

Annual Business Plan 2014/2015



Ontario

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

Table of Contents

1	Context	1
1.1	Mandate and Strategic Directions of the (ESC LHIN)	1
1.2	Overview of the ESC LHIN's Current and Forthcoming Programs/Activities	2
1.3	Assessment of Issues Facing the ESC LHIN	12
2	Core Content - Integrated Health Services Priorities and Other Support Areas	16
2.1	Emergency Department	16
2.2	Alternate Level of Care	21
2.3	Chronic Disease Prevention and Management	25
2.4	Mental Health and Addictions	31
2.5	Rehabilitative Care System	39
2.6	Hospice Palliative Care	45
3	ESC LHIN Operations and Staffing Templates	51
3.1	ESC LHIN Operations Spending Plan	51
3.2	ESC LHIN Staffing Plan	52
4	ESC LHIN Annual Business Plan Integrated Communications Strategy	53
4.1	Objectives	53
4.2	Context	54
4.2.1	Provincial Strategies/Initiatives/Programs	55
4.2.2	Planning & Integration Activities	56
4.3	Target Audiences	56
4.4	Strategic Approach	57
4.5	Key Messages	58
4.6	Evaluation	59
5	ESC LHIN Annual Community Engagement Plan	60
5.1	Introduction	60
5.2	Community Engagement Activities	61

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.”

The 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, a system of high quality, that is 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 that are 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 Prevention and Management (CDPM)

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 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 seven years of activity, the ESC LHIN's perceptions and activities were shaped through the initial strategic directions of the IHSP 1, 2 & 3 that included initiatives related to:

- Chronic disease prevention and 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 (ALC)
- Improved outcomes in emergency department (ED) care
- Improved outcomes in diabetes management
- Improved outcomes in mental health and addictions
- Improved outcomes in rehabilitation care and interventions

These directions became the foundation for our implementation 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 structures that would guide the receipt of focused feedback and advance action-orientated initiatives.

As part of the activity framework used for the first seven 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 (WRH) and Hôtel-Dieu Grace Healthcare (HDGH), the acute and sub-acute realignment of services between the organizations, as well as a Stage 1A Program and Services Plan
- Improving efficiency (back office)
- Building system capacity and capability (within CDPM and mental health and addictions)
- Promoting and improving health maintenance (with CDPM)
- 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 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. The dimensions are supported as follows:

➤ Improved Access

- Investments in transportation to decrease the incidence of social isolation for seniors, and to help them connect to health care services
- Investments in the creation of additional convalescent care beds to help sustain acute care services
- Investments in the creation of additional units for assisted living for seniors
- Investments in the creation of assess and restore beds at HDGH and Leamington District Memorial Hospital (LDMH), to improve outcomes for ALC patients in acute care beds
- Creation of 58 interim long-term care (LTC) beds in Windsor/Essex
- Development of formal patient care paths for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), stroke and diabetes

➤ Improved Quality

- Investments in standardized utilization tools and care processes
- Investments of a psychiatric assessment team in the ED at HDGH to enhance services for psychiatric patients presenting in ED
- Investments in geriatric emergency medicine (GEM) nurses in all hospital EDs
- Investments in end of life care (EOLC) teams and CDPM teams

➤ Cost Effectiveness

- Working with ESC Community Care Access Centre (CCAC) to ensure that the frail and elderly continue to receive the care they need in a cost-effective, sustainable manner
- Timely funding recoveries and subsequent transfer of funds to organizations facing strategic needs and pressures
- Investments in Ontario Telemedicine Network (OTN) equipment and telemedicine nurses in all hospitals
- Investments in Telehomecare remote access units to better serve patients in their own homes

➤ Co-ordination/Integration

- Enhanced integration initiatives in the Windsor/Essex hospitals
- Backroom integration opportunities with ESC CCAC
- Investment in the implementation of a coordinated dialysis transportation system in Windsor/Essex
- Coordinated and improved transportation across Lambton County

With regard to IHSP progress, success was realized in a number of key areas between 2009 and 2013 as illustrated below:

➤ Emergency Department Wait Times Improvement Activities:

The 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 beds. This is a key LHIN priority. A key enabler for improved wait times is the Pay-for-Results (P4R) Program. The P4R program is monitored (in collaboration with the ESC LHIN lead and the ED/ALC manager) on a monthly basis, with the goal to reduce ED wait times, monitor performance and financial accountability through quality process improvement planning, evidence-based practice, and redesigned strategies. Since the program inception ED wait times have progressively decreased while the acuity and volume of patients accessing care has steadily increased.

The ESC LHIN aims to leverage P4R funding to establish and implement focused (based on data) high impact patient flow improvement action plans, which are integrated into each organizations corporate planning. Action plans are coordinated with other key LHIN patient flow strategies (e.g. Home First, Discharge Framework, and various Outreach Programs). In addition, the P4R program leverages the successes earned by other similar high performing P4R sites.

In 2012, the 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 ESC LHIN Primary Care Physician Lead created a Primary Care Council (PCC) to advise the ESC LHIN on improving integration and quality improvement within Erie St. Clair's primary health care system. The PCC's first initiative is focused on reducing avoidable ED visits and avoidable hospitalizations for COPD patients in Chatham-Kent.

➤ Alternate Level of Care:

There are a significant number of ALC patients in the hospitals within the Erie St. Clair region. The demographics of our aging population continue to exert pressures on our local health care system. For example, the Windsor/Essex population cohort aged 75+ is projected to increase 15% in the next 5 years, from 28,330 (2012) to 32,620 (2017), and 33% to 37,750 by 2022. Aging will generate a commensurate increase in incidence of chronic conditions. Overall, the Erie St. Clair region projections are greater than the provincial average growth in arthritis, hypertension, diabetes, vascular and respiratory disorders, as well as Alzheimer's disease and related dementias. These are common conditions amongst the 1% of the population who are high users of the health care system. As a result of this context, ESC LHIN continues to experience significant ALC pressures, with 20.6% of acute care inpatient beds occupied by ALC patients at the end of March 2014 (ALC Summary Report- April 2014), the third highest in Ontario. The corresponding post-acute rate for the same period was 26.9%, the second highest in the province.

The ESC LHIN, in partnership with the ESC CCAC, will be developing a regional ALC Performance Management Working Group commencing February 2014 as part of our ESC LHIN Patient Flow/ALC Action Plan . The working group will promote and support strategies across ESC LHIN to ensure persons are living in the most appropriate setting, optimize system capacity, and avoid and reduce duplication of integrating sectors. A patient flow strategy needs to be viewed as a system issue where all components of the strategy need to be implemented and aligned.

➤ Chronic Disease Prevention and 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, CHF, and complex conditions. Work has begun in the Chatham-Kent, Sarnia/Lambton and Windsor/Essex to advance a COPD Integrated Care Path/Model. The main objectives of this work is 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 PCC, ensuring better access to ongoing primary care and the maintenance of chronic illnesses.

Building on the COPD approach, ESC LHIN staff have expanded their CDPM work to include CHF, stroke and diabetes. Looking to the future, the longer term priority is focused on prevention and directing efforts to those populations most at risk of developing a chronic disease due to their current risk behaviors.

Finally, through ESC LHIN community planning work and community engagement it has become apparent that success in managing people with a chronic illness closer to home, outside of the ED and in-hospital, is contingent on improving community capacity in the future. Toward this end the ESC LHIN is engaging the wider health care community in order to advance specific community capacity business cases focusing on five priority areas:

- A community clinic model of care for individuals with a chronic illness
- Advancing mobile teams to care for non-ambulatory clients recently released from hospital and residing in the community
- Developing a community restorative (bedded) model of care as an alternative to a hospital admission
- Advancing a hospital discharge standardized tool kit for CHF and COPD patients
- Developing CDPM preventative strategies and expanding self-management models of care ESC LHIN-wide

Currently a number of community and hospital CDPM working groups are advancing the business cases for the above priority areas. Once all business cases are completed, the ESC LHIN review process will take approximately two to three months following which, specific improvement programs will be implemented.

➤ Mental Health and Addictions (MH&A):

In September 2013, the ESC LHIN Board approved funding to support five mental health promising practices. The promising practices aim is to increase access, coordination, and linkages with primary care, while decreasing ED repeat visits, community-based service wait times and unnecessary admissions. The promising practices are designed to meet each community's unique demographic needs while maximizing existing resources and clinical strength, for instance:

The Rapid Assessment, Intervention & Treatment (RAIT) Team - is an urban/rural model designed for Chatham-Kent and Sarnia/Lambton. The model leverages existing and enhanced integrated resources based at Chatham-Kent Health Alliance (CKHA) and Canadian Mental Health Association (CMHA) Lambton-Kent. The RAIT Team is a direct arm of primary care with referrals accepted for the moderate and the seriously mentally ill. No formal psychiatric diagnosis is required. The RAIT Team provides access to mobile mental health and addiction resources that travel to the client's home. The team is comprised of registered nurses (RNs), social workers (SWs), therapist, psychiatrist, and embeds personal support workers (PSWs) as core staff responsible for assisting the client to achieve self-management goals with motivational coaching. To date, over 125 clients in Chatham-Kent and Sarnia/Lambton have been served. The RAIT Team initially focused on supporting primary care physicians not practicing in team-based models (e.g. Community Health Centre (CHCs)/Family Health Team (FHTs)). By targeting solo practice, aging rural physicians, the RAIT Team enhances physician retention for rural areas, that were identified by the MOHLTC, as underserved. The RAIT model, while still in the early stages of implementation, is building new bridges with primary care physicians who previously did not have access to services for patients with moderate mental health issues such as depression or anxiety.

The Fast Access to Community Experts (FACE) – is a partnership between ESC LHIN, ConnexOntario and OTN. This ESC LHIN-wide, initiative focuses on facilitating access for mental health and addiction screenings quickly and efficiently in three streams: face-to-face, OTN, and through electronic scheduling for ED staff such as Psychiatric Assessment Nurses. The FACE initiative utilizes existing mental health and addiction providers and telemedicine nurses. In June of 2014, a soft launch was monitored and analyzed over a three month time period.

Psychiatry Lead - Similar to the primary care and ED/ALC Lead, this role will champion evidence based best practices. The Psychiatry Lead will work in partnership with the Primary Care Lead to develop shared care treatment practices. The Psychiatry Lead, in partnership with the WRH Schedule One Chief of Psychiatry, initiated an access number for primary care physicians in need of a single psychiatric consult. This service provides rapid consultation assessment and feedback to a primary care physician within 72 hours. The psychiatric consult includes critical and timely treatment and medication advice for primary care practitioners who are maintaining the patient as the most responsible physician.

Suicide Coordination and Prevention - This time limited ESC LHIN-wide initiative will leverage existing community capacity building synergies as well as champion the adoption of risk screening and assessment tools across sectors – community, primary care, and hospital. In 2015, this initiative will provide a report to the ESC LHIN which will include recommendations for sustaining community momentum. While suicidal ideation is acknowledged as a common symptom of mental illness, substance abuse, and dependency, greater system level coordination and proactive clinical interventions are anticipated as a direct result of this initiative.

In addition to the mental health promising practices, the ESC LHIN provided the following investments for the addiction sector:

Community & Residential Withdrawal Management Services - In the first quarter of 2014/2015 fiscal year, Bluewater Health (BWH) Withdrawal Management Services provided 126 screens for suitability/eligibility of individuals for the program. Of the 126 screens completed, 90 people have begun work with the team in Community Withdrawal Management.

The BWH Withdrawal Management Services provides telephone and face-to-face supports seven days per week for all of Lambton County, including three First Nation/Aboriginal communities. Bluewater Health is now focusing on engaging community and key stakeholders in the search for an appropriate location for the bedded arm of the service.

