIN-wide is a key enabler • Lead Tables will break down silos between mental health and primary care as well as, mental health & addictions. This enabler will result in shared care practices and standardized clinical tools • Develop strong relationships between police services, the corrections system and mental health & addiction providers • Advance community-based treatment options for addicted pregnant women, as a means of reducing ED visits • Increased emphasis on consumer/family initiatives as a key resource for psycho social rehab and vocational employment opportunities • Leadership Tables will empower mental health & addiction providers to work together bridging silos with concrete deliverables, such as, county by county education strategies to address stigma, wait times and overall access issues. This includes posting of Connex 1-800 number in all public locations links to next day bookings • Continued evolution of BSO for older adults with responsive behaviours. All 35 LTC homes are now operating as a Hub and Spoke Model. Protocols as per repatriation of LTC residents with behaviours back to the LTC home with supports is planned for 2013/14. ALC BSO patients in Windsor are being reduced via a dedicated CCAC specially trained Case Manager. This model will be replicated for Chatham-Kent and Sarnia/Lambton 2013/14 • Specialized opiates management services are now in place and linked to the ED as per a red flagging system for addiction repeat ED visits • Continue to pursue the advancement of an "Inner City Model" involving primary care, mental health & addictions, pain management existing providers. Advancement of this model has received high level support from the ESC LHIN providers, the City of Windsor, Windsor Police Department and the OPP

3 Erie St. Clair LHIN Operations and Staffing Templates

3.1 Erie St. Clair LHIN Operations Spending Plan

Template B: LHIN Operations Spending Plan				
LHIN Operations Sub-Category (\$)	2012/13 Forecast (Dec)	2013/14 Allocation	2014/15 Planned Expenses	2015/16 Planned Expenses
Salaries and Wages	2,467,780	3,110,700	3,121,968	3,100,017
Employee Benefits				
HOOPP	217,155	363,710	364,723	362,159
Other Benefits	319,360	323,700	340,077	360,857
Total Employee Benefits	536,515	687,410	704,800	723,016
Transportation and Communication				
Staff Travel	70,866	93,200	80,000	80,000
Governance Travel	12,640	15,000	15,000	15,000
Communications	72,255	89,380	90,000	90,000
Other Benefits	(31)	10,000	10,000	10,000
Total Transportation and Communication	155,730	207,580	195,000	195,000
Services				
Accommodation (includes Insurance)	215,078	261,290	290,000	290,000
Advertising	3,275	10,000	10,000	10,000
Banking	-	-	-	-
Community Engagement	56,534	50,000	50,000	50,000
Consulting Fees	17,293	75,500	75,500	75,500
Equipment Rentals	24,477	29,100	29,100	29,100
Governance Per Diems	81,375	83,500	83,500	83,500
LSSO Shared Costs (includes LHINC)	389,020	411,650	411,650	411,650
Other Meeting Expenses	55,526	72,500	72,500	72,500
Other Governance Costs	26,583	50,610	50,610	50,610
Printing & Translation	9,487	22,000	22,000	22,000
Staff Development	92,636	77,010	40,000	40,000
Total Services	971,284	1,143,160	1,134,860	1,134,860
Supplies and Equipment				
IT Equipment	21,171	40,000	32,222	35,957
Office Supplies & Purchased Equipment	187,268	47,450	47,450	47,450
Total Supplies and Equipment	208,439	87,450	79,672	83,407
LHIN Operations: Total Planned Expense	4,339,748	5,236,300*	5,236,300	5,236,300
Annual Funding Target	4,339,748	5,236,300	5,236,300	5,236,300
Variance	-	-	-	0

- LHIN budget increase for 2013-14 due to LHIN assuming role for diabetes coordination

3.2 Erie St. Clair LHIN Staffing Plan

Template C: LHIN Staffing Plan (Full-Time Equivalents)				
Position Title	2012/13 Actuals as of Jan 31/2013 FTEs	2013/14 Forecast FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs
CEO	1	1	1	1
Senior Director	1	1	1	1
Director	3	3	3	3
Manager	10.5	10.5	10.5	10.5
Lead	5	5	4	4
Analyst	3	3	3	3
Executive Assistant	2	2	2	2
Admin Assistant	9	9	9	9
Receptionist	1	1	1	1
Total FTEs	35.5	35.5	34.5	34.5

4 ESC LHIN Annual Business Plan Integrated Communications Strategy

4.1 Objectives

Guiding Principles of Communication

- Clear language
- Transparent
- People-first language (e.g. person with diabetes)
- Respectful of Canada's two official languages
- Aligned to LHIN branding

We want to demonstrate to the residents of Erie St. Clair, the work being done to improve patient care in their community. The communication of successful ESC LHIN initiatives and investments will prove the value of LHINs, as measurable in better care, better experiences, and better value. If changes in health behavior and metrics tied to our strategic goals and IHSP 3 are achieved, we will have also met our communication objectives.

