



Annual Business Plan

2015-2016

FINAL
December 3, 2015

Table of Contents

1	CONTEXT	1
1.1	Mandate and Strategic Directions of the Erie St. Clair Local Health Integration Network	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	27
2.4	Mental Health and Addictions	33
2.5	Rehabilitative Care System	40
2.6	Hospice Palliative Care	46
2.7	Aboriginal	52
2.8	French Language Services	58
3	ESC LHIN OPERATIONS AND STAFFING TEMPLATES	62
3.1	ESC LHIN Operations Spending Plan	62
3.2	ESC LHIN Staffing Plan	63
4	ESC LHIN ANNUAL BUSINESS PLAN INTEGRATED COMMUNICATIONS STRATEGY	64
4.1	Objectives	64
4.2	Context	65
4.3	Target Audiences	67
4.4	Strategic Approach	67
4.5	Key Messages	69
4.6	Evaluation and Monitoring	70
5	ESC LHIN ANNUAL COMMUNITY ENGAGEMENT PLAN	71
5.1	Introduction	71
5.2	Community Engagement Activities	72

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 nine years of activity, the ESC LHIN's perceptions and activities were shaped through the initial strategic directions of the IHSP 1, 2 and 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 nine 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
- New 256 LTC bed facility in Windsor/Essex (Schlegel Village – Aspen Lake Home)
- 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 the 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 2014 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 ESC LHIN priority. In general, hospitals with a higher percentage of complex Canadian Triage Acuity Scale (CTAS) 1 and 2 patients had a higher 90th percentile overall emergency department length of stay (LOS).

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. Chatham-Kent Health Alliance (CKHA) is a medium volume community hospital that has experienced the greatest percentage change in 90th percentile ED LOS.

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 ESC LHIN patient flow strategies (e.g. Home First Philosophy, Discharge Framework, Assess and Restore Framework, and various outreach and community support programs). In addition, the P4R program leverages the successes earned by other similar high-performing P4R sites, such as Bluewater Health (BWH) in Sarnia/Lambton. Recently, BWH has been recognized as one of the province's fifteen 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 an ESC 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 community engagement activities include the ESC LHIN Primary Care Roadshow, and continue to focus efforts on reducing avoidable ED visits, CDPM and avoidable hospitalizations for ESC LHIN residents.

➤ 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 among 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, however improvements have been made to 18.8% of all inpatient beds occupied by ALC patients contributing 7,166 ALC days at the end of December 2014 (ALC Summary Report- January 2015), the fifth highest in Ontario. In December 2014, ESC LHIN had the seventh highest percentage of patients designated ALC occupying acute care beds (17.4%). For post-acute care, ESC LHIN had the fourth highest percentage of beds being occupied by patients designated ALC (21.0%).

The ESC LHIN, in partnership with the ESC CCAC, has developed a regional ALC Performance Management Working Group commencing February 2014 as part of our ESC LHIN Patient Flow/ALC Action Plan. The working group continues to promote and support strategies across Erie St. Clair region to ensure persons are living in the most appropriate setting, optimize system capacity, and avoid and reduce duplication of integrating sectors. Areas of focus are post-acute care programming, transitional care planning for individuals waiting greater than 30 days for the most appropriate discharge destination, and complex needs of individuals requiring special needs and supports (e.g. acquired brain injury (ABI), neurological, behavioural, chronic mechanical ventilation). 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 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 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 ESC PCC, ensuring better access to ongoing primary care and the maintenance of chronic illnesses.

Building on the COPD approach, ESC LHIN staff 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 behaviours.

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 has engaged the wider health care community in order to advance specific community capacity business cases. Currently, all capacity considerations are on hold until the ESC LHIN funding opportunities/strategies are determined for 2015/16.

Starting in April/May, an education, communication strategy and detailed implementation plan will be advanced to support the roll-out of the COPD Care Path (and Logic Model) ESC LHIN-wide. The CDPM Physician Lead will be a key champion of this initiative. In each geography, structures (implementation working groups) and process will be put in place to support these directions. Identification of appropriate performance measures and target setting will also be completed as part of this initiative.

➤ Mental Health and Addictions (MH&A):

The population with MH&A disorders is recognized by the MOHLTC and the ESC LHIN as a strategic priority for targeted activities and investments over the next four years. Starting 2013/14 and through fiscal year 2015/16, the ESC LHIN has invested in a number of promising practices and investments designed to address key performance metrics, such as ED repeat visits, community wait times, capacity pressures and avoidable admissions. Promising practices and investment highlights include:

- The Bluewater Health Withdrawal Management Services currently operates on a mobile outreach and day program basis. Expansion to include withdrawal management beds and stabilization capacity is anticipated in 2015/16. This initiative is designed to reduce reliance on ED and in patient services.
- The Rapid Assessment Intervention Treatment Team (RAIT) in Chatham-Kent provides clinical outreach for clients with moderate MH&A conditions such as depression and anxiety. The clients are referred from existing primary care practices. This program has expanded its scope to reach a greater proportion of clients in the Sarnia/Lambton area. The focus is on preventing moderate conditions from increasing in acuity and supporting primary care practice clinical core competencies.
- The Second Stage Relapse Prevention Program has shifted from a pilot to a core addiction program based at Westover residential treatment facility. The program is available to clients who have received addiction treatment (residential or outpatient), and are self-identifying as being at risk for relapse. This program is unique and is now undergoing consideration as it relates to replication on a day or community outpatient capacity.