Second Stage Relapse Prevention Program for High Risk Clients – The Westover pilot program provides intensive one-week residential supports for clients who self-identify as being high risk for relapse. This abstinence-based program is showing great promise in the identification of key clinical and social factors that require greater attention at the point of assessment. In addition, this initiative will undergo a peer evaluation at both Brentwood and the House of Sophrosyne with support from ESC LHIN Performance Team. Depending upon the results, this program could be replicated throughout the Erie St. Clair region or become a core service within Westover Residential Treatment Facility serving clients who have previously accessed Brentwood and the House of Sophrosyne.

Transitional Housing for Pregnant Addicted Women at Risk of Homelessness – In 2013, the ESC LHIN worked with the MOHLTC, the House of Sophrosyne, and the CMHA Windsor Essex County Branch (CMHA WECB) to re-purpose an under-utilized group home. This community-based group home was legally transferred between the two providers and now acts as a transitional bridge for addicted pregnant women or women who have recently given birth and have graduated from the House of Sophrosyne's residential program. This community-based home has the bedded capacity for three individuals (includes children). In addition to the group home, the City of Windsor Department of Housing partnered with the ESC LHIN by providing five permanent, rent-supplement housing units for House of Sophrosyne clients. The five City of Windsor units are in addition to the existing eight rent-supplement housing units funded in 2012. In the fall of 2014, the entire housing continuum, 13 rent-supplement housing units and one group home, have reached capacity.

As a monitoring mechanism for the promising practices and 2013/14 mental health and addiction funding investments, the ESC LHIN Mental Health and Addiction Network was restructured. As a reporting arm, up to the Mental Health and Addiction Network a number of Leadership Tables were developed including:

- The Inter-Hospital and Community
- Mental Health and Addiction Performance Table
- The Child and Youth Leadership Table includes representation from the Ministry of Children and Youth Services (MCYS) funded providers and MCYS Regional Office
- Psychiatrist Quarterly Leadership Forum

In 2015, additional leadership tables are being developed including the Mental Health, Addictions, and Aboriginal Leadership Table, and the Family/Consumer, Peer Support Network. In May 2014, the ESC LHIN initiated an Addiction Strategic Planning process and is anticipated to be completed in 2015.

➤ Rehabilitative Care:

In September 2012, the ESC LHIN Board approved a three-year ESC LHIN Rehabilitation System Strategic Plan, along with recommendations to move the plan forward. A new Mission and Vision for an integrated and coordinated system of rehabilitative care services guides the work toward achieving nine strategic goals. The strategy prioritizes goals that will impact the experiences and clinical outcomes of the highest volume rehabilitation patient populations (patients with stroke, orthopaedic conditions and geriatrics).

The plan endeavors to strengthen the implementation of best practices across the continuum of care, facilitate appropriate utilization of inpatient rehabilitative care beds, and ensure access to funded community and outpatient rehabilitative care services. Additionally, a predictive modeling exercise will inform system capacity planning in order to accommodate anticipated increasing service needs for the next 5-10 years due to the aging population. These deliverables are expected to have positive effects on improving patient flow, reducing inpatient length of stay (LOS), increasing access to rehabilitative care at the right time, in the right place, and improving functional outcomes and quality of life for patients.

Finally, a ESC LHIN-wide Rehabilitation Strategic Plan Implementation Committee has been in place since January 2013. A comprehensive rehabilitation system scorecard has been developed, and is beginning to provide system evaluation to target improvement activities and celebrate successes.

➤ Hospice Palliative Care:

Erie St. Clair has a long history of excellence in Hospice Palliative Care (HPC) service delivery. Building on this excellence, new HPC program development and integration has taken place since the inception of ESC LHIN. The ESC LHIN has worked with and supported the ESC End of Life Care Network (EOLCN) and its members to prioritize and implement improvements. Some of these improvements are:

- Palliative Care Consultation Teams (PCCT)
- Education Collaborative (funding flow to ESC CCAC)
- Residential Hospices (Leamington and Chatham-Kent)
- Nurse Liaison role in Windsor/Essex; this nurse serves as a connector between hospice and hospitals
- CMHA WECB enhancement of bereavement services

All hospitals in Erie St. Clair have enhanced HPC services since 2006, using global funding. Bluewater Health in Sarnia has formalized its inpatient HPC beds within an integrated care unit and has recently added a consultation service to serve all units (including ICU, ED, etc.). CKHA has augmented its supportive care program to include nurse experts who consult across the continuum and has a Complex Continuing Care (CCC) HPC 6-bed 'pod'. LDMH has consultation expertise and is working closely with the community in developing shared services with the emerging hospice. Windsor hospitals have committed to providing enhanced HPC services as part of their current restructuring activities. The Windsor Regional Cancer Centre has also augmented its HPC services.

In the community sector, the ESC CCAC and community service providers have enhanced HPC services through PCCT funding and new MOHLTC Nurse Practitioner (NP) funding. The Hospice of Windsor and Essex County and its Palliative Medicine Program (PMP) have supported community palliative care for many years. The St. Joseph's Hospice of Sarnia Lambton houses the HPC clinic and provides support for that community. Long-term care homes (LTCHs) in Erie St. Clair have received significant HPC education.

A HPC Education Strategy has been undertaken with the ESC Hospice Palliative Care Education Subcommittee serving as a venue for coordinating HPC education across the Erie St. Clair region. All groups that provide HPC education have committed to working together thereby reducing duplication and filling gaps. These groups include: The Palliative Pain and Symptom Management Consultation Program, the hospices, the Regional Cancer Program, other specific sectors which may be providing HPC education to their own staff as well as the Education Collaborative. All sectors have received some HPC education. A recent example of a cross sector initiative is education on Advance Care Planning and Health Care Consent which received attendance from all health care sectors as well as developmental services etc.

In terms of HPC planning, two complete regional strategic plans have been completed (2005 and 2009), with annual updates, reviews and formal evaluations. Additionally, significant sector specific HPC planning, implementation and review has taken place (e.g. Regional Cancer Program, hospices, and hospitals etc.). This sector-specific work is part of the recommended system design framework process and aligns with the regional recommendations.

Erie St. Clair Leadership has been very active in the development of the provincial level document *Advancing High Quality, High Value Palliative Care in Ontario, A Declaration of Partnership and Commitment to Action, December 2011* which has been adopted as a roadmap for enhanced HPC service delivery in Erie St. Clair and across Ontario.

As it relates to system development of hospice/palliative care in Erie St. Clair, targets have been set and met. All of the recommendations of the 2009 five-year strategic plan have been addressed and ongoing priorities and action plans are included in this ABP and in the work plans of the ESC Hospice Palliative Care Program/Network. In keeping with the action commitments articulated in *Declaration Document*, Erie St Clair is now developing a more formal regional program. This includes a "refresh" to the Strategic Plan.

➤ French Language Services:

In 2013-14, the French Language Services (FLS) focused on the development and distribution of the *French Language Services Toolkit*. This new resource is designed to support health service providers in meeting the needs of their Francophone patients/clients through the delivery of quality culturally sensitive care.

During the next twelve months, the focus will be placed on working with identified providers in achieving designation under the FLS Act. In addition, the FLS will continue to explore opportunities to develop Francophone services for those living with mental health or addiction issues, chronic diseases, and seniors in need of supportive housing and assisted living services, adult day program, falls prevention and primary care.

➤ Aboriginal Health Care:

Concentrated support affecting Aboriginal health matters within the Erie St. Clair region has been undertaken on multiple levels over the past twelve months. Largely, attention has been dedicated to improving Aboriginal patients' access to care, and building relationships with Aboriginal communities. The most notable accomplishments over the past twelve months include:

Improved access to care:

- Nurse Practitioner at the Cam Am Indian Friendship Centre
- Cultural sensitivity training for ESC LHIN staff and Board of Directors
- Aboriginal Palliative Care consultation meeting
- Traditional Healing support for a palliative patient

Building relationships:

- Aboriginal Mental Health and Addictions Sector Engagement Forum
- Participation in the Provincial Aboriginal Leads Network
- Re-engagement with the Erie St. Clair Aboriginal Health Planning Committee
- Hiring of the Aboriginal Lead
- Hosting a Windsor/Essex Indigenous Engagement meeting

For the next twelve months efforts will be dedicated towards developing an Erie St. Clair Aboriginal health strategy including Provincial Aboriginal Leads Network priorities: mental health and addictions, Indigenous Cultural Competency training, hospice palliative care, and CDPM (diabetes). Building off the successes of the past twelve months, efforts will continue to be made to improve service integration, accountability and communications between Aboriginal health agencies, the ESC LHIN and mainstream HSPs across the Erie St. Clair region.

➤ 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:

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

These activities will directly address the main goals of “Ontario’s Action Plan for Health Care”:

- 1) Keeping Ontario Healthy
- 2) Faster Access to Stronger Family Health Care
- 3) Right Care, Right Time, Right Place

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 (and two additional areas) that the ESC LHIN will focus on are:

- 1) Improved outcomes in alternate level of care (ALC)
- 2) Improved outcomes in the emergency department (ED)
- 3) Improved outcomes in chronic disease prevention and management (CDPM)
- 4) Improved outcomes in mental health and addictions
- 5) Improved outcomes in rehabilitative care
- 6) Improved outcomes in hospice/palliative care (HPC)

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 643,495 people, or 4.8% of the population of Ontario. During the years 2006–2012, the population of Erie St. Clair decreased by 1.6%, while Ontario’s population grew by 6.6%.

Erie St. Clair has a growing seniors’ population and in 2012 it represents 16.5% of the population, while the province has 14.6% aged 65+. The Erie St. Clair population is aging faster than the province as a whole, while our younger population, those between 0 and 44 years, is decreasing. These differences in age distribution are most pronounced in the Chatham-Kent and Sarnia/Lambton communities.

Of the total Erie St. Clair population, 16.9% live in Chatham-Kent, 62.8% in Essex County and the remaining 20.4% in Lambton County. Compared to the province as a whole, the Erie St. Clair region 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, from 2006 to 2012, the population has declined by 3.5% in Chatham-Kent, 1.2% in Lambton County, and 1.2% in Essex County. Between 2012 and 2016, the population is expected to experience slow growth and increase by only 3,582 residents (0.6%); by 2021, it is forecasted to increase by 1.5%. 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 2.5% of the population, slightly higher than for the province as a whole (2.4%). The largest numbers of Aboriginal people — 50% — live within Windsor/Essex; 29% live in Sarnia/Lambton; and 21% 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. Slightly more than half of the population (59.3% vs Ontario at 67%) has completed post-secondary education. Levels of education are highest in Windsor/Essex and lowest in Chatham-Kent.

In 2012, the unemployment rate in Erie St. Clair was 8.8%, which is higher than the 7.8% unemployment rate for the rest of Ontario. Unemployment was highest in Essex (9.3%) and lowest in Sarnia/Lambton (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 MOHLTC'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 83 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 ESC 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.

With regard to voluntary integration efforts, a noteworthy integration/realignment of services occurred on March 26, 2013 between Windsor Regional Hospital and Hôtel-Dieu Grace Healthcare. This decision was based on months of community engagement which identified that there was a strong interest from the Windsor/Essex community for the development of a state of the art, single site acute care hospital to become the centre of an integrated health care system.

As a result of the voluntary integration, a mechanism was put into place for the transfer of programs, services and funding, between the two corporate entities, based on the revised mission and responsibilities of the hospitals

In order to finalize the realignment of services between hospitals, the ESC LHIN Board will approve the final revised funding allocation and related service volumes in order to remain in compliance with the Ministry-LHIN Performance Agreement (MLPA), and in order to trigger the adjustments of cash flow required by the hospitals to continue operations without incidence.