Communication Objectives:

1. **Become more visible and vocal within the community.** What it means: We have to be more proactive about communicating messages that support our leadership position and we have to make ourselves more available to media and others who act as interfaces between us and the community.
2. **Provide better health care system information and education.** What it means: As leaders, we need to help people gain a better understanding of the health care system, how it works, and how they can make the most of the services available to them. Education must better target the system's users and service providers.

Supporting Business Goals:

Our communication strategies support the ESC LHIN business goals through the communication plans created for the planning and implementation of the initiatives of the IHSP 3, other key local initiatives, and pan-LHIN/provincial programs. All ESC LHIN communication products support the ESC LHIN vision of *better care, better experiences, better value*, and supports our organizational strategic directions of:

1. Chronic Disease Management
2. Bold, Focused Leadership
3. Partnerships in Health Promotion

We want our communication strategies and tactics to positively influence health behaviours (e.g. make better choices around ED visits, enroll in LHIN-funded programs, etc.), ultimately to improve the health of our local residents. We also want to influence the opinion of LHINs, build trust in the work being done at the local level, and to demonstrate the bold and focused leadership the LHIN provides to system transformation. Additionally, it is our aim to positively shift attitudes of the LHIN by demonstrating that the work of the LHIN results in *better care, better experience, and better value*. ESC LHIN priorities and supportive communication objectives are in line with the Minister's Action Plan for Health and support the philosophy of *right care, right place, right time*.

Community engagement is a foundation of LHINs and through extensive interaction with the public and stakeholders we are able to inform our planning processes and validate our direction to improve health care locally. Because planning takes a patient-focus, we can be confident in improving the system in ways to make the patient experience better, at a better cost to the system.

Opportunities for engagement with the public and stakeholders are considered as part of all planning initiatives and are further detailed in *ESC LHIN Annual Community Engagement Plan* found in Section 5.

4.2 Context

Erie St. Clair, the southernmost LHIN, comprises Essex County, the Municipality of Chatham-Kent, and Lambton County. It is home to over 640,000 people, or 4.8 % of the population of Ontario. During the years 2006–11, the population of Erie St. Clair decreased by 1.6 %, while Ontario's population grew by 5.6 %.

Erie St. Clair has a growing seniors' population, and is aging faster than the province as a whole, while our younger population, those between 0 and 44 years, is decreasing. In 2011, almost 16 % of the population were seniors (aged 65+), an increase from 14 % in 2006. Compared to the rest of Ontario, Erie St. Clair has a slightly higher proportion of the population over the age of 60 and a slightly lower proportion of the population between the ages of 30 and 34. These differences in age distribution are most pronounced in the Chatham-Kent and Sarnia/Lambton communities.

ESC LHIN Business Objectives:

The ESC LHIN's Health Care Vision:

"Better Care, Better Experiences, Better Value."

ESC LHIN's mandate is to create a local health care system that:

- Generates better clinical and functional results, especially for the most vulnerable, fragile patients
- Creates a more coordinated system that provides the right care at the right place and the right time, especially for the most vulnerable, fragile patients
- Boldly transforms the health care system, positioning it to become a highly efficient and effective performance leader

The ESC 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

Strategic Directions:

The ESC LHIN Board Strategic Plan developed a series of directions to guide the LHIN's activities:

Direction #1: Chronic Disease Management (CDM)

Objective: Realign the health care system so that people with chronic diseases receive better regular care, are better able to self-manage their conditions, and are less reliant on emergency and acute care services.

Direction #2: Bold, Focused Leadership

Objective: As leaders of local health care, make courageous decisions that create a more tightly integrated, better aligned, and sustainable system where people receive the best care possible.

Direction #3: Partnerships in Health Promotion

Objective: Create better links between all health promotion and prevention organizations so that people have better access to programs and information that help them live healthier lives.

The ESC LHIN's Integrated Health Service Plan (IHSP 3), supports the ESC LHIN Board local strategic plan, by further advancing directions intended to integrate and improve the clinical and effectiveness outcomes of the local health system. The IHSP 3, which is consistent with the vision and strategic directions of the Ministry of Health and Long-Term Care (MOHLTC), communicates the priority areas that will guide ESC LHIN activities from fiscal years 2013 to 2016 and is the basis for this Annual Business Plan (ABP).