- The Fast Access to Community Experts (FACE) initiative has moved from a soft launch to becoming embedded in MH&A providers dedicated service delivery as per a one to two one-hour time slot held for scheduling. While this initiative is still in the early stages, providers have embraced the navigation and access mechanism as a foundation. For instance in fiscal year 2015/16, telephone crisis lines are being consolidated. Streamlining access and navigation are key enablers for reducing ED visits.
- The ESC LHIN and addiction providers have embarked on a strategic plan for the sector. Since April 2014, 31 engagement sessions have occurred. In addition to focus groups, 549 individuals responded to an electronic survey. Consistently, the themes demonstrate that the Erie St. Clair region does not have a full continuum of addiction services, and this is one of the reasons why residential treatment services are at capacity with wait times.
- The ESC LHIN has invested in additional housing and transitional supports for people with MH&A. Continued partnership work with the three municipalities is anticipated to result in greater MH&A supports for people living in affordable/geared-to-income housing.
- The Geriatric Mental Health Outreach Team and Behavioral Supports Ontario (BSO) local system requires a review and evaluation of strengths and identification of areas within the flow process that needs improvement. A formal review is anticipated in 2015.
- A concentrated focus on high-risk population groups such as acquired brain injury (ABI) or other neurological and MH&A conditions are required. For instance, there are a sub-population of high users of the system that are not a “good fit” with Health Links, nor can they be serviced by existing MH&A providers. Concurrently, access to specialized services in other regions is severely limited. With these factors in mind, a deeper analysis of local capacity and creative options is taking place.

The ESC LHIN's investments align well with the following five pillars and build upon the promising practices.

Pillar 1: Promote Resiliency and Well-Being in Ontarians

Pillar 2: Ensure Early Identification and Intervention

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

Pillar 4: Provide the Right Care, at the Right Time in the Right Place

Pillar 5: Funds Based on Need and Quality

The ESC LHIN, through the Mental Health & Addiction Network and Leadership Tables, are engaged in on-going discussions as it relates to monitoring and accounting for the status of the promising practices and new investments.

➤ 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 of rehabilitation patient populations (patients with stroke, orthopaedic conditions and geriatrics).

In the first two years, 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, have resulted in development of cross continuum care paths for hip fracture, stroke and frail/medically complex seniors. A predictive modeling exercise has informed system capacity planning for bedded levels of rehabilitative care in order to accommodate anticipated increasing service needs for the next five to ten years due to the aging population. These deliverables are expected to have positive effects on improving patient flow, reducing inpatient 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, an ESC LHIN-wide Rehabilitation Strategic Plan Implementation Committee has been working actively on these deliverables since January 2013. A comprehensive rehabilitation system scorecard has been developed and is being refined, to provide system evaluation to target improvement activities and celebrate successes.

➤ Hospice Palliative Care (HPC):

The ESC HPC Network and ESC LHIN continue to advance the Action Commitments as articulated in the provincial report: “Advancing High Quality, High Value Palliative Care in Ontario: Declaration of Partnership and Commitment to Action” (Declaration Document).

In February 2015, the ESC HPC Strategic Plan was released. This is the third formal strategic Plan for HPC for Erie St. Clair since the LHIN’s inception in 2006.

This Strategic Plan for HPC in Erie St. Clair builds on extensive previous work in Erie St. Clair region, and includes and align the many initiatives currently underway related to HPC provincially, regionally and locally.

The Erie St. Clair strategic priorities are:

1. Advocate for and facilitate creative planning and implementation of a full continuum of funded and volunteer services for HPC in Erie St. Clair.
2. Encourage each organization/provider to clarify and update its own internal HPC program elements and identify linkages to the system and community as a whole.
3. Promote cross-sector initiatives which advance a system perspective. Enhance knowledge transfer and exchange regarding best practice.
4. Continue to develop and implement creative models to maximize human resource expertise. Facilitate recruitment and training.

5. Strengthen regional accountabilities and regional enabling structures, clearly defining the role of the ESC HPC Network/Program aligned with the ESC LHIN and other regional partners.
6. Work with provincial partners to advance improvements in policy and education for HPC.

In addition to the six strategic priorities there are three overarching facilitating priorities:

1. Promote advance care planning (ACP) and health care consent (HCC) across the continuum in Erie St. Clair.
2. Build public awareness and community focus (including public health approach).
3. Advance best practices (including clinical and system best practices).

The ESC HPC Strategic Plan is focused and framed by the six provincial priorities and provincial implementation requirements.

Nearly 30 Strategic Initiatives, flowing from the strategic priorities, are identified within this plan.

Priority areas for regional investment are highlighted. These are:

- Regional Program for ACP and HCC
- Bereavement Services in Sarnia/Lambton and Chatham-Kent

Priority areas for further review include:

- How to implement community hubs as described in the provincial Residential Hospice Working Group Report,
- Review of Windsor/Essex Community HPC specialist level consultation (and alignment with Windsor Charter work),
- Sustainability Plan for ESC HPC Network/LHIN Leadership (including Clinical Infrastructure).

The process for implementation of these initiatives is through a shared accountability approach. As described in the Declaration Document, the ESC HPC Network, as delegated by the ESC LHIN, will provide a structure and mechanism to facilitate implementation and to monitor progress. This Network also connects and aligns the many regional and provincial initiatives. Provincial enabling activities will facilitate fulfillment of the ESC HPC Strategic Plan, in particular as it relates to: accountability agreements, clinical best practice and a provincially endorsed process for establishing regional palliative care patient registries. Evaluation is based on outcomes on provincially identified indicators, as well as regional measures.

Building on past excellence and leveraging current momentum, Erie St. Clair is well positioned to implement these priorities and recommendations. A number of these initiatives are already underway. Immediate action will be taken on the three priority areas for further review and the two priority areas for further investment. Current provincial and regional tactical enabling activities will facilitate implementation of all of regional priorities and initiatives.