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

2.1 Emergency Department

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY: Emergency Department	
Integrated Health Services Priority:	
Emergency Department (ED)	
IHSP Priority Description:	
In the Erie St. Clair region, ED services are available across all five main hospitals and at two rural hospital sites. The Erie St. Clair ED volume remained quite consistent from 2013/14 Q4 and 7,438 to 7,454 in Q1 of 2014/15. The Erie St. Clair is the second best performer in the province of 31.6 hours for high acuity admitted LOS at 23.2 hours. Erie St. Clair remains the most underserved LHIN for ED physicians currently and projected over the next year. The ESC LHIN has the highest number of advanced care practitioners (NPs/physician assistants (PAs)) that help extend the work of the ED physician. Improvements have been seen with inpatient flow thus providing improved throughput within the ED. The largest potential for improved gains will be by concentrating our P4R resources within the hospital, led by the team that is most accountable for the "time to inpatient bed and ED admitted LOS metrics". Work will continue with Health Force Ontario (HFO) and local sites to improve recruitment and retention across the ESC LHIN and it continues to be a top priority. Currently in the Erie St. Clair region there is a need for 11 full-time ED physicians, realizing a net gain of three physicians in 2013/2014. However, 48% of the current practicing ED physicians are in the 45 to 69 year old range. With regard to the age demographic, analysis of the 2011 Ontario Physician Human Resources Data Centre data indicates that ED physician numbers go down after age 45, and decrease significantly after age 60 (it is unknown if this is due to retirement, or fewer physicians in total in these age groups). Therefore while the ESC LHIN has had success in recruiting ED physicians and the general need is lower than in previous years, this area has almost half of the currently practicing ED physicians in the age range that begin to reduce their hours and/or retire from the ED. Succession planning and a strong, on-going recruitment initiative will be integral to Health Human Resources plan for the EDs across the Erie St. Clair region.	
Challenges and Opportunities Include: (Date reflective of fiscal year (FY) 2013/14) • Opportunities are seen to improve ED LOS for admitted patients, time to inpatient bed and patient flow in all sites. ESC LHIN continues to experience (ALC) pressures. The ESC LHIN Q4 2013/14 percentage of ALC days was 16.4%, which represents a decline of 20% over Q3 values, and approaches current ESC LHIN target of 15.3%. Post-acute care has been consistently declining since January 2014 • Opportunities to improve readmissions for chronic diseases (i.e. CHF, COPD, diabetes and stroke). The volume of non-admitted high acuity has increased by almost 9%. The ESC LHIN non-admitted high acuity visits increased by about 9% from 36,407 to 39,861 • Challenge of providing care to populations that require special needs and supports (i.e. behavioral requirements, dialysis requirement and infection control/isolation requirements) • Provision of timely follow-up with primary care for patients who revisit and are discharged from acute care	

**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 23.2 hours in the ED
- Nine out of 10 people with complex conditions requiring more time for diagnosis, treatment not requiring an admission to a hospital bed spent up to 6.9 hours
- Nine out of 10 people with minor or uncomplicated conditions requiring less time for diagnosis, treatment, and observation spent up to 3.8 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, Canadian Triage and Acuity Scale (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. For fiscal year (FY) 2013/14, the rate of ED visits that could be managed elsewhere per 1000 population is 29. In Sarnia/Lambton the rate is 77/1000 population, Chatham-Kent is 55/1000 population and for Windsor/Essex the rate is 7/1000 population.

ED Planning Objectives Considered

- Emphasis to establish and implement focused (based on data) high impact patient flow improvement action plans that are integrated into organizations corporate planning
- P4R Action Plans are coordinated with other key ESC LHIN patient flow strategies (e.g. Home First, Discharge Process Planning, Complex Discharge Reviews, Special Needs and Supports)
- Reduction in avoidable re-hospitalization for key diagnosis with Quality Based Procedures (QBPs) and utilization of predictive tools such as LACE index to predict risk of death and unplanned readmissions of cognitively intact medical or surgical patients after discharge
- Improved transitions, care coordination and intensive case management at the interfaces between care settings
- Enhancing coaching, education, and support for patient self-management
- Streamlined mental health and addiction services between community providers and the hospital
- Continued utilization of HCC for unattached patients to existing primary care providers
- Improved primary care access aligned with ESC LHIN Primary Care Strategy
- Enhanced adequate after-hours/weekend/holiday coverage by primary care practitioners
- Improved regional access to primary care assessments in LTCHs for episodic care, and follow-up and ongoing care
- Increased effectiveness of Nurse Lead Outreach Teams (NLOT) to LTCHs, targeting high ED users across the Erie St. Clair region
- Increased use of transitional care programming aligned with the Rehabilitative Care Alliance (RCA), and ESC CCAC programs for high and very high MAPLe scores
- 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 high users through Health Links • Continue to develop recruitment and retention initiatives for the ED • Continue with the Home First philosophy and Complex Discharge Review planning and readjust per revised plan • Improve leadership and interfaces between care settings: - Pre Hospital - Hospital - NLOT - Outreach Programs - CDPM Plan - ESC CCAC - GEM Nurses - Primary Care - Transitional Care Programming - Community Support Services (CSS) - End of Life and Palliative Care • Utilize ALC Performance Monitoring Team to improve patient flow strategies and accountabilities • Increase the number of Aboriginal and Francophone people with a primary care provider • Continue to initiate education collaborative in HPC, with an emphasis on best practice uptake in all care settings The action plans will focus on the following priority populations within the ED: • High users of the ED • High-risk seniors aged 65+ • Frail Elderly people • Behavioural and acquired brain injury (ABI) special needs requirements • 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 Ministry and the ESC LHIN have been concentrating on applying a wide range of key strategies, aims and measures, implementing a multi-pronged Erie St. Clair ALC Strategy built upon various key recommendations such as Dr. Samir Sinha's Senior Strategy Report (2013), Health Links aligning with the Ministry, the ESC LHIN vision of Better Care, Better Experience, Better Value. ALC and wait times need to be addressed differently, LTC demand, and leveraging community resources. We will continue to enhance the support of the NLOT in the nursing homes to reduce ED transfers and strategies for the offload nursing in the ED to help emergency medical services (EMS) get back into the community. Part of our role is to promote best practices and the ESC LHIN has held a ED/P4R symposium for the past three years to help support this.

TEMPLATE A: PART 2: GOALS and ACTION PLANS Emergency Department (cont'd)			
Action Plans / Interventions:	% Completion by Year		
	2014-15	2015-16	2016-
Expand the ED hours of NP/PA coverage for treat and release patients	70%	100%	-
Develop a referral process and primary care path for COPD/CHF initiated by the ED and ESC CCAC	90%	100%	-
Continue and expand P4R and Process Improvement Program (PIP) strategies to reduce wait times in the ED	90%	100%	-
Develop mechanisms so that unattached patients (CHF/COPD) are auto- referred to NP or primary care provider for follow up and self - management	70%	100%	-
Explore research opportunities related to a predictive model approach within Erie St. Clair to support patient flow and efficiencies for admitted patients	100%	-	-
Support health promotion best practices related to influenza prevention practices in acute care and LTC sectors diseases	100%	-	-
Develop strategies to support improved admission and discharge policies and processes to enhance smooth transitions of care	75%	100%	-
Develop strategies to support mental health and addiction health service provision	100%	-	-
Develop improved communications, customer service and patient satisfaction strategies for patients waiting in the ED	100%	-	-
Explore opportunities to support ED diversion strategies with HSPs (EMS, primary care, ESC CCAC) with LTCHs in the Erie St. Clair region	100%	-	-
Review ED Physician recruitment and retention strategies and coverage for Erie St. Clair region	100%	-	-
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 palliative care visits to the ED to reach the 10th percentile of provincial performance • Increase the percentage of Aboriginal and Francophone 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 ESC 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 and high needs populations (behavioural, acquired brain injury (ABI))
- 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 Erie St.Clair PCC 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, ED Diversion Strategies and health service delivery models for those individuals with ALC, COPD, CHF, stroke, diabetes, mental health ED revisits, and substance abuse
- Develop standardized discharge policies and processes in collaboration with acute/post acute care, ESC CCAC and community services (assisted living/supportive housing) to support transitions of care for an improved patient care experience

What are some of the key enablers that help us to achieve our goal?

- Standardized approach to health promotion, CDPM, prevention and self-management strategies that support best practices and knowledge translation through the Erie St. Clair region
- Emphasis to improve patient flow across the continuum of care to create bed flexibility and bed turnaround.
- Continue building Behavioural Supports Ontario (BSO) capacity within Erie St. Clair for ED, acute and LTCHs
- Develop a regional approach for ED aversion and episodic care for LTCHs.
- 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 (ALC)	
IHSP Priority Description:	
Too often, people remain in hospital when an ALC is available and would serve them better, for instance, at home or in LTC, 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 indicator is a new performance indicator to inform variance of percentage ALC from an operational perspective and represents an accurate account of total ALC days and total patient days for both open and closed cases in a given month therefore providing an accurate picture of ALC performance that can be trended over time. In March 2014, ESC LHIN had the second highest (23.1%) ALC rate in the province. The ESC LHIN ALC Performance Working Group goals are to develop and monitor initiatives that will assist in reducing the ALC days across the Erie St. Clair region. As of April 30, 2014, there were 288 ALC patients on the waitlist in acute and post-acute care settings. This translates to 86 (23%) fewer patients on the waitlist compared to April 30, 2013. Specifically, there were 26% fewer patients waiting in acute care beds, 14% fewer patients waiting in CCC beds, 67% fewer patients waiting in mental health beds, and 40% fewer patients waiting in rehab beds (Apr 2014 vs. Apr 2013). At the end of April 2014, 52% of ALC patients were waiting in acute care and 48% were in post-acute care. Of the 150 ALC patients in acute care beds as of April 30, 2014, 62 (41%) cases had been waiting 30 days or longer. There were 9 (6%) cases that had been waiting at least a year. Patients waiting ≥ 30 days account for 97% (35,262 of 36,496) of total acute and post-acute ALC days. By inpatient service, ALC patients were occupying approximately 20.6% of acute care beds, 47.8% of CCC beds, 5% of mental health beds, and 7.1% of rehab beds in March 2014. Reductions were seen in acute care beds (3.2%), CCC beds (8.7%), mental health beds (2.6%), and rehab beds (8.1%) for March 2014 vs. March 2013 (ESC LHIN ALC rate).	
Current Status:	
<u>ALC 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, case management, coordinated access and follow-up for selected diagnosis • Increased community and provider knowledge of hospital access implications and impact of ALC patients on emergent care processes • Enhance restorative programming to support transitional care and improved function • Reduce hospital utilization incidence rate for identified high-risk users • Reduce hospital and inappropriate ESC 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 NLOT to support LTCHs and appropriate ED aversion opportunities • Alignment with the integrated vascular model and CDPM • 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 LTCH placement for hospital inpatients and community	