LHIN/Ontario Government Initiatives or Programs:

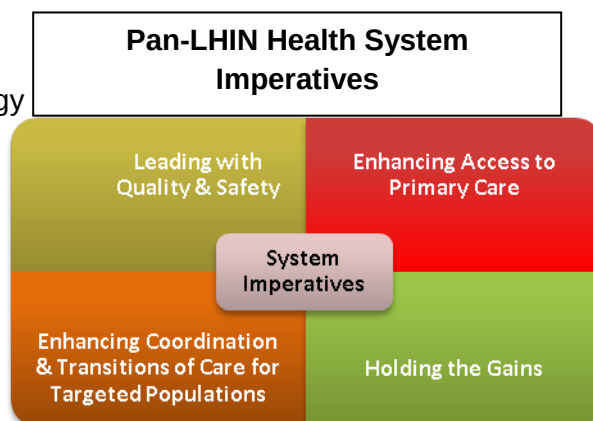
There are specific activities and areas of involvement through which the overall corporate strategies are being executed; including the following provincial programs:

4.2.1 Provincial Strategies/Initiatives/Programs

- Minister's Action Plan for Health
- Ontario's Senior Care Strategy
- Health System Funding Reform
- Health Links
- Home First
- Pay-for-Results
- Residents First
- Expanded CCAC Role
- Behavioural Supports Ontario
- Patient-Based Funding (HBAM)
- e-Health
- Quality Improvement Plans

Planning & Integration Activities

- IHSP 3
- ESC LHIN Strategic Plan
- Leadership Councils
- COPD Care Path & Future Chronic Disease Management Care Paths
- Mental Health Strategic Plan
- Rehab Strategic Plan
- Primary Care Strategy
- Aboriginal Mental Health and Addictions Strategy
- Integration Activities
- LHIN-wide Hospital Discharge Policy
- Orthopaedic Plan
- FLHPE/LHIN Joint-Strategic Plan
- Capital projects
- System Imperatives (see chart)
- Other planning activities as they develop



The ESC LHIN strategic goals and IHSP 3 strategic directions are aligned with, and support, the above mentioned provincial priorities. Strategic communication plans are developed and implemented for the local and pan-LHIN role out of these priorities/initiatives.

4.3 Target Audiences

Audiences, Primary

- Consumers/patients of the health care system
- General Public
- Media
- Health Service Providers
- Elected Officials
- Ministry of Health and Long-Term Care
- ESC LHIN Board
- ESC LHIN Staff

Audiences, Secondary

- Universities and Colleges
- Partner Organizations and Stakeholders e.g. OMA, OHA, OACCAC, OACHC
- Physicians, allied healthcare workers
- Non LHIN-funded health care partners e.g. Public Health Units
- Other LHINs

4.4 Strategic Approach

Become more visible and vocal within the community.

What it means: We have to be more proactive about communicating messages that support our leadership position and we have to make ourselves more available to media and others who act as interfaces between us and the community. In alignment with our strategic direction of Bold, Focused Leadership we will communicate the leadership decisions that have been made to ultimately create a more tightly integrated, better aligned, and sustainable system where people receive the best care possible.

Provide better health care system information and education.

What it means: As leaders, we need to help people gain a better understanding of the health care system, how it works, and how they can make the most of the services available to them. Education must better target the system's users and service providers. For example, by providing clear, understandable and publically available information on the programs and services available, we will strive towards improving the health outcomes for all of our residents while improving overall system navigation. Also in alignment with our strategic direction of Health Promotion Partnerships, we will work in collaboration with our stakeholders to deliver health promotion and illness prevention messaging.

Support our leadership role by being more vocal about our accomplishments and successes. Be upfront about issues and how we're dealing with them.

What it means: We have to be better, as an organization, at internally communicating our successes so that our front-line spokespeople have a richer reservoir of stories to draw upon. We also have to be more willing to openly discuss our plans, the issues that arise in their implementation, and the ways in which we are adapting to changing circumstances. Openly discuss our plans, the issues that arise in their implementation, and the ways in which we are adapting to changing circumstances. For example, as improvements are made in our Strategic Direction of Chronic Disease Management we will tell the success stories of those patients/clients so that others may be inspired to use the programs and services to improve their own health outcomes.

Tactics:

For all audiences noted above, a variety of strategic communication tactics are used.