➤ Aboriginal Health Care:

Concentrated support affecting Indigenous 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 patients' access to care, building relationships with communities, and health planning. The most notable accomplishments over the past twelve months include:

Improved Access to Care:

- Increased primary care access for First Nations and urban centres
- Expand provision of Indigenous Cultural Safety training for ESC LHIN staff, Board of Directors and health service providers (HSPs)
- Advance a strategy for traditional healing

Building Relationships:

- Re-engagement and development of a cultural model for the Erie St. Clair Local Indigenous Health Planning Committee (LIHPC) . This committee is instrumental in providing support and direction to ESC LHIN health strategies and initiatives
- Engagement with local First Nation and urban communities
- Facilitating relationships between ESC LHIN and First Nation Chief and Councils
- Establishing connections with the London District Chiefs Council
- Participation in the Provincial Indigenous Leads Network

Health Planning:

- Align local and provincial areas of focus with ESC LHIN departments and initiatives (i.e. CDPM and Mental Health and Addictions). In the advancement of these focus areas the LIHPC has established working groups for:
 - Cultural awareness/safety training and strategic planning
 - Community needs assessments and videos
 - Mental health and addictions
 - Data collection and utilization
- Hosting community engagement sessions with First Nation and urban communities

In 2015/16 a formalized engagement needs assessments will be completed with the First Nation and urban Indigenous communities to identify and develop strategies to address health disparities for First Nation, Inuit and Metis communities within the Erie St. Clair region for inclusion in the IHSP 4.

Through the needs assessments and identified strategic directions, the ESC LHIN will have better insight of where to make targeted investments to enhance and augment the Indigenous patient journey through the health care system. In aiming to improve the patient journey, a collaborative model of care will be created that recognizes and promotes cultural practices and traditions as essential elements to overall health and wellbeing and sets out to:

- Improve service integration, accountability and communications between First Nation health agencies, the ESC LHIN and mainstream HSPs across Erie St. Clair
- Improve leadership and interfaces between care settings (hospital, nurse practitioner, primary care, and specialists)
- Streamline coordination across service providers

The above undertakings support and advance the MOHLTC Patients First: Action Plan for Health Care aiming to:

- Improve access – providing faster access to the right care
- Connect services – delivering better coordinated and integrated care in the community
- Support people and patients – providing the education and information they need to make the right decisions about their health

➤ French Language Services (FLS)

The ESC LHIN will continue to engage and work in collaboration with the Erie St. Clair/South West French Language Health Planning Entity in order to ensure the best possible health outcomes for the Francophone population. Activities of both parties are either undertaken jointly or complement each other. A Joint Action Plan has been developed and is updated yearly and guides the development of FLS.

During the next twelve months, the focus will remain on four key goals, and activities will aim to address these.

- To ensure French language service capacity for key service functions (case management, counselling, crisis response, treatment, tier/bedded capacity, maintenance, family services, and support)
- To enhance and/or build on services for the management and prevention of chronic diseases, in person or through OTN
- To help seniors reach and maintain the greatest level of independence, no matter where the person lives
- To enhance French language services capacity across the system

After the French Language Services Toolkit in 2013, two other instrumental initiatives will be undertaken in 2015/16. The first initiative will see the start of an inventory of French-speaking health professionals in the Erie St. Clair region, in order to better understand the capacity to provide FLS. The second initiative will focus on the development of training material and tools on linguistic and cultural competence, as it relates to the Francophone population in the context of healthcare.

Engagement with the Francophone community will also be key in 2015-2016 as the ESC LHIN develops its 2016-2019 IHSP and directions for the development of FLS in the coming years will be validated by the community. The remainder of the activities will continue to focus on building services in French and responding to the needs of the Francophone community.

➤ 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 “Patient’s First: Action Plan for Health Care” (February 2015):

1. Improve access – providing faster access to the right care
2. Connect services – delivering better coordinated and integrated care in the community
3. Support people and patients – providing education, information and transparency they need to make the right decisions about their health
4. Protect our universal public health – making decisions based on value and quality, to sustain the system for generations to come

In the coming year(s), as we continue to build on previous successes and the efforts already underway, including the IHSP 3. ESC LHIN will focus on:

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)
7. Aboriginal Health Care
8. French Language Services

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 to 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%.

Based on the Inclusive Definition of Francophones adopted by the government of Ontario, Francophones represents 3.6% of the population of the ESC LHIN, which is slightly lower than for the province as a whole. The Francophone population is also much older than the general population: seniors represent 32% of this group, in comparison to 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. However, immigration is steadily increasing.

The proportion of the population identifying itself as Aboriginal in the Erie St. Clair region 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.

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 WRH and HDGH. 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 29.5 hours for high acuity admitted length of stay (LOS) at 24.8 hours. Erie St. Clair remains an 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 through-put within the ED. The largest potential for improved gains will be by concentrating our Pay for Results (P4R) resources within the hospital, led by the team that is most accountable for the "time to inpatient bed and ED admitted LOS metrics" as well as Physician Initial Assessment. 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 2013/14. 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: (Data reflective of fiscal year (FY2013/14)) • Opportunities are seen to improve ED LOS for admitted patients, time to inpatient bed, physician initial assessment and patient flow in all sites. ESC LHIN continues to experience alternate level of care (ALC) pressures. The ESC LHIN Q2 2014/15, percentage of ALC days was 23.2%, 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 (e.g. 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, acquired brain injury (ABI), mental health (MH), 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 the 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 24.8 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 4.0 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 FY2013/14, 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, Rehabilitation Network Goals, Special Needs and Supports)
- Reduction in avoidable re-hospitalization for key diagnosis with Quality Based Procedures (QBPs) and utilization of predictive tools such as length of stay/acute admission thru ED/comorbidities/Ed visits in past six months (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 long-term care homes (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 e.g. Convalescent Care Programs and Assisted Living/Supportive Housing aligned with the Rehabilitative Care Alliance (RCA), and ESC Community Care Access Centre (CCAC) programs for high and very high method of assigning priority levels (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):

ED Overall Goals:

- Improve core discharge planning/policies and transition processes from hospital to community through standardization and role clarity
- Implement Resource Matching and Referral standards
- Initiate an early-warning, high-risk identification process for potential repeat ED high users through Health Links
- Development of an Influenza Surge Plan across region
- 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
 - Nurse Led Outreach Team (NLOT)
 - Outreach Programs
 - CDPM Plan
 - ESC CCAC
 - Geriatric Emergency Medicine (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 hospice palliative care (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 ABI special needs requirements
- Individuals with multiple chronic diseases
- MH&A 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 an 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		
	2015-16	2016-17	2017-18
Expand the ED hours of NP/PA coverage for treat and release patients	80%	90%	100%
Develop a referral process and primary care path for COPD/CHF initiated by the ED and ESC CCAC	80%	90%	100%
Continue and expand P4R and Process Improvement Program (PIP) strategies to reduce wait times in the ED	50%	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%	90%	100%
Explore opportunities related to a predictive bed capacity rehabilitation model approach within Erie St. Clair to support patient flow and efficiencies for acute and post-acute patients	40%	80%	100%
Support health promotion best practices related to influenza prevention and regional surge protocols practices in acute care and LTC sectors diseases	40%	80%	100%
Develop strategies to support improved admission and discharge policies and processes to enhance smooth transitions of care	60%	80%	100%
Develop strategies to support mental health and addiction health service provision	50%	80%	100%
Develop improved communications, customer service and patient satisfaction strategies for patients waiting in the ED	60%	80%	100%
Explore opportunities to support ED diversion strategies with HSPs (EMS, primary care, ESC CCAC, Expansion of NLOT Teams regionally) with LTCHs in the Erie St. Clair region	30%	60%	100%
Review ED physician recruitment and retention strategies and coverage for Erie St. Clair region	40%	80%	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 ED 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?

- Access to primary care
- Continued challenges experienced by ALC and high needs populations (behavioural, ABI, chronic ventilation needs)
- Continued higher than provincial rates of chronic conditions (e.g. arthritis, asthma, diabetes, hypertension, mood disorder, anxiety disorder) driving up ED visits

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

- Aligning and engaging ESC Primary Care Council (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 the acute phase of illness has been managed, and an ALC would better serve their ongoing needs in recovery, 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; representing an accurate account of total ALC days and total patient days for both open and closed cases in a given month, as a result, providing an accurate picture of ALC performance that can be trended over time. In March 2014, the 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 January 31, 2015, there were 217 patients designated ALC on the waitlist in acute and post-acute care settings. This translates to 106 (33%) fewer patients on the waitlist compared to January 31, 2014. Specifically, there were 31% fewer patients waiting in acute care beds, 32% fewer patients waiting in complex continuing care (CCC) beds, 13% fewer patients waiting in mental health (MH) beds, and 69% fewer patients waiting in rehab beds (RB) (January 2015 vs. January 2014). The highest number of patients designated ALC on the waitlist since July 2011 was on April 30, 2013 (375). Currently, 51% of patients designated ALC are waiting in acute care and 49% are in post-acute care (CCC: 44%, MH: 3%, RB: 2%). In December 2014, patients designated ALC were occupying 18.8% of inpatient beds in ESC LHIN, which is 3.6% less than December 2013. By inpatient service, patients designated ALC were occupying approximately 17.4% of acute care beds, 35.1% of CCC beds, 5.7% of MH beds, and 9.2% of RB in December 2014. A reduction was seen in CCC beds (18.8%) for December 2014 vs. December 2013. In December 2014, ESC LHIN had the fifth highest (18.8%) ALC rate in the province and had contributed 0.8% to the provincial ALC rate. The highest ALC rate since July 2011 was 27.4% in March 2013 (data not shown). As of January 31, 2015, 36% of patients designated ALC waiting in acute care beds were waiting for home services with ESC CCAC, 15% for CCC, and 13% for RB; 15 (60%) more patients were waiting for home services with ESC CCAC compared to January 31, 2014. In addition, 21 (57%) fewer patients were waiting for CCC. As of January 31, 2015, 59% of patients designated ALC waiting in post-acute care beds were waiting for home services with ESC CCAC, 21% for LTC, and 8% for supervised or assisted living; 25 (66%) more patients were waiting for home services with ESC CCAC compared to January 31, 2014. In addition, 73 (76%) fewer patients were waiting for LTC.	

TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN
PRIORITY: Alternate Level of Care

IHSP Priority Description: cont'd

As of January 31, 2015, there were 217 patients designated ALC on the waitlist. These patients have accumulated 16,711 ALC days. This translates to 21,115 fewer ALC days (56%) compared to January 31, 2014. Specifically, 2,760 (17%, 110 patients) ALC days were spent waiting in acute care and 13,951 (83%, 107 patients) ALC days were spent waiting in post-acute care. In acute care, 34% of total ALC days were spent waiting for home services with ESC CCAC, 23% for CCC and 22% for LTC. In post-acute care, 39% of total ALC days were spent waiting for LTC, 31% for home services with ESC CCAC and 10% for supervised or assisted living. In January 2015, Bluewater Health (BWH) had contributed the highest percentage of ESC LHIN total ALC days (45%), followed by Hôtel-Dieu Grace Healthcare (HDGH) (33%) and Windsor Regional (WRH) (14%). By facility, WRH had the highest number of patients designated ALC on the waitlist, followed by BWH. Comparing January 2015 vs. January 2014, there were five (100%) more patients on the waitlist for St. Josephs Healthcare, and 12 (100%) fewer patients on the waitlist for Sydenham.

In December 2014, the ESC LHIN had the seventh highest percentage of patients designated ALC occupying acute care beds (17.4%). For post-acute care, the ESC LHIN had the fourth highest percentage of beds being occupied by patients designated ALC (21.0%). WRH had the highest percentage of acute care beds occupied by patients designated ALC (21.1%), followed by Leamington (LDMH) (19.2%). BWH had the highest percentage of CCC beds occupied by patients designated ALC (67.2%), followed by St. Josephs Healthcare (21.4%). HDGH had the highest percentage of MH beds occupied by patients designated ALC (8.3%), followed by WRH (5.7%). BWH had the highest percentage of RB occupied by patients designated ALC (13.2%), followed by WRH (10.8%).