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY: Alternate Level of Care (cont'd)	
Current Status:	
• Improve time to convalescent care programming for 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 LTCH • Reduction in acute LOS for chronic disease populations, and subsequent transfer of a greater proportion of care to community services or restorative care services	
Goal(s):	
<u>ALC Overall Goals:</u> • Continue to support and enhance Home First philosophy and Restorative Potential • Continue to support coordinated approach to discharge process and complex discharge reviews to identify barriers • Integrate Assess and Restore philosophy with primary focus of care within rehabilitative level of care • Facilitate appropriate use of post-acute care options (rehab, mental health, CCC, convalescent care, supportive housing, assisted living) • Continue to implement the Rehabilitation System Strategic Plan for the Erie St. Clair region • Identify and implement best practices for top three rehabilitation clinical conditions • 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 and Physiotherapy Reform • Support the implementation of residential hospice services in Chatham-Kent and Leamington • Enhance the primary care role in managing end-of-life patients • Transform 2% of all LTC beds into convalescent care beds (currently at 1%) • Initiate early warning risk assessment tool (the LACE index — LOS, acuity, comorbidity, and ED visits) 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 appropriate rehabilitation services inpatient and community • High-risk frail seniors aged 65+ • Frail Elderly/Geriatric Care Path, Stroke Care Path, Fractured Hip Care Path • 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 • Chronic Ventilation Strategy • Frequently readmitted CDPM and behavioral patients • Infection control situations • Special needs and supports	

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:	% Completion by Year		
	2014-15	2015-16	2016-17
Develop and increase capacity for restorative care/transitional care programs (e.g. convalescent care programming ESC LHIN-wide)	80%	100%	-
Develop key messages/market plan to highlight services offered by each LTCH (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	100%		
Develop a comprehensive Falls Prevention Program ESC LHIN-wide	100%	-	-
Develop an ALC Performance Management Working Group to monitor key priorities for improved patient flow, ED wait times, efficiencies, and accountabilities	50%	100%	-
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	70%	100%	-
Support a robust discharging planning process with Home First as the primary goal	100%	-	-
Support BSO Collaborative and Resident First Strategy to support mental health patients and individuals with behaviours and transitions of care	100%	-	-
Expand NP outreach program, behavioral supports, psycho-geriatric fostering – to cover nursing homes (with goal of preventing ED visits and enhanced community services)	100%	-	-

TEMPLATE A: PART 2: GOALS and ACTION PLANS Alternate Level of Care (cont'd)
Expected Impacts of Key Action Items
• Reduce acute percentage ALC to 15.3% ESC LHIN-wide and total ALC days • Additional capacity in Windsor/Essex seen with addition of 256 LTCH beds Fall 2014 • 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
What are the Risks/Barriers to Successful Implementation?
• Need to ensure seamless transitions and a consistent approach for discharge planning 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 and chronic disease • Behavioural/ABI • 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, timely access to RIA assessments completed within the acute care sector to improve transitions of care and restorative potential opportunities • LTCH education, supports, and resources for high intensity needs for BSO, EOLC, best practices, (ACP) to appropriately support ED aversion to include long and short stay client experience What are some of the key enablers that help us to achieve our goal? • Improve primary care access and follow up to seniors • Implementation of QBPs for specific conditions • 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, chronic vent strategy and rehabilitation) • Explore and develop primary care access opportunities in prevention and self-management for CDPM, mental health and addictions and seniors • Transitional Care programming and intensive case management • Expansion of NLOT program ESC LHIN-wide

2.3 Chronic Disease Prevention and Management

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY PRIORITY: Chronic Disease Prevention and Management
Integrated Health Services Priority:
Chronic Disease Prevention and Management (CDPM)
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, COPD, and heart disease. Of these conditions, the largest proportions of ED visits are associated with arthritis, heart disease, and COPD. Some of the issues related to CDPM are: • Lack of information technology (e.g. electronic medical record (EMR)) needed to monitor and track patient care to ensure consistency with best practices and improved health outcomes • Need for a greater focus on prevention including patient education and self-management programming • Need for better lifestyle choices including awareness of risk factors and healthier choices • Need for timely access to primary care and ongoing community support <u>CDPM Planning Objectives Considered</u> • Simplified access to care (single point of access/centralized intake) • Standard assessment and discharge processes • Improved patient flow across the care continuum • More shared – collaborative care • Better uptake on best practice • Clear agreed-upon roles and accountabilities for all health service providers • Expand community capacity (alternatives to the ED/hospital) • Greater focus on performance and reporting (including performance target setting and advancement of standardized measures of success)

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES
PRIORITY: Chronic Disease Prevention and Management (cont'd)

Current Status:

The ongoing prevalence of unhealthy (risky) lifestyle behaviors 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
- The need to reduce variation in care provision across the provider system
- A need for improved case management of long-term conditions
- A 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
- Higher smoking rates
- A need for more timely access to primary care
- A need for a better rural transportation network
- Generally, a need to enhance community capacity and capabilities thus ensuring risk mitigation and patient safety within community care programs vs. a hospitalization

**TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Chronic Disease Prevention and Management (cont'd)**

Goal(s):

CDPM Overall Goals:

- Improve the short-term integration of service delivery in the CDPM sector through better defined care roles and accountabilities
- Advance ESC LHIN-wide standardized Care Paths (based on best practices) beginning in Windsor/Essex (CHF, stroke and diabetes) and eventually ESC LHIN wide
- Initiate COPD Care Path development ESC LHIN-wide (beginning in Sarnia/Lambton)
- Develop an ED/hospital standardized discharge tool kit for COPD and CHF (starting in Windsor/Essex)
- Implement a centralized intake (single-point of access for high-end users of the health care system) process for CDPM in ESC LHIN-wide (beginning in Windsor/Essex)
- Advance CDPM community capacity enhancement business cases for priority areas identified through the community engagement process (e.g. clinic model, mobile teams, restorative bedded resource)
- Advance/link with more culturally based models of care
- In the longer term formalize the approach to chronic disease prevention focusing on populations most at risk due to their current behaviors and lifestyle choices (e.g. continuing to smoke)

The action plans will focus on the following priority populations (consistent with the 1% high-end users of the health care system) for people in need of CDPM care:

- Individuals with COPD
- Individuals with CHF
- Individuals who have suffered a stroke
- Individuals with complications/high needs due to diabetes
- Aboriginal people with a chronic disease and co-morbidities
- New comers (immigrants) to the area with a chronic disease and co-morbidities
- Francophone seniors with a chronic disease and co-morbidities

TEMPLATE A: PART 2: GOALS and ACTION PLANS Chronic Disease Prevention and Management (cont'd)			
Consistency with Government Priorities:			
The above goals are consistent with MOHLTC directions for CDPM			
Action Plans / Interventions:	% Completion by Year		
	2014-15	2015-16	2016-17
Establish a COPD Integrated Care Path/Model starting in Sarnia/Lambton and expanding ESC LHIN-wide by 2015	70%	100%	-
Establish care paths for CHF, stroke and diabetes starting in Windsor/Essex and expanding ESC LHIN-wide by 2017	30%	60%	100%
To improve overall system accountability and reporting implement an Electronic Assessment Tool for COPD in Chatham-Kent and expanding ESC LHIN-wide by 2015	40%	80%	100%
Advance protocols and clear accountabilities to manage COPD care transition points on the care path (e.g. discharge, EOLC, flow from ESC CCAC to the rapid response teams)	80%	100%	-
Advance a crisis management – after hours strategy hours model of care and reflect this element on all CDPM care paths	80%	100%	-
Improve linkages with primary care through the care paths	30%	50%	100%
Advance performance measures and targets for all priority areas by 2015 (COPD, diabetes and CHF)	40%	70%	100%
Develop an overall prevention strategy and care path for the chronic disease population in Erie St Clair (starting in Windsor/Essex by 2015)	80%	100%	-
Develop a smoking cessation care path for Chatham-Kent and Windsor/Essex by 2015 expanding ESC LHIN-wide by 2016	30%	60%	100%
Develop an ED/hospital standardized discharge tool kit for COPD and CHF (for Windsor/Essex by 2015)	80%	100%	-
Implement a centralized intake (single-point of access for high end users of the health care system) process for CDPM ESC LHIN-wide (beginning in Windsor/Essex)	30%	60%	100%
Advance CDPM community capacity enhancement business cases for priority areas identified through the community engagement process (e.g. clinic model, mobile teams, restorative bedded resource)	100%	-	-

TEMPLATE A: PART 2: GOALS and ACTION PLANS Chronic Disease Prevention and Management (cont'd)
Expected Impacts of Key Action Items
The following performance goals will be initiated (and tracked) once the care paths have been approved and implemented (for a specific geographic region). Moreover these gains will not be realized until the appropriate CDPM future system 'community capacity' supports are in place. • 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 • Inability to switch the current health care system focus of treating acute illness and managing crisis to offering more preventative supports and tools to prevent/manage/alleviate risk behaviors • Continued lack of standardized community care paths (COPD, CHF, stroke, 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 after-hours health care service • No community alternatives to ED and hospital care especially during after-hours and weekends • No community capacity to better support the chronic disease population in their own homes for longer periods of time

**TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Chronic Disease Prevention and Management (cont'd)**

What are the Risks / Barriers to Successful Implementation? (cont'd)

For each risk/barrier describe the plan to mitigate risk.

- To improve overall accountability and tracking performance, implement an electronic assessment tool intended to measure performance 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 and lifestyle change
- Formalize and operationalize linkages with primary care through care path and program/protocol development
- Expand current self-management supports through a formalized comprehensive approach to secondary prevention and report results on uptake through a CDPM system scorecard
- Advance a comprehensive prevention strategy and fiscal plan to begin to invest (redirect) more resources into preventative measures
- Develop standard integrated care paths/logic models for high-end users of the health care system in the Erie St. Clair region (COPD, CHF, stroke, diabetes)
- Develop and implement an electronic assessment tool to track results across all key planning areas (COPD, diabetes, stroke, CHF, smoking cessation)
- Through care path/logic model development, outline best practice (linkages and targets) for connecting with primary care after a discharge and other critical primary care support components needed at time of discharge up to 14 days post discharge
- As part of the integrated care path advance and/or extend models of after-hour care and crisis management within community settings
- Advance a process to assess, and where needed, advance formal CDPM business cases that address community capacity needs

What are some of the key enablers that help us to achieve our goal?

- Training and signed service accountability agreements for the use of an electronic assessment tool
- ESC LHIN support for planning and establishing structures in the community (working groups) to design an operational integrated care paths
- Identification of best practices and agreement from providers on uptake of these ESC LHIN-wide
- Completion of formal community capacity business cases intended to advance alternatives to ED and in-hospital care for people living with a chronic disease
- Ability to accurately measure and report on health system performance (and return on investment)
- 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: PART1: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 have been traditionally vulnerable population groups with high utilization of ED, acute care settings, and community resources. The Erie St. Clair region ED repeat visits, within 30 days for substance abuse accounted for 1% of the overall ED visits in 2013/14. In 2013, Erie St. Clair region was one of the worst performers in the province and currently ranks third highest performer with this indicator. While gains have been made, Erie St. Clair region continues to experience significant wait times for community-based addiction services. For instance: • Second longest wait for our provincial resource of women only residential addiction treatment services • Overall the Erie St. Clair region ranks ninth in the Province for wait times for residential addiction treatment (co-ed) • Wait times for initial addiction assessment and referral ranged from 10 days to as long as 65 days The ESC LHIN performs poorly for repeat ED visits within 30 days for mental health conditions. In 2013/14, mental health diagnostic conditions accounted for 3% of all ED visits and the ESC LHIN is currently ranked eighth highest in the province. Consistently, high volumes are noted for the Windsor/Essex area. While the promising practices are anticipated to have a positive impact on ED visits, additional variables such as community wait times must be considered. For instance • Counseling and treatment ranged from 0 - 218 days • Case management ranged from 0 – 122 days • Support within housing ranged from 0 – 222 days • Assertive community treatment ranged from 41 days or longer