These tactics include, but are not limited to:

- Traditional media products, social media, events, email, web/online, Community Report, Annual Report, LHINfo Minutes, media engagement strategy, meetings, open board meetings, board highlights, open mic, advance dissemination of Board meeting materials and agenda, etc.
- Additionally, for media we use: proactive media pitches, third party publications, availability as a health care resource, etc.
- Additionally for HSPs: Leadership Councils, networks and advisory groups, memos, ESC LHIN Communications & Outreach Committee (includes ESC LHIN Board members, as well as members of the community)
- Additionally for Elected Officials: council meetings, one-on-one meetings, briefing notes

We make choices for communication tactics based on local, provincial, and pan-LHIN strategies while being in line with the IAP2 Best Practice for Public Engagement and MOHLTC input and directives. We strive to be proactive in our communications and use a methodical reactive approach when needed. Following the guiding principle of transparency, we are open and transparent in our communications and make our material publically accessible, primarily through the ESC LHIN website and other directed approaches.

By collaborating with our HSPs and health care consumers, we encourage sharing of success stories and health care investments/programs through supportive media releases, events, website material, newsletters, etc.

4.5 Key Messages

Our messaging platform must recast our core values and mission; our goals, roles and responsibilities, in language that is easy to understand and remember. This is captured in our ESC LHIN vision of:

BETTER CARE, BETTER EXPERIENCES, BETTER VALUE

What is the ESC LHIN:

- We're the government agency that plans and funds health care services totaling a billion dollars a year in our region alone – everything from hospitals to Meals on Wheels.
- Our goal is to make the system better by understanding and responding to local needs and by getting services to work together more efficiently. That's how we'll all get better health care, while saving money and making the system sustainable for our children and grandchildren.

Transformational Messaging:

- LHINs are key partners in transforming the health system to provide quality care that meets the needs of Ontarians today and into the future.
- We are changing from an old system designed to treat people once they are sick to a more coordinated, value-driven model that promotes wellness.
- Populations are growing and aging. The rates of chronic conditions are rising. We are working with our health service partners to address these realities and develop innovative solutions to keep ESC LHIN residents healthy.
- Current fiscal realities have resulted in even more challenges. LHINs have already brought about significant and positive change to the local health care system. By working with our health service providers we will continue to work towards positive changes that will result in better care, better experience and better value for our residents
- LHINs have already brought about significant and positive change in the way health services are delivered, and we must continue that work. In fact, we must aggressively build upon that work, because the status quo is neither acceptable nor sustainable.
- Transformation requires a collective call to action and we have created many planning and community engagement tables/forums that bring together the agencies and people required to make positive change happen.
- Everyone has an important role to play in making healthy change happen, including health-service providers, the LHINs, community leaders and the public.

Project specific Key Messages:

- Are developed at the onset of the project and updated throughout the implementation phases.

4.6 Evaluation

To gauge the effectiveness of ESC LHIN's communication activities, the following evaluation methods will be used:

Wildly Important Goals (WIG)

Use Franklin Covey execution methodology (Wildly Important Goals) to set measurable targets through lead indicator metrics for communication outputs and impact.

Media Analytics (reported in board CEO Report)

Tracks shifts in activity resulting from LHIN communication efforts. An effort will be made to track and measure media tonality in ESC LHIN articles. Statistics are drawn from a variety of tools such as: Google clips, MOHLTC Media Clips, Cormex Report, and Vocus.

Social Media Tracking (reported in CEO Report)

Use online resources to track and report on social media output (e.g. volume of communications) and impact (e.g. retweets, click-thru rates, etc.)

Communication Metrics (reported in CEO Report)

We continue to refine the communication metrics used for reporting on public communication including communication outputs (e.g. news releases, interviews, media impressions, etc.)

Feedback

Both formal and informal feedback is used as a constant source of communication evaluation as it is imbedded in the daily work we do. Through both regular and planned channels we receive feedback and use it to inform our strategy and evaluate effectiveness. Examples of feedback include, but are not limited to: that received from the public through our complaints and concern process, open mic sessions at board meetings, meetings, surveys, and engagement sessions.

5 ESC LHIN Annual Community Engagement Plan

5.1 Introduction

All Local Health Integration Networks (LHINs) are required to publish a plan for community engagement that is updated on an annual basis. The plan is intended to provide the LHIN community with an overview of activities planned within the fiscal year.