**TEMPLATE A:
PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN
PRIORITY: Alternate Level of Care**

Current Status:

ALC Planning Objectives Considered

- Improved outcomes for ALC patients through dissemination and integration of evidence-based practice across the continuum of care for selected diagnoses, improved transitions of care, discharge processes, case management, coordinated access and follow-up for selected diagnoses
- Increased community and provider knowledge of hospital access implications and impact of ALC patients on emergent care processes
- Enhance restorative programming to reduce hospital acquired functional decline and support transitional care
- Reduce hospital utilization incidence rate for identified high-risk users
- Reduce hospital and inappropriate ESC CCAC utilization target high-needs individuals
- Avoidable admissions and re-admissions on selected case mix groups (CMGs) who become ALC
- Implementation of Ontario's Seniors Strategy, specifically the MOHLTC Assess and Restore Guideline and Senior Friendly Hospital initiatives
- 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 (EOLC))
- Improved time to LTCH placement for hospital inpatients and community
- Improve time to admission from acute to all levels of post-acute rehabilitative care
- Provide restorative options for individuals aligned to the Rehabilitation Alliance Decision Tree – Align bedded rehabilitative care programs in the ESC LHIN to the Rehabilitative Care Alliance (RCA) Definitions Framework for Bedded Levels of Rehabilitative Care
- Align bedded rehabilitative care programs in the ESC LHIN to the RCA Definitions Framework for Bedded Levels of Rehabilitative Care
- 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
- Determine next steps for the predictive bed capacity model for frail geriatric seniors population
- Define next steps to ensure adequate bedded capacity as demonstrated by the ESC LHIN Rehabilitative Care System Capacity Planning Report
- Improve time to admission from acute to all levels of post-acute rehabilitative care
- Expand the role and capacity of outpatient rehabilitative care resources – to avoid admission to bedded levels of care and support earlier discharge

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

Goal(s):

ALC Overall Goals:

- 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
- 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 and timely care transitions within an integrated system of care
- Standardized cross continuum care paths
- Incorporate focus on self-management within patient/client capabilities
- Identification of earliest rehabilitation opportunities to restore functioning and reduce LOS across the care continuum
- Alignment with the provincial RCA strategic directions and deliverables
- Integrate Assess and Restore philosophy with primary focus of care within rehabilitative level of care – develop a Geriatric Care Path for ESC LHIN in alignment with the MOHLTC Assess and Restore Guideline released in Dec 2014
- Facilitate appropriate use of post-acute care options (rehab, mental health, CCC, convalescent care, supportive housing, assisted living)
- Implement a regional approach to NLOT for LTCHs
- Identify high needs population contributing to long waiter ALC volume
- Ensure adequate access to outpatient and community rehabilitation services
- Implement strategies within the Assess and Restore Framework
- Increase assisted-living capacity/beds ESC LHIN-wide
- Continue to implement ESC LHIN-wide falls prevention initiative
- 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 AUA, 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- ABI, MH, Neurological, Behavioral

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		
	2015-16	2016-17	2017-18
Develop and increase capacity for restorative care/transitional care programs (e.g. convalescent care programming ESC LHIN-wide, and implementation of a cross-continuum Assess and Restore philosophy through the work of the ESC LHIN Rehabilitation Network, and RCA)	40%	80%	100%
Continue to refine ALC Performance Management Working Group to monitor key priorities for improved patient flow, ED wait times, efficiencies, and accountabilities	50%	90%	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	50%	80%	100%
Expand NP outreach program, behavioral supports, psycho-geriatric fostering – to cover nursing homes (with a goal of preventing ED visits and enhanced community services)	50%	80%	100%
Assess and Restore Framework across the Erie St. Clair region	20%	60%	100%
Implementation of ALC Resource Matching and Referral (RM&R) Standardization	30%	70%	100%
Explore redesign of complex discharge review process across the Erie St. Clair region for long and exceedingly long waiters	40%	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 (Community Geriatric Rehabilitation Team)	30%	60%	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%
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 (Geriatric Care Pathway)	20%	40%	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
- Reduce the need for hospital acute services (inpatient discharges) within the next three years to meet the provincial discharge rate of 100%- from 500 to 350 acute patient days
- Increase community patient days to 150
- 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 throughput ratio at or above provincial target (e.g. greater than one)
- Five percent reduction 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
- Accurate ALC Data Analysis by site
- Variance of ALC reporting , monitoring and complex discharge review
- Timely uptake on best practices in discharge planning
- Growing elderly (aging) population with higher acuity needs and chronic disease
- Challenges in quantifying proportions of older adults in acute care and community who might benefit from rehabilitative care and do not currently access these services (complexity of comorbidities, ICD-10 codes, etc.)
- Rehabilitation Capacity
- Behavioural/ABI populations
- 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 resident assessment instrument (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, geriatric conditions, EOLC, best practices, advanced care planning (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
- Resource Matching and Referral (RM&R)
- Provincial Rehabilitation Alliance Framework
- Assess and Restore Framework
- Implementation of QBPs for specific conditions
- Improving capacity in post-acute and community services
- Health Links
- Appropriate allocation or redistribution of resources to adequately support equitable access and health service models for high risk populations and seniors (Health Links, MH&A, chronic vent strategy and rehabilitation)
- Explore and develop primary care access opportunities in prevention and self-management for CDPM, mental health and addictions (MH&A) 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 early patient (general population) education and self-management programming and tools • Need for better lifestyle choices including awareness of risk factors (smoking, poor nutrition, lack of exercise and alcohol consumption) • Need for timely access to primary care and ongoing coordinated community supports <u>CDPM Planning Objectives Considered</u> • Simplified access to care (single point of access/centralized intake) • Standard assessment and discharge processes • Better management of care 'transition' points on the patient's care path • Improved patient flow across the care continuum (right place at the right time) • More shared – collaborative care • Better uptake on best practices (evidenced based care models) • Clear agreed-upon roles and accountabilities for all health service providers • Expanded 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/vascular diseases, and heart disease.