TEMPLATE A: PART1:IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY: Mental Health and Addictions (cont'd)
IHSP Priority Description: (cont'd)
The anticipated result over the next 12 to 36 months to address the ESC LHIN key performance measures include: • Maintain current ranking as one of the top performers for repeat ED visits for substance abuse within 30 days • Reduction of mental health ED visits by 10 to 15% over the next two years, specifically addressing high volumes in the Windsor area • In the community, wait times for addiction assessment and referral, residential treatment, and counseling for concurrent disorders require improvement. The top three substances identified are alcohol, cocaine, and narcotics/opiates • In the community wait times and demands for mental health counseling and treatment, housing and case management continues to stretch resources. In addition, long acting injections, community treatment orders, and support from the justice teams are experiencing capacity pressures • Mental health and addictions continue to be growing populations that require a comprehensive, measured, and action-oriented approach • In the acute care setting medical units and the Schedule One are experiencing an increase in the number of ALC older adult with responsive behaviors due to refusals by LTCHs to accept the resident back. Lack of appropriate residential/care settings are clearly an issue for complex individuals with early onset dementia, ABI with co morbid mental health and or addiction issues The anticipated return from the promising practices and previously mentioned investments include: • A decrease of ED visits for individuals requiring withdrawal management services • A decrease of acute care admissions for individuals with mental health and addiction needs that are being better served in the community by their primary care physician with psychiatry supports (shared care models) • Decrease in wait times for individuals seeking community-based mental health and addiction services • Decrease in ALC rates for older adults with responsive behaviors who are transitioned by ESC CCAC BSO Hospital Care Coordinators, back to their home with mobile team supports including to LTC and rest and retirement homes • Increase in individuals served by addiction assessment and referral, counseling and treatment by coordination via the ESC LHIN-wide FACE Model • Increase in individuals with opiate addictions served by harm reduction/methadone clinics • Increase in early identification of individuals with suicidal ideation linking them to needed community-based counseling services

**TEMPLATE A:
PART1:IDENTIFICATION OF INTEGRATED HEALTH SERVICES
PRIORITY: Mental Health and Addictions (cont'd)**

Current Status:

Mental Health & Addiction Planning Objectives Considered

- Reduce ED repeat visits (within 30 days) for mental health and addiction clients by implementation of community-based alternatives to ED – Transitional Stability Centre, RAIT Teams and Erie St. Clair FACE Mechanisms
- Continued focus on older adults with responsive behaviors who are at risk for acute or early LTC admissions
- Reduce community wait times by implementing promising practices and wrap around services for people with mental health issues (moderate or severe) and/or addictions. Wrap around services include shared care models between psychiatrist and primary care physicians
- Strengthen relationships between MCYS-funded providers and ESC LHIN-funded providers as it relates to transitional age youth
- Evaluate Second Stage Relapse Prevention Pilot for applicability ESC LHIN-wide
- Psychiatry and Primary Care Lead to implement and evaluate shared care models targeting solo, remote or rural physician practices that do not have on-site counseling supports
- Strengthen relationship between Ministry of Community and Social Service funded providers and ESC LHIN-funded providers as it relates to complex individuals with special needs (e.g. dual diagnosis)
- Implement shared clinical resources as a means of extending specialized psychiatry services for communities with gaps
- Reduce reliance on the ED and inpatient services for withdrawal management and addiction services
- Implement new housing models in partnership with the three Municipalities Department of Housing
- Implement a Forensic Transitional Rehabilitation Program (TRP) Pilot

TEMPLATE A: PART 2: GOALS and ACTION PLANS Mental Health and Addictions (cont'd)
Goal(s):
• Increased capacity (service volumes) and reduced wait times (referral to service initiation) for individuals with mental health and or addiction issues • 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 mental health and addiction services are available for individuals within Erie St. Clair • Prevent or delay admission to hospital or placement in a LTCH for older adults with responsive behaviors • Improve transition points along the continuum of care for mental health, addictions and people with behavioral issues • Provide help early including identification and intervention for individuals with moderate mental health/addiction issues • Strengthen the consumer and family system via peer support models • Build an evidence-based and experienced-driven mental health and addiction service system • Augment and support psychiatrists and service extenders to primary care physicians • Increase clinical core competencies and ensure high quality of services • Reduce repeat ED visits within 30 days for mental health and substance use • One of ESC LHIN's agencies is the host site for Head Space. Future opportunities as it pertains to youth, transitional aged youth and early intervention first episode psychosis • Greater linkages and true shared care models. Build upon the RAIT model to ensure that individuals with moderate mental illness and addictions are served • Addictions – out patient, community-based day programs, evening/weekend counseling and services on a continuum basis (across the life span and service sector) • Invest further in supports for housing and supports within housing (outreach model) • Explore peer support models that are showing promise in other LHINs for applicability and replication in Erie St. Clair region • Expand population focus to be inclusive of individuals with complex neurological and mental health/addiction conditions (e.g. ABI/early onset dementia) • Consider counseling/therapist as a core service that requires further strengthening
Consistency with Government Priorities:
The MOHLTC 10-year Mental Health and Addiction Action Plan focused the first three years on children and youth. During the first year of the Provincial plan, ESC LHIN invested heavily in additional resources for the Early Intervention, First Episode Psychosis Program. This program is now undergoing a province wide review of key indicators as it relates to ministry standards. Erie St. Clair is a member of the Provincial Working Group. An internal review shows Erie St. Clair Early Intervention Teams are high performers with clinical practices demonstrating consistency to new standards. In 2014 the Erie St. Clair Early Intervention Program in two counties showed significant capacity pressures. The ESC LHIN in partnership with the providers is embarking on a service review and action plan for 2015/16.

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

Consistency with Government Priorities:

During year two of the plan new funding was provided for two Eating Disorder NPs in our region. Erie St. Clair aligned the new resources with primary care (CHCs). The Eating Disorders NP in Windsor/Essex became a successful shared resource between the Windsor Essex CHC and Bulimia Anorexia Nervosa Association (BANA) as it relates to an integrated model. The model included ESC LHIN investments of a single access mechanism with a 1-800 number, intake worker, a social worker, and dietician. This model also evolved to include changes in the population with the CHC serving adolescents and BANA serving adults (note transitional aged youth 18–23 are served by both providers). The Eating Disorder NP in Chatham-Kent also provided services for Sarnia/Lambton. During the first two years of implementation, volumes were manageable; however, by the second quarter of 2013/14 the demand for service exceeded capacity leading to retention issues. As a result, the ESC LHIN is reviewing the need for greater resources in each county. The service would remain based out of the CHC. Similarly, an ESC LHIN review will include examining what services are available for adults with eating disorders in Chatham-Kent and Sarnia/Lambton including leverage lessons learned from the integrated model implemented in Windsor/Essex.

During year three of the plan, new funding was provided for seven ESC CCAC Mental Health and Addiction School Based Nurses (MHAN) and one Nurse Lead. The ESC CCAC MHAN program, since inception, experienced retention issues and uptake and acceptance of the program by existing mental health and addiction ESC LHIN-funded providers was slow. The ESC CCAC MHAN program is represented at the ESC LHIN Child and Youth Leadership Table which is comprised of ESC LHIN and MCYS-funded providers and the MCYS Regional Office. The Leadership Table is envisioned as a vehicle to strengthen system-wide acceptance of the ESC CCAC role by maximizing the nursing scope as it relates to monitoring children and youth discharged from Schedule One/Maryvale facility. Concurrently, the ESC LHIN has invested in a time-limited, Mental Health Child and Youth Lead to develop current state care pathways from the tipping point of crisis to community treatment. This work is anticipated to result in better communications between ESC LHIN-funded providers, MCYS providers and the Erie St. Clair region School Boards. Care pathways will align with the provincial ED best practices and break down remaining silos of care.

Year four through ten are anticipated to focus new investments on the adult population including those with moderate mental health issues as well as the addiction sector. ESC LHIN is well positioned to align with government priorities as they relate to significant investments made in 2013/14 fiscal year. For instance based on the five pillars:

1) Pillar One: Promote Resiliency and Well-being in Ontarians

- The Rebound Choices Program has been implemented in Chatham-Kent with the Sarnia/Lambton Rebound Program being the provincial model. This pillar also aligns with the Head Space Initiative in which Chatham-Kent is the only Ontario-based site nationally

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

Consistency with Government Priorities:

2) Pillar Two: Ensure Early Identification and Intervention

- Early Intervention Program early investments made by the ESC LHIN
 - Fast Access to Community Experts (a coordinated access model currently highlighted by the MOHLTC as an example of leveraging existing resources such as Connexontario and OTN)
 - Rapid Assessment, Intervention and Treatment Team – aligns fast, mobile interdisciplinary teams for primary care practices in need of support for moderate mental health issues
 - Suicide Coordination and Prevention – time-limited initiative
 - Caring Connections – addicted pregnant women additional funding provided staff based in each county child welfare office
- Community based and residential withdrawal management services in Sarnia/Lambton. Starting with community, the mobile, 24/7 team provides rapid intervention for addictions in a county that has historically accessed services as far away as Windsor (1.5 hours away) or London (1 hour)

3) Pillar Three: Expand Housing, Employment Supports and Diversions from the Justice System

- Through partnerships between the three municipalities, departments of housing, the ESC LHIN has resulted in maximizing limited resources. As an example the City of Windsor has provided five rent-supplements units for addicted pregnant women. An additional 20 units are potentially available as it relates to complex individuals with an ABI, mental health and addiction issues. The ESC LHIN will be required to invest in additional clinical supports
- The ESC LHIN in partnership with the MOHLTC is in the process of exploring the establishment of a Forensic Transitional Rehabilitation Program (TRP). The ESC LHIN is one of four LHINs that does not fund a forensic hospital. Nevertheless, we have a significant population of vulnerable individuals who could be deemed ALC as they cannot successfully transition back to the community. The ESC LHIN is working closely with a number of partners including St Joseph's, Regional Mental Health Care St. Thomas and Ministry staff
- Past investments include Release from Custody Workers to CMHA Windsor/Essex as it relates to the Southwest Correctional Centre, and Police Mental Health Teams (HELP and COAST)

4) Pillar Four: Right Service, Right Time, Right Place

- Mental health and addictions are identified as a co morbid population within several Health Links
- Invested in creating a "hub" of existing service providers based in Windsor – mandated to serve the county by funding one-time coordination for LDMH. This coordination endeavor has resulted in an increase number of new mental health and addiction services in the county. It is noteworthy that the on-site services occurred at the same time as the Heinz factory restructuring which resulted in a significant economic downsize and impact on the community

5) Pillar Five: Funds Based on Need and Quality

- Considerable time and investment spent on integration. To date, successful integration between CMHA Lambton Kent and CKHA Mental Health and Addiction Services. Current focus is vertical integration between CMHA Windsor/Essex and HDGH
- The Erie St. Clair region has successful investments in geographical areas that are typically underfunded as well as population groups that experience health equity issues. For instance, ESC LHIN provided funding for a FTE Tele-med nurse for North Lambton CHC to provide OTN nursing support linking methadone clients from Kettle and Stony Point First Nation Reserve to Bluewater Methadone Clinic in Sarnia. Without access, these clients would utilize methadone sporadically due to limited transportation.