Community Engagement in 2013/14 will primarily support the implementation of key improvement initiatives outlined in the Annual Business Plan specific to:

- Alternate Level of Care
- Emergency Department Care
- Mental Health and Addictions
- Chronic Disease Management

Consistent with past engagement practices within the ESC LHIN, key populations and stakeholder groups will be targeted to further develop relationships and meet our overall objectives and responsibilities as outlined in the Local Health System Integration Act, 2006 (LHISIA).

Key population and stakeholder groups include:

- Consumers of the health care system
- Francophone Community
- Aboriginal and First Nation communities
- Health Service Providers (ESC LHIN funded)
- Physicians
- Allied Health Care Professionals

Although this plan identifies specific, targeted communities, the ESC LHIN will continue to welcome community engagement opportunities; as yet unidentified, that present themselves over the course of 2013/14.

This document is not intended to provide a comprehensive detailed community engagement plan for activities that are project-related. The community engagement needs of individual projects will be identified in project-specific plans developed in-year and as required.

5.2 Community Engagement Activities

The following are initiatives where community engagement will be undertaken by the ESC LHIN in 2013-2014 supporting our strategic objectives:

Alternate Level of Care

- **Integrated Orthopaedic Capacity Plan:** Support the implementation of the Integrated Orthopaedic Capacity Plan by establishing a Steering Committee of stakeholders including:
 - orthopaedic surgeons
 - hospital administrators
 - community care representatives.

The committee will be a process for establishing a regionalized assessment and referral process for orthopaedic surgery, care paths to support better transitions of care, and implementing expanded Quality Based Procedures.

- **Home First:** Realign the Home First initiative by establishing a network structure that will implement and monitor ongoing change initiatives to improve alternate level of care rates region-wide. The network structure will provide for greater LHIN oversight and streamline/align ALC related working groups and networks to the Home First initiative.
- **ESC LHIN-wide Hospital Discharge Policy:** Engage and communicate to a broad range of stakeholders in implementing a standardized ESC LHIN-wide Hospital Discharge Policy. The emphasis on engagement will be in providing education and gaining support for the policy and practice changes required for successful uptake.
- **Rehab Strategic Plan:** Support implementation of the Rehab Strategic Plan, including engagement required to identify and gain consensus on best practice initiatives among rehab care providers.

Emergency Department Care

- **Pay-for-Performance Forum:** Hold the annual Pay-for-Performance Forum to share and advance promising practices on various improvement initiatives being piloted in ESC LHIN emergency departments for the improvement of wait times and patient care.
- **Physician Recruitment and Retention:** Support the development of a recruitment and retention strategy targeted to emergency department physicians, through partnership and engagement with hospital departments of medical affairs, local recruiters, municipal recruitment committees, and other strategies through the ESC LHIN Emergency Department Lead.
- **Physician Database:** Maintain and expand upon the ESC LHIN physician database to support engagement and communication with local physicians, and Health Human Resource planning.

Mental Health & Addictions

- **Mental Health Strategic Plan:** Once prioritized through a collaboration of health service providers, support the implementing recommendations of the Mental Health and Addictions Strategic Plan.
- **Behavioral Supports Ontario:** Continue to collaborate with the working groups established for implementing the Behavioral Supports Ontario plan. Additionally, provide clinical education on best practice care standards to LTC home employees.
- **Sarnia/Lambton Withdrawal Management Services:** Community and stakeholder engagement will be undertaken through the collaboration with Bluewater Health, the County of Lambton, Lambton County Public Health Unit, and Windsor Regional hospital. The primary goal of the engagement will be to educate stakeholders on opening of the new withdrawal management service and its impact on the community.

Chronic Disease Management

- **Health Links Implementation:** Collaborate and engage health service providers, Physicians, allied health care professionals, and others as identified to establish Health Links across ESC LHIN, by:
 - Supporting the alignment and standardization of Health Links startups to local and provincial goals
 - Spreading knowledge from learnings coming from the province-wide roll out
 - Provide project management and epidemiological support to Health Links leads
 - Support partnership development targeting non MOHLTC funded organizations, and other ministries.
 - Advancing the formal submission readiness assessments and business case to the MOHLTC
- **Care Pathway and Best Practice Spread:** Develop partnerships to support the provision of clinical education initiatives on best practices for COPD, diabetes, and CHF care. Also, look for opportunities to support other key ESC LHIN initiatives with clinical education to front-line providers.
- **Primary Care Council:** Continue to leverage the ESC LHIN Primary Care Council in implementing Chronic Disease Care Pathways; communicating, engaging, and educating physicians across the ESC LHIN; and, seeking advice in the planning for various ESC LHIN initiatives.