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

- A need for improved information technology to monitor and track patient care results and ensure ongoing uptake of best practices
- A need to reduce variation in care provision across the provider system (more standardization in processes and practice)
- A need for improved case management of long-term conditions (including follow-up)
- A lack of patient education and self-management programming
- A need for more timely access to primary care
- A need for a better rural transportation network
- Cost, especially for the working poor who cannot afford medications
- Lack of education programming to aid people to make better lifestyle choices
- Higher obesity rates in children
- Higher smoking rates
- Generally, a need to enhance community capacity and capabilities, thus ensuring risk mitigation and patient safety within community care programs vs. hospitalization

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

Goal(s):

CDPM Overall Goals:

General:

- To improve CDPM population health
- To provide better care for individuals who have a chronic illness/condition
- To achieve a lower per capita cost for service provision to this population

Specific:

- Improve the short-term integration and/or coordination of service delivery in the CDPM sector through better defined care roles and accountabilities
- Develop and implement ESC LHIN-wide standardized care paths (based on best practices) ESC LHIN-wide
- Initiate a 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
- Identify priority areas for future community enhancement through the engagement process
- 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
- Newcomers (immigrants) to the area with a chronic disease and co-morbidities
- Francophone seniors with a chronic disease and co-morbidities
- Longer term palliative patients who are experiencing chronic conditions

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		
	2015-16	2016-17	2017-18
Establish a COPD Integrated Care Path starting in Sarnia/Lambton and expanding ESC LHIN-wide by 2016	80%	100%	-
Establish care paths for CHF, stroke and diabetes starting in Windsor/Essex and expanding ESC LHIN-wide by 2017	60%	100%	-
Improve overall system accountability and reporting by implementing an Electronic Assessment Tool for COPD in Chatham-Kent and expanding ESC LHIN-wide by 2016	80%	100%	-
Advance protocols and clear accountabilities to manage COPD care transition points on the care paths	100%	-	-
Advance a crisis management – after hours strategy model of care and reflect this element on all CDPM care paths	100%	-	-
Improve linkages with primary care through the care paths	50%	100%	-
Advance performance measures and targets for all priority areas by 2016 (COPD, diabetes and CHF)	70%	100%	-
Develop an overall prevention strategy and care paths for the chronic disease population in Erie St Clair (starting in Windsor/Essex by 2016)	80%	100%	-
Develop a smoking cessation care paths for Chatham-Kent by 2015 expanding ESC LHIN-wide by 2016	60%	100%	-
Develop an ED/hospital standardized discharge tool kit for COPD and CHF (for Windsor/Essex by 2015)	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)	60%	100%	-
Develop CDPM community capacity business cases aligned with best practice requirements	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 and targets* will be initiated (and tracked) once the care paths have been approved and implemented (for a specific geographic region). These gains may not be realized in full initially as appropriate CDPM future system 'community capacity' supports need to be addressed.

- 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 paths

**targets subject to adjustment as implementation occurs*

What are the Risks / Barriers to Successful Implementation?

- Inability to quantify accountability measures in the health care system
- People not adopting better lifestyle choices
- 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 measure the 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
- Challenges of current system to effectively implement best practices

**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 paths 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 paths 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 and implement 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 from hospital and other critical primary care support components needed at time of discharge up to 14 days post discharge
- As part of the integrated care paths, 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 – tie this to 2015/16 funding strategy

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 – tied directly to 2015/16 funding strategy
- 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: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY PRIORITY: Mental Health and Addictions
Integrated Health Services Priority:
Mental Health and Addictions (MH&A)
IHSP Priority Description:
In the Erie St. Clair region, local MH&A planning is guided by the vision of “an integrated continuum of person-centered and accountable services” with recognition of the need for supportive communities that are respectful, helpful and inclusive. This vision has served as an overarching guide for MH&A strategic planning during the past 18 months. The prevalence of mental health/addiction disorders in ESC LHIN is 18.2% or 118,667 people, which is higher than the provincial average of 16%. One measure of how the system is performing is captured in the indicator repeat ED visits within 30 days. In fiscal year 2013/14, the Erie St. Clair region was the best performer in the province, ranking first, for repeat visits for substance abuse and now ranks third highest. The number of patients revisiting the ED has also increased from Q2 2013/14 by 28.2% (from 142 visits to 182 visits). During the 2014/15 time frame, the trending is starting to increase with notable changes from alcohol use reducing to more complex, poly substance use. Similarly, in 2013/14, the Erie St. Clair region ranked 11th in the province for repeat ED visits for MH conditions. We have reduced visits by 14.2%, which translates into a reduction of 259 visits. In 2014/15, gains have been made and the ESC LHIN now ranks third highest. Despite the above progress the greatest opportunity to maintain and impact the repeat ED metric overall is noted for the Windsor-Essex area. Diagnostic changes were recently noted from neurosis stress-related conditions to the more serious psychosis and mood disorders presenting more frequently as a repeat visit.