TEMPLATE: PART 2: GOALS and ACTION PLANS Mental Health and Addictions (cont'd)			
Action Plans/Interventions:	% Completion by Year		
	2014-15	2015-16	2016-17
Mental Health			
Increase community education and promotion of early intervention first episode psychosis. Ensure that the early intervention and extended psychosis programs in Erie St. Clair meet provincial program standards	100%	-	-
Implement the Erie St. Clair BSO Model for older adults with responsive behaviors and their caregivers	100%	-	-
Evaluate the effectiveness of the Erie St. Clair BSO Model for older adults with responsive behaviors and their caregivers. Evaluation will include recommendations and potential re-alignment of funding		100%	
Implement OTN clinic days ESC LHIN-wide aligns with FACE initiative	80%	100%	-
Implement and evaluate psychiatric sessional funding. Adjust sessional funding as volumes dictate.	-	100%	-
Implement the Mental Health Strategic Plan	100%	-	-
Continue to advance the 'Integrated Assessment Record' ESC LHIN-wide – including ED Psych Screener	80%	100%	-
Implement Ontario Common Assessment of Need (OCAN) assessments for assertive community treatment (ACT) clients ESC LHIN-wide and compare clinical levels of need/risk to (CMHA) intensive case management clients	80%	100%	-
Implement Eating Disorders Integrated Care Team and evaluate model for replication in other communities	20%	80%	100%
Implement and monitor impact of promising practices as it relates to ED repeat visits and community service volumes	90%	100%	-
Implement and monitor mental health investments as it relates to return on investment indicators	-	100%	-
Evaluate Restructured Mental Health and Addiction Network and Leadership Tables for effectiveness and strategic intent	-	100%	-
Review and adjust mental health cost centres to align with actual service delivery	80%	100%	

TEMPLATE: PART 2: GOALS and ACTION PLANS Mental Health and Addictions (cont'd)			
Addictions			
Based on best practices develop protocols and care paths between the ESC LHIN-funded Chronic Pain Program and Mental Health/Addiction Providers	60%	100%	
Initiate the Addictions Strategic Plan	80%	100%	
Implement and monitor addiction investments as it relates to return on investment indicators and the Addiction Strategic Plan	-	50%	50%
Implement and monitor second stage relapse prevention model for ESC LHIN-wide replication	80%	20%	-
Continue addicted pregnant women service partnership with Child Welfare and evaluate	70%	100%	-
Continue withdrawal management service partnership work in respective communities	90%	100%	-
Review and adjust addiction cost centres to align with actual service delivery	100%		
Implement and evaluate psychiatric sessional funding. Adjust sessional funding as volumes dictate	-	100%	
Expected Impacts of Key Action Items			
- Increased utilization of withdrawal management services/decreased use of ED or acute care - Increased public awareness of where to go for help (FACE Model) - Increase uptake of shared care between psychiatrists and primary care (RAIT Teams) - Increased provider knowledge and standardized use of suicide risk screening tools - Clinical care pathways for suicidal youth and adults – increased communication between sectors			
What are the risks/barriers to successful implementation?			
- Increased utilization of withdrawal management/addiction services may result in the need for additional investments of out-patient counseling or day program treatment models - Increased public awareness about suicidal ideation and or the FACE Model may increase the need for targeted investments in mental health and addiction services - Shared Care Models may result in greater number of people with moderate mental health/addiction issues coming forward requiring additional, new services and investments along with identification of core services - Psychiatry and specialized mental health/addiction human resources may not be able to keep up (e.g. demand exceeding supply)			

2.5 Rehabilitative Care System

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY PRIORITY: Rehabilitative Care System	
Integrated Health Services Priority:	
Rehabilitative Care	
IHSP Priority Description:	
Rehabilitative care is a process of treatment provided by a single discipline, or an interdisciplinary team which may include: Nurses (RN and RPNs), Physiotherapists (PTs), Occupational Therapists (OTs), Speech Language Pathologists, Rehabilitation Assistants, Recreation Therapists, Social Workers (SW), Dietitians, Pharmacists, Psychologists, Psychiatrists, and Geriatricians. Rehabilitation is typically required following acute illness or injury, or health and functional changes resulting from chronic disease or disability, and may occur through a series of coordinated transitions across a variety of care settings in the health care system. The goal of the rehabilitative system is to restore the patient/client to the highest level of independence and functioning, then to maintain them at that level. Ideally, the goal of every rehabilitative patient/client is to return home or to an assisted living setting. Services are provided to clients in their homes, schools, workplaces, clinics, hospitals and residential care facilities. Increasing need for rehabilitative care system capacity is anticipated for the next 5-10 years and forward due to the growing burden of chronic disease and population aging in Erie St. Clair. The 2012 Rehabilitation System Strategic Plan identified several areas of gaps in the current state system as well as areas of strengths to build upon. The Rehabilitation System Strategic Plan prioritizes goals that will impact the experiences and clinical outcomes of the highest volume rehabilitation patient populations (patients with stroke, orthopaedic conditions and geriatrics). <u>Rehabilitative Care Planning Objectives Considered</u> • Three dimensions of the Institute for Healthcare Improvement (IHI) triple aim approach: improving the health of the population, enhancing the patient experience and reducing, or at least controlling the per capita cost of care • Service providers have specialized expertise and work to their full scope of practice at all stages of care • Best practice interventions to optimize recovery and outcomes • Focus on prevention and risk reduction • Equitable, timely access to care for urban and rural residents • Smooth care transitions within an integrated system of care • Standardized cross continuum care pathways • Incorporate focus on self-management within patient and client capabilities • Appropriate allocation of resources with creative and flexible funding models • Identification of earliest rehabilitation opportunities to restore functioning and reduce LOS across the continuum	

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

Current Status:

While best practice care approaches are well established and documented for the top three priority rehabilitative care populations, there is variable implementation across the ESC LHIN. Timely access to inpatient rehabilitative care within targets is variable, contributing to acute care ALC days and delays in recovery for patients. Availability of community and outpatient rehabilitative care of sufficient intensity and duration contributes to delays in discharge from inpatient programs as well as early intervention opportunities and potential prevention of acute hospitalization. Some patients are disproportionately admitted to CCC or LTC, where availability of rehabilitative care services is partial and variable.

Older adults are a significant proportion of clients requiring rehabilitative care in all settings. Expertise, capacity and competency standards for health human resources to manage the specialized geriatric care needs of this population are partially developed across the continuum of care.

Determining system areas for focus of targeted improvement activities has been challenging due to availability of accurate data on patient and system outcomes. The need for a comprehensive Rehabilitative Care System report card was identified and is now available in draft stage. As the scorecard begins to accumulate data, opportunities for improvement and celebration of successes will be realized.

The formation of the Provincial Rehabilitative Care Alliance and associated working groups in 2013 has provided additional direction toward development of provincially standardized rehabilitative care programs and initiatives, and positive influence on activities in Erie St. Clair.

**TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Rehabilitative Care System (cont'd)**

Goal(s):

Rehabilitative Care System Overall Goals:

Strategic Themes	Strategic Goals
Theme 1: Providing the Best Care in the Right Location	Identify and implement Best Practices for the top three rehabilitation clinical conditions across the continuum Facilitate the appropriate use of inpatient rehab beds Ensure adequate access to funded outpatient and community-based rehabilitation services
Theme 2: Supporting Prevention, Activation and Self-Management	Roll-out the ESC LHIN-wide collaborative seniors falls prevention strategy Expand rehabilitation for the complex inpatient population (activation on medical units). Integrate self-management philosophy with residents and families in each program
Theme 3: Developing Expertise and Sharing Knowledge	Develop standards for rehabilitation expertise and an ESC LHIN-wide strategy for professional development Increase public/health care professional understanding of rehab and the resources available through formal education and marketing Develop regional centres of excellence for the top clinical conditions

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

- Patients with stroke
- Patients with orthopedic conditions, including hip fracture
- Frail and medically complex older adults

TEMPLATE A: PART 2: GOALS and ACTION PLANS Rehabilitative Care System (cont'd)			
Consistency with Government Priorities:			
The above goals are consistent with MOHLTC Seniors Strategy and directions for CDPM and the work of the Rehabilitation Care Alliance			
Action Plans / Interventions:	% Completion by Year		
	2014-15	2015-16	2015-17
Implement a Community Rehabilitative Team for patients with stroke ESC LHIN-wide that includes early supported discharge	100%		
Develop and implement a model of care for patients with stroke that incorporates access to comprehensive inpatient rehabilitation for all stroke survivors who are unable to return home from acute care	50%	100%	
Determine and recommend an optimal rehabilitative care bed mix for ESC LHIN that aligns with Rehabilitative Care Alliance Definitions Working Group (including rehab, CCC and convalescent care beds)	80%	100%	
Develop and implement a standardized hip fracture care pathway ESC LHIN-wide	70%	100%	
Develop and implement Community Rehabilitative care services for patients with hip fracture that incorporate early supported discharge from acute/inpatient rehabilitation or convalescent care stay, and full community re-integration	70%	100%	
Develop and implement comprehensive specialized geriatric medicine services to support care of patients with hip fracture in acute, inpatient rehab and community settings and supports the development of the ESC LHIN Senior Strategy	20%	60%	100%
Implement Hospital Elder Life Program (HELP) ESC LHIN-wide in acute and inpatient rehabilitation care settings	30%	100%	
Develop and implement a community-based early screening process to identify individuals with frailty/functional decline, which triggers a comprehensive assessment and appropriate rehabilitative care services	30%	70%	100%
Develop specialized geriatric medicine/rehabilitation capacity across the ESC LHIN interfaced with geriatric mental health services to support the development of the ESC LHIN Senior Strategy	20%	60%	100%

**TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Rehabilitative Care System (cont'd)**

Expected Impacts of Key Action Items

Appropriate rehabilitative system inpatient bed capacity to:

- Increase access to inpatient rehabilitative care for patients with moderate and severe stroke to within targets (target to be determined)
- Increase access to inpatient rehabilitative care for patients with hip fracture up to 70% of those who lived in the community prior to injury
- Reduce ALC days in acute care waiting for rehab (targets to be determined)
- Reduce ALC days in acute care to LTC
- Reduce ALC days to CCC
- Reduce the rates of patients with stroke and hip fracture admitted to LTC

Appropriate access to funded outpatient and community rehabilitative care to:

- Reduce LOS in acute and inpatient rehabilitative care
- Reduce 30-day re-admissions (targets to be determined)
- Reduce admissions to LTC from the community (targets to be determined)
- Improving ALC discharges to home with support (targets to be determined)
- Improve the outcomes and quality of life for residents of Erie St. Clair experiencing disabling illness or injury

What are the Risks / Barriers to Successful Implementation?

- Inability to quantify proportions of older adults in acute care and community who might benefit from rehabilitative care and do not currently use these services (complexity of comorbidities, ICD-10 codes, etc.)
- Inability to effectively track results and impact of programs on patient outcomes especially in the community sector
- Inadequate or poor-quality data to inform decision making and planning
- Facilities/stakeholders undertake their own initiatives and strategic plans to manage their patient flow and costs due to system funding pressures

For each risk/barrier describe the plan to mitigate risk.

- Monitor progress of senior-friendly hospital indicators implementation, particularly identification of hospital acquired functional decline – this will inform data for the population in acute care requiring supported care transitions and rehabilitative care
- To improve overall accountability and tracking performance, implement a comprehensive rehabilitative system report card with key performance indicators and report quarterly to the ESC LHIN
- Close communication and collaboration with stakeholders
- Accelerate the ESC LHIN Rehab Committee's work
- Introduce a sharing mechanism to support awareness and exchange of emerging practices including resources and standards developed by the provincial Rehabilitative Care Alliance
- Clear direction from ESC LHIN

**TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Rehabilitative Care System (cont'd)**

What are the Risks / Barriers to Successful Implementation? (cont'd)

What are some of the key enablers that help us to achieve our goal?