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

Current Status

The population with MH&A disorders is recognized by the MOHLTC and the ESC LHIN as a strategic priority for targeted activities and investments over the next four years. Since 2013, the ESC LHIN has invested in a number of promising practices and investments designed to address key performance metrics including:

- The Bluewater Health Withdrawal Management Services currently this service operates on a mobile outreach and day program basis. Expansion to include withdrawal management beds and stabilization capacity is anticipated in 2015/16. This initiative is designed to reduce reliance on ED and in patient services.
- The Rapid Assessment Intervention Treatment Team (RAIT) in Chatham-Kent provides clinical outreach for clients with moderate MH&A conditions such as depression and anxiety. The clients are referred from existing primary care practices. This program is expanding its scope to reach a greater proportion of clients in the Sarnia-Lambton area. The focus is preventing moderate conditions from increasing in acuity and supporting primary care practices clinical core competencies.
- The Second Stage Relapse Prevention Program has shifted from a pilot to a core addiction program based at Westover residential treatment facility. The program is available to clients who have received addiction treatment (residential or outpatient), and are self-identifying as being at risk for relapse. This program is unique and is now undergoing consideration as it relates to replication on a day or community outpatient capacity.
- The Fast Access to Community Experts (FACE) initiative has moved from a soft launch to becoming embedded in mental health and addiction providers dedicated service delivery as per one to two one hour time slots held for scheduling. While this initiative is still in the early stages providers have embraced the navigation and access mechanism as a foundation. For instance, the in fiscal year 2014/15, telephone crisis lines are being consolidated. Streamlining access and navigation are key enablers for reducing ED visits.
- The ESC LHIN and Addiction providers have embarked on a strategic plan for the sector. Since April 2014, 31 engagement sessions have occurred. In addition to focus groups, 549 individuals responded to an electronic survey. Consistently the themes demonstrate that the region does not have a full continuum of addiction services, and this is one of the reasons why residential treatment services are at capacity with wait times.
- The ESC LHIN has invested in additional housing and transitional supports for people with MH&A. Continued partnership work with the three municipalities is anticipated to result in greater MH&A supports for people living in affordable/geared to income housing.
- The Geriatric Mental Health Outreach Team and Behavioral Supports Ontario local system requires a review and evaluation of strengths, and identification of areas within the flow process that needs improvement. A formal review is anticipated in 2015.
- A concentrated focus on high risk population groups such as ABI or other neurological and MH&A is required. For instance, there is a sub-population of high users of the system that are not a “good fit” with Health Links, nor can they be serviced by existing MH&A providers. Concurrently, access to specialized services in other regions is severely limited. With these factors in mind, a deeper analysis of local capacity and creative options is taking place.

TEMPLATE A: PART 2: GOALS and ACTION PLAN Mental Health and Addictions (cont'd)
Goal(s):
• Reduce addiction wait times and ED visits by redesigning the front end of the addiction system focusing first on creating a centralized assessment and referral service. This service would consolidate all addiction service wait lists as well as provide a navigation function. Increase community treatment capacity and options including flexible service hours. • Complete the back office integration for MH peer support agencies. • Increase community based counselling capacity as a core service. • Conduct a current state analysis comparing MH&A resources compared to other LHINs and the province. Analysis to aid in strategic investments. • Review and evaluate the current service delivery model for older adults with responsive behaviors and geriatric MH system. • Improve and/or maintain current ED repeat visit performance ranking. • Improve and increase housing options, supports within housing and transitional care options. • Address service disparity for police/MH services. Develop a Crisis Outreach and Support Team (COAST) or HELP model for Sarnia/Lambton. • Improve transitional points to be seamless and reduce duplication through vertical integration. • Build upon transitional aged youth investments to ensure that care paths are clear, inclusive and roles clearly defined through a Memorandum of Understanding (MOU) Service Agreement among care providers. • Develop community and bedded strategies to address high-risk, high-cost, complex ABI, dual diagnosis, MH, addictions and/or concurrent disordered clients. • Complete capacity improvement review for eating disorders services in Windsor/Essex and address the disparities in Chatham-Kent and Sarnia/Lambton. • Monitor and report quarterly as a score card on all community funded MH&A initiatives as per clinical outcomes, costs, and satisfaction and system impact as a return on investment accountability mechanism.
Consistency with Government Priorities:
In January 2015, the 14 LHINs were required to report on intended investments as they aligned to the MOHLTC's pillar framework and to inform the Provincial MH&A Leadership Advisory Council. As a result, in the 2014/15 community investment allocation, each LHIN was provided with \$2M dedicated to the MH&A sector for the FY2014/15 and additional allocations specific to the FY2015/16. In which the ESC LHIN's 2015/16 MH&A dedicated allocation was \$3.2M. The ESC LHIN's investments align well with the pillars and build upon prior investments. At a high level the new investments are clustered under the respective pillar: <u>Pillar 1: Promote Resiliency and Well-Being in Ontarians:</u> • Mental Health Literacy is an evidence based program increasing awareness of healthy mindfulness as well as focusing on reducing stigma about mental illness, signs and symptoms. • Aboriginal Wellness Nursing Program Phase One: Promotion of a wellness lens for MH clients receiving long acting injections, metabolic monitoring and wellness checks. • Transitional Aged Youth Crisis – Community Capacity. In partnership with Maternal, Child and Youth Services (MCYS) MH providers after-hour, walk-in services will be streamlined and based on best practices.

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

Consistency with Government Priorities:

Pillar 2: Ensure Early Identification and Intervention:

- Early Intervention, First Episode Psychosis Expansion/Headspace: Building upon the foundation of the Early Intervention Multi-Disciplinary Team structure, reach out to transitional aged youth who are complex and deemed high risk, but not yet experiencing a psychosis.
- Rapid Assessment Intervention Treatment Team Phase 2: Phase 2 builds upon the team and scope to reach primary care providers in the Sarnia/Lambton community.
- Enhanced Access to Psychiatry Supports for Concurrent Disorders: Increased access to psychiatry has resulted in ED diversion for residential treatment clients.
- Relapse Prevention Second Stage Recovery: One week intense addiction treatment for clients who are at risk for relapse.

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

- Mobile Police/Mental Health Response Unit (COAST): Supports MH justice diversions for the county of Essex.
- Release from Custody/Community Treatment Orders Capacity Pressures: Address capacity pressures.
- Addicted Pregnant Women/Transitional Housing: Continue to support the needs of pregnant addicted women/addicted women with young children who are transitioning from recovery to a safe environment.
- Back Office Peer Support Initiative: Support the promotion of greater autonomy for the consumer survivor/family initiatives.

Pillar 4: Provide the Right Care, at the Right Time in the Right Place:

- Wellness Nursing: Provides wellness nursing lens for high-risk, complex MH clients that are part of Assertive Community Treatment (ACT), Intensive Case Management and Wellness for Extended Psychosis.
- Young Adults Addiction Program: Transitional aged youth are increasingly accessing an addiction day program and residential (16+) treatment.
- Addiction Program for Homeless Men: Homeless men who have addiction issues will be able to access harm reduction treatment services in the shelter.

Pillar 5: Funds Based on Need and Quality:

- Capacity Pressures and one-time needs.

TEMPLATE: PART 2: GOALS and ACTION PLANS Mental Health and Addictions (cont'd)			
Action Plans/Interventions:	% Completion by Year		
	2015-16	2016-17	2017-18
Mental Health			
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	50%	100%	-
Implement and Monitor FACE initiative	80%	100%	-
Implement and evaluate psychiatric sessional funding. Adjust sessional funding as volumes dictate.	80%	100%	-
Implement the Mental Health Strategic Plan	100%	-	-
Continue to advance the 'Integrated Assessment Record' ESC LHIN-wide – including ED Psych Screener	80%	100%	-
Review the Eating Disorders Integrated Care Team and evaluate model for replication in other communities	50%	100%	-
Implement and monitor impact of promising practices as it relates to ED repeat visits and community service volumes	90%	100%	-
Implement and monitor MH investments as it relates to return on investment indicators	80%	100%	-
Evaluate Restructured MH&A Network and Leadership Tables for effectiveness and strategic intent	80%	100%	-
Review and adjust MH cost centres to align with actual service delivery	80%	100%	-
Develop a strategic community plan to address high needs, complex ABI/MH/neurological client's long-term needs.	50%	100%	-
Monitor housing investments	30%	60%	100%

TEMPLATE: PART 2: GOALS and ACTION PLANS Mental Health and Addictions (cont'd)			
Addictions	2015/16	2016/17	2017/18
Implement Phase One of the addiction plan: redesign assessment and referral, navigation and address community capacity needs for treatment options	60%	100%	-
Monitor housing investments	80%	100%	-
Implement and monitor addiction investments as it relates to return on investment indicators and the Addiction Strategic Plan	30%	50%	100%
Implement and monitor second stage relapse prevention model for ESC LHIN-wide replication	80%	100%	-
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	50%	100%	-
Implement and evaluate psychiatric sessional funding. Adjust sessional funding as volumes dictate	25%	50%	100%
Decrease drop-out rate from addiction programs/increase treatment readiness and satisfaction	25%	50%	100%
Implement monitoring mechanism for neonatal abstinence syndrome (NAS) babies and implement Caring Connections Strategically	25%	50%	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 partnerships and vertical integration opportunities. - Develop strategies to address high-risk population groups such as ABI/addictions, - Increased utilization of community-based addiction services, decreased use of residential – right client served by the right provider - Decreased ED repeat visits and admissions to in-patient services - Greater accountability - Decreased drop-out rate (residential treatment) – Increased “treatment readiness” - Increased knowledge reported by the public of where to go for help (centralized assessment and referral) - Increased appropriate assessment and referral - One centralized wait list for addiction services - Right service reporting the right numbers in the right cost centre - Higher satisfaction rates reported by MH&A clients			

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

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 counselling or day program treatment models
- Increased public awareness about the FACE Model may increase the need for targeted investments in MH&A services
- Shared Care Models may result in greater number of people with moderate MH&A issues coming forward requiring additional, new services and investments along with identification of core services
- Psychiatry and specialized MH&A human resources may not be able to keep up (e.g. demand exceeding supply)
- Restrictions to implement programs in terms of capital resources that are required.
- 'Not in my back yard' (NIMBY) as it relates to housing

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

- Phase 1 of the Addiction Strategic Plan will increase the capacity and the scope for community based counselling and treatment models
- Phase 1 also streamlines access into the addiction system including the development of withdrawal management protocols for all counties
- To date, the capacity within the FACE Model has been sufficient. Surge needs are anticipated to flow to community based crisis
- The RAIT Team has managed MH&A clients within a 72 hour turnaround time. Expansion is planned for Sarnia/Lambton
- Whenever possible, we will utilize local resources. When needed, telemedicine/telepsychiatry will be utilized
- Anticipated changes to the capital process are pending further information from the MOHLTC
- Extensive engagement with communities will occur with the implementation of any MH&A housing

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

- Telemedicine
- OTN equipment
- Community engagement
- Cross training of MH&A resources
- Implementation and funding of the Addiction Strategic Plan

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 care provided to address needs of patients following acute illness or injury, health and functional changes resulting from chronic disease, disability, or a degenerative condition. The goal of rehabilitative care is to restore patients/clients to the highest level of independence, activity and participation, adapt to a new level of functioning, and maintain their independence. Rehabilitation may occur in one care setting, or through a series of coordinated transitions across a variety of care settings in the health care system, including homes, schools, workplaces, community based locations, LTCHs, and hospitals. Care may be 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, Physiatrists, and Geriatricians. Ideally, the goal of every rehabilitative patient/client is to return home or to an assisted living setting. Increasing need for rehabilitative care system capacity is anticipated for the next 10-20 years and forward due to population aging and the growing burden of chronic disease 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 prioritized goals to 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 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 access, recovery and outcomes • Standardized cross continuum care paths • Equitable, timely access to care for urban and rural residents • Smooth and timely care transitions within an integrated system of care • Focus on prevention and risk reduction • Incorporate focus on self-management within patient/client capabilities • Appropriate allocation of resources with creative and flexible funding models • Identification of earliest rehabilitation opportunities to restore function and reduce LOS across the care continuum • Alignment with the provincial Rehabilitative Care Alliance (RCA) strategic directions and deliverables

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

Current Status:

A comprehensive ESC LHIN Rehabilitative