- A dedicated ESC LHIN-wide Rehabilitation Coordinator to support the research, analysis and process improvement initiatives across Erie St. Clair region
- ESC LHIN support for establishing structures in the community (working groups) to design and operationalize integrated care paths and other system improvements
- Availability of data and decision support resources to accurately measure and report on health system performance
- Standardized tools for application in assessment, communication and measurement of patient and program outcomes
- Agreement from health care providers on performance targets and measures
- Standardized staffing models (staff mix and skill sets) in rehab programs across the Erie St. Clair region
- Predictive models for rehab utilization and growth for sustainability of programs for the top three populations/diagnoses over the next ten years
- A system map that streamlines the services to meet the varied rehab needs of Erie St. Clair residents across the continuum of care

2.6 Hospice Palliative Care

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY PRIORITY: Hospice Palliative Care	
Integrated Health Services Priority:	
Hospice Palliative Care (HPC) links with all of the other IHSP priorities and serve as an enabler to leverage improvements.	
IHSP Priority Description:	
Erie St. Clair has a significantly higher mortality rate than the province as a whole (812.9% vs. 648.7%) with 5,200 deaths in FY2011/12. The need for HPC is increasing. Chronic health conditions are rapidly increasing in Erie St. Clair. Compared to the province, the Erie St. Clair population has higher rates of many chronic health conditions (refer to CDPM section of this ABP). HPC is needed for all disease categories (including chronic diseases), and is required in all care settings where persons die. HPC has been shown to: • Improve quality of life for persons with life limiting illness and their caregivers • Improve resource utilization Despite the demonstrated benefits of Palliative Care there are still far too many: • Needlessly unpleasant deaths • Procedures conducted on persons at the end of life which may neither prolong nor improve life • Avoidable admissions to acute care • LOS in hospital that are too long • Persons dying in inappropriate locations • Unnecessary visits to the ED • Referrals to palliative care that are too late or not at all By making HPC a priority in Erie St. Clair we seek to positively impact patients, care providers and the system as a whole.	

**TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Hospice Palliative Care (cont'd)**

Goal(s):

HPC overall goal is to move to the new model of care of virtual extended inter-professional teams, this would require that:

- A full continuum of care settings and services is in place
- In each care setting where individuals die, there is a clearly defined care program that is founded on a palliative care philosophy and approach
- Sectors and services are linked by common practices, processes, structures and understanding of the palliative care philosophy
- Enough trained professionals and trained volunteers are available
- Accountability is clearly defined and communicated
- Funding models, guidelines and policy directions support an integrated system

The action plans below are framed around these standards and focus on the following priority populations for HPC in Erie St. Clair:

- Persons with any diagnosis and deemed to require palliative care services in any care settings (persons own home, residential hospice, LTCHs, acute care, CCC, and community/outpatient settings, etc.)
 - Pre-empting or managing crisis situations in the setting where they occur to prevent ED visits, hospital admissions and/or prolonged LOS
 - Enhancing care provision and patient/family experience
 - Providing more timely symptom response for tertiary level HPC crisis intervention thereby facilitating earlier discharge and decreased ALC days

Additional priority populations within the above care settings include:

- First Nation people
- Marginalized populations
- Frequently readmitted chronic disease

Shared priorities for the above populations include:

- Broadening access and increasing timeliness of access
- Strengthening caregiver supports
- Strengthening service capacity and human capital in all care settings
- Improving integration and continuity across care settings
- Strengthening accountability and introduce mechanisms for shared accountability

Consistency with Government Priorities:

The above goals are consistent with the priorities and action items outlined in the document: *ADVANCING HIGH QUALITY, HIGH VALUE PALLIATIVE CARE IN ONTARIO, A Declaration of Partnership and Commitment to Action, December 2011*. This document in turn cites linkages with a number of other government priorities.

TEMPLATE A: PART 2: GOALS and ACTION PLANS Hospice Palliative Care (cont'd)			
Action Plans / Interventions:	% Completion by Year		
	2014-15	2015-16	2016-17
Advance a full continuum of care settings and services for EOLC/HPC LHIN wide:			
Residential hospices in Chatham-Kent and Leamington - open, integrate with other sectors, evaluate etc.	50%	90%	100%
Bereavement Services – enhancement of professional care for addressing complicated grief situations in Chatham-Kent and Sarnia/Lambton (possibly based on model advanced in Windsor/Essex partnership with CMHA.)	40%	80%	100%
Conducting and responding to program and service gap analysis (as part of strategic planning “refresh”)	50%	80%	100%
Support building of HPC programs in all care settings where persons die:			
Supporting advanced care planning (ACP) education and policy development across all sectors/services	50%	80%	100%
Supporting development of Palliative Care Program as part of Windsor hospital realignment as well as advancing Palliative Care programming in all Erie St. Clair hospital settings based on the identified key program elements (particular emphasis on ED)	40%	60%	100%
Continuing to evaluate and enhance community based access to expert HPC (including Hospice Windsor Palliative Medicine Program (PMP), PCCT and linkages among sectors and services)	60%	90%	100%
Providing enhanced HPC services in LTCHs through increased access to PCCT, NPs, collaboration with PPSMCP, RNAO best practice advisor, hospice resources including Palliative Medicine Programs, education etc. (Focus of this activity will be guided by the outcomes of the formal evaluation of pilot project in Sarnia/Lambton homes.)	30%	60%	100%
Continue with integration & collaboration activities:			
Advancing Education Strategy (this includes culturally specific education for First Nation people and their care providers as well as other culturally diverse populations; emphasis on enhancing best practice in all care settings and professional groups (including informal care providers)	50%	80%	100%
Exploring and implementing opportunities for enhanced integration; (as part of strategic planning “refresh”)	50%	80%	100%
Re-doing analysis of relative role of each care setting in each county; revise care paths accordingly. Develop process for ongoing updating			

TEMPLATE A: PART 2: GOALS and ACTION PLANS Hospice Palliative Care (cont'd)			
Build human resources capacity for HPC by:			
Advancing the use of team-based care. Evaluate current teams and build on learnings (including improving capacity by removing duplication and inefficiencies)	50%	80%	100%
Continuing to support education to formal and informal care providers (including primary care and specialist level HPC providers)	50%	80%	100%
Support Palliative Medicine Residency Program	50%	80%	100%
Strengthen system level accountabilities including:			
Completing system level review with particular emphasis on data and outcome measures (as part of strategic planning "refresh")	100%	-	-
Using data to improve HPC programming	20%	90%	100%
Advancing and implement performance measures and targets for all priority areas	40%	80%	100%
Developing a more formal regional program as articulated in the <i>Declaration Document</i>	60%	80%	100%
Advance funding models, guidelines and policy directions that support an integrated system including:			
Participating in the development of and implementation of provincial/federal level policy/guidelines/strategies to enhance HPC	40%	80%	100%
Developing mitigating strategies to work around current limitations	60%	100%	-

**TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Hospice Palliative Care (cont'd)**

Expected Impacts of Key Action Items

- Reduced avoidable ED visits, avoidable admissions and ALC days
 - Indicator avoidance of ED visits/admissions in 70% of PCCT and PMP clients who might have otherwise visited the ED
 - Indicator increase by 5% HPC direct admissions (vs. admissions via ED), thereby by-passing ED
- Increased options in care settings for dying patients and increased prevalence of concordance between client preference and place of death
 - Indicator at least 60% of PCCT clients will achieve concordance between preference and place of death
 - Indicator increase by 5% percentage of palliative coded patients who are discharged home from acute care
- Increased percentage of non-hospital deaths
 - Indicator at least 50% of PCCT clients will die in non-hospital locations
- Increased percentage of timely referrals to palliative care
 - Indicator increase of at least 5% in the percent of deaths in hospital that show a palliative care designation
- Enhanced Palliative Care Programs in all settings where patients die
 - Indicator within two years at least 70% of these care settings have a definable and viable HPC program for their clients. These programs will include program evaluation (tracking and quality measures of care)
- Improved capacity to provide palliative care in ESC First Nation communities
 - Indicator provide at least one education opportunities per year for the next 3 years to First Nation formal and informal care providers (as requested by First Nation partners)
- Improved long term, population based outcomes in HPC
 - Indicators for positive outcomes and trends in all palliative care/EOLC indicators as published by the Cancer Quality Council of Ontario and as determined by provincial work currently underway (meet and/or exceed the provincial average)
- Improved understanding of Advance Care Planning and Health Care Consent - 50% increase in direct care providers who report enhanced understanding of Advance Care Planning and Health Care Consent

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

**TEMPLATE A:
PART 2: GOALS and ACTION PLANS
Hospice Palliative Care (cont'd)**

What are the Risks / Barriers to Successful Implementation?

- Public (and health care provider) misconception that palliative care means abandoning hope and just “doing nothing”, resulting in delayed referrals and continued acute care approach
- Sector specific priorities that may not support a system-wide approach to palliative care service delivery; failure to collaborate among sectors thereby reducing effectiveness of scarce resources
- Recruitment issues – Specialist level Palliative Care Physicians, NPs and other team members
- Need for improved data collection methodologies to allow HPC evaluation at a system level (e.g. National Ambulatory Care Reporting System (NACRS) to capture increased use of ED by persons who require palliative care)
- Few resources in LTCHs to support increased staffing requirements that may be needed to handle complex palliative care needs (especially for midnight and evening shifts)
- Need to clarify policy directions regarding the role of residential hospices within the HPC system
- Continued use of ED as the default position for care with few resources to assist ED staff provide care from a palliative perspective (In some cases if a palliative perspective were used admissions may be averted)
- Lack of HPC education for physicians in all sectors
- Inadequate numbers of physicians with physician palliative status to access appropriate drugs for EOLC

For each risk/barrier describe the plan to mitigate risk.

- Continue with education of formal care providers across the continuum including physicians
- Strengthen accountability structures as described in the *Declaration Document*
- Implement “grow your own experts” strategies
- As part of strategic plan “refresh” emphasize measurement and data
- Work with provincial level data groups
- Include LTCHs in mandate of PCCT. Work with partners in LTCHs (e.g. RNAO Best Practice, PPSMCP, NPs in homes, PMPs and hospices, etc.)
- Include ED in ACP education and other HPC education
- As HPC resources become available deploy them to ED and inpatient areas. Set up direct admissions processes for patients who clearly require admission, thereby bypassing ED
- Continue to work with provincial level partners to clarify role of residential hospices within the HPC system

What are the Risks / Barriers to Successful Implementation?

What are some of the key enablers that will help us to achieve our goal?

- Work at the provincial level will help clarify and advance HPC solutions. Erie St. Clair has strong connections with this work
- Strong cross-sector community based local networks and groups have been working together for many years and are very patient-focused
- Erie St. Clair has a history of strong palliative care support
- Tele-Med equipment ESC LHIN-wide is a key enabler
- Enhanced HPC Program structure will help break down silos between sectors
- Strategic Planning “refresh” will provide valuable information to prioritize actions going forward

3 ESC LHIN Operations and Staffing Templates

3.1 ESC LHIN Operations Spending Plan

Template B: LHIN Operations Spending Plan				
LHIN Operations Sub-Category (\$)	2013/14 Actual	2014/15 Allocation	2015/16 Planned Expenses	2016/17 Planned Expenses
Salaries and Wages	3,060,831	3,145,400	3,145,400	3,145,400
HOOPP	257,467	352,380	352,380	352,380
Other Benefits	391,112	331,700	331,700	331,700
Total Employee Benefits	648,579	684,080	684,080	684,080
Transportation and Communication				
Staff Travel	114,305	93,520	93,520	93,520
Governance Travel	11,541	17,000	17,000	17,000
Communications	77,280	79,380	79,380	79,380
Other Benefits	-17,684	10,000	10,000	10,000
Total Transportation and Communication	185,442	199,900	199,900	199,900
Services				
Accommodation (includes Insurance)	272,843	339,500	339,500	339,500
Advertising	-3,512	10,000	10,000	10,000
Community Engagement	27,958	50,000	50,000	50,000
Consulting Fees	56,223	25,500	25,500	25,500
Equipment Rentals	30,684	50,000	50,000	50,000
Governance Per Diems	62,975	77,500	77,500	77,500
LSSO Shared Costs (includes LHINC)	399,162	406,500	406,500	406,500
Other Meeting Expenses	44,962	51,210	51,210	51,210
Other Governance Costs	36,805	50,250	50,250	50,250
Printing & Translation	16,071	16,000	16,000	16,000
Staff Development	100,106	56,500	56,500	56,500
Total Services	1,044,277	1,132,960	1,132,960	1,132,960
Supplies and Equipment				
IT Equipment	37,112	33,960	33,960	33,960
Office Supplies & Purchased Equipment	76,142	40,000	40,000	40,000
Capital	147,372	0	0	0
Total Supplies and Equipment	260,626	73,960	73,960	73,960
LHIN Operations: Total Planned Expense	5,199,755	5,236,300	5,236,300	5,236,300
Annual Funding Target	5,236,300	5,236,300	5,236,300	5,236,300
Variance	36,545	0	0	0

- The funding target includes (base, Diabetes Regional Coordination Centres, ED/ALC, French Language Services (FLS), Aboriginal Engagement)
- Increase in salaries for 2014/15 vs. 2013/14 reflect full-year costs for staff complement
- Risk: zero forecasted increase in funding target may not allow sufficient performance merit increases, forecasted one less FTE to offset

3.2 ESC LHIN Staffing Plan

Template C: LHIN Staffing Plan (Full-Time Equivalents)				
Position Title / Classification	2013/2014 Actuals as of Jan 31/2014 FTEs	2014/15 Forecast FTEs	2015/16 Forecast FTEs	2016/17 Forecast FTEs
CEO	1	1	1	1
Senior Director/CFO	2	2	2	2
Director	3	3	3	3
Manager	9	10	9	9
Lead	2	2	2	2
Analyst	4	4	4	4
Executive Assistant	1	1	1	1
Coordinators	3	3	3	3
Admin Assistant	9	9	9	9
Receptionist	1	1	1	1
Total FTEs	35	36	35	35

4 ESC LHIN Annual Business Plan Integrated Communications Strategy

4.1 Objectives

➤ 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 aims:

- 1) Chronic Disease Prevention and Management
- 2) Bold, Focused Leadership
- 3) Partnerships in Health Promotion

and the IHSP 3 key directions:

- 1) Improved outcomes in alternative level of care (ALC)
- 2) Improved outcomes in emergency department care (ED)
- 3) Improved outcomes in chronic disease prevention and management (CDPM)
- 4) Improved outcomes in mental health and addictions
- 5) Improved outcomes in rehabilitative care
- 6) Improved outcomes in hospice/palliative care (HPC)

➤ 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.

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
- Influence the public's 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
- Positively shift attitudes of the LHIN by demonstrating that the work of the LHIN results in *better care, better experience, and better value*
- The 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 of this ABP.

4.2 Context

For a description of the ESC LHIN's future demographics, projections and trends, see 1.3, page 11.

➤ ESC LHIN Business Objectives:

The ESC LHIN's Health Care Vision:

"Better Care, Better Experiences, Better Value."

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 Prevention and Management

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 to help them live healthier lives.

The ESC LHIN's IHSP 3, supports the ESC LHIN Board 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 MOHLTC, communicates the priority areas that will guide ESC LHIN activities from fiscal years 2013 to 2016 and is the basis for this 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
- Physiotherapy Reform
- Home First
- Pay-for-Results
- Residents First
- Expanded ESC CCAC Role
- Behavioural Supports Ontario
- Patient-Based Funding (HBAM)
- e-Health
- Quality Improvement Plans

4.2.2 Planning & Integration Activities

- IHSP 3
- ESC LHIN Strategic Plan
- Leadership Councils
- COPD Care Path and 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
- French Language Health Planning Entity/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 accessible 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 are 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 Prevention and 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 health service providers (HSPs): Leadership Councils, networks and advisory groups, memos, ESC LHIN Communications and 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 International Association for Public Participation (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 are 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 is how we will all get better health care, while saving money and making the system sustainable for our children and grandchildren

➤ Transformational Messaging:

Ontario is shifting the focus of its health care system to revolve around the person. We have a plan to ensure Ontarians have access to high quality care and a sustainable health system for years to come. By organizing our system differently and focusing on the medical evidence, we will provide Ontarians with better care and better value for tax dollars.

Through these changes, we expect to see:

- Reduced wait times and faster access to family doctors
- Fewer unnecessary visits to the ED and re-admissions to hospital
- Patients receiving care at home or in the community instead of in a hospital

How are we transforming the health care system?

- Partnering with the sector and enabling them to play an active role in how the system will change
- Strengthening community agencies to support providers and encourage integration around the patient's needs
- Health care funding will be determined based on the best evidence and will follow the patient

What can we expect from these changes to the healthcare system?

- A system built for patients by the health care providers and leaders closest to them
- A health care system that integrates providers around patients to deliver better outcomes

➤ Project Specific Key Messages:

- 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:

➤ Media Analytics (reported in Board CEO Report)

Track 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 Board 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 Board 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 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 2014/15 will primarily support the implementation of key improvement initiatives outlined in the ABP.

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
- Public Health and social service providers

During 2014/15 there will be a considerable focus on engaging patients and their families as part of the development and implementation of Health Links. Health Links will identify frequent/high users of health care services so that better coordinated individual care plans can be developed to support their care across the continuum, with an emphasis on identifying and addressing psycho-social care needs. Health Links embraces a patient-centre approach with their participation and feedback occurring throughout, including:

- Governance – active members of Health Link Leadership Teams
- Business Planning – as part of Value Stream Mapping (VSM) events that document the current state and develop a plan for an improved future state
- Direct Patient Care and coordination - collaborative case conferencing, assessments and interviews)
- System-level learning – evaluation of the patient experience and their outcomes shared with LHIN planning structures for CDPM

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 2014/15.

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 2014/15 supporting our strategic objectives:

➤ Chronic Disease Prevention and Management:

- The ESC LHIN has established a number of formal planning groups for specific health care populations including: CHF, COPD, diabetes, stroke, prevention and smoking cessation. These groups involve a wide range of health services providers from the community and institutional sector, as well participation from clients and patients as an integral component. Current activities include advancement of patient flow care paths that also outline provider roles, responsibilities and accountabilities. These groups are currently working on advancing community capacity business cases for the CDPM system. Input will be actively sought from patients/clients, their families, physicians and the wider health care provider community in advancing these business cases and the decision making/approval – implementation process

➤ Health Links Implementation:

Continue to collaborate and engage health service providers, physicians, allied health care professionals, and others as identified to establish and implement Health Links across Erie St. Clair, including:

- Establish a Regional Health Link Steering Committee as a means to create a decision support structure for standardization, sharing of best practices, and streamlined engagement of regional partners and Health Link Leads, including Public Health and social service providers, and Connecting South West Ontario. This includes possible regional working groups to develop strategies and capacity system-wide
- Provide strategic and project management support to established Health Link partnerships in Chatham-Kent, South Essex (known as Essex County South Shore), Sarnia/Lambton, Lambton Shores/South Huron (known as the West Coast) to develop and/or implement Health Link business plans
- Develop the commitment of partners in Windsor/Essex to potentially launch two Health Links
- Continue to engage patients and family members across all aspects of Health Link planning and implementation

➤ Integrated Orthopaedic Capacity Plan:

- In Collaboration with the Steering Committee, support the continued implementation of the Integrated Orthopaedic Capacity Plan. During 2014/15, focus on the primary goal of implementing the new Novari referral and scheduling software across all ESC LHIN hospitals and into primary care. This will require various engagements with specialists and primary care physicians to introduce and provide training on the new tool, as well as support change management in maximizing its use among physicians

➤ Leadership Council:

Continue to engage governors and CEOs/EDs of ESC LHIN-funded health service providers and other key stakeholders, as a collective, through the Leadership Council. In 2014/15 the activities of the Leadership Council will include:

- Two tri-county face-to-face meetings per year (governors and CEOs/EDs) focused on system-level strategic topic
- Two governance webinars per year focused on topics identified by governors focus on increasing level of governance knowledge to enhance decision making skills and governance effectiveness
- Surveys conducted with governors on topics of relevance

➤ Leamington/South Essex Mental Health Services:

As a follow-up to the ESC LHIN's Mental Health Strategic Plan, and the subsequent stakeholder engagement that took place in the Leamington/South Essex, a change in service patterns are forecasted. The future LDMH vision for service delivery includes the implementation of a "hub & spoke" model of care in partnership with Windsor/Essex. This will include the establishment of a Psychiatry Out-Patient Clinic and community-based mental health and addictions services through partnerships with various regional providers. To enable this transition engagement with a working group of local providers will continue to meet and implement changes in 2014/15.

➤ Mental Health Network Collaboration:

As per the direction of the Mental Health Strategic Plan, the ESC LHIN will work with the Mental Health Networks of the Erie St. Clair region to support greater collaboration, standardization, and equity for access to consumer survivor and psycho-social rehabilitation services.

➤ Primary Care Council:

Continue to leverage the ESC LHIN PCC in implementing CDPM strategies, Health Links Strategy, and regional deployment of eHealth technologies slated for implementation in 2014/15. In creating a regional steering committee for Health Links, the PCC will be leveraged to provide expert advice in solidifying standardization of Health Link practices.

➤ Regional Transportation:

Engage with funded transportation providers on a regional level to build upon sub-LHIN collaboration and standardization with the goal of creating equity of access to transportation across the ESC LHIN geography. In doing so, the ESC LHIN will look to increase transportation efficiency and capacity, and explore other opportunities to leverage ESC LHIN-funded transportation providers to service at risk populations (e.g. out of region dialysis patients).

➤ Rehab Strategic Plan:

The current focus of the Rehabilitation Strategic Plan (in the shorter-term) is on the following priority populations: patients with stroke, orthopaedic conditions and geriatrics. Planning groups have been set up to examine each area and get input from consumers and health care providers on how to make improvements and advance a future care model that is more patient focused in order to improve patient outcomes and the overall quality of the patient experience. Consistent with the local work of the ESC LHIN, the province has initiated a number of working groups through their Rehabilitation Health Care Alliance – a specific emphasis has been placed on consumer/patient involvement, toward this end a consumer/patient network is now being established.

Priority Populations

➤ Aboriginal/First Nation:

Efforts to support better access to care for Aboriginal peoples and First Nation in 2014/15 will focus on urban populations in Windsor/Essex. Specifically, engagement stakeholders will look to bring aboriginal specific programs and services for people living with or at risk of developing chronic disease. Broad engagement with aboriginal communities in Erie St. Clair will also take place to enhance services ESC LHIN-wide. This will include collaboration with the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) to increase their presence and services to the ESC LHIN.

➤ Francophone:

The ESC LHIN created a French Language Services Providers Network to ensure continued engagement with providers, and improve collaboration between providers as they build their capacity to provide services in French, and work towards achieving designation under the FLS Act. At the same time, the ESC LHIN, in conjunction with the French Language Health Planning Entity, maintained its engagement with the Francophone community through various methods, such as community events, and focus group on addiction services.

➤ Newcomer/Immigrant Health:

The ESC LHIN is beginning in Windsor/Essex to build a bridge between settlements and healthcare. The goal of these engagements will be to augment existing programs for newcomer health to ensure that this at-risk population has equal access to timely and appropriate healthcare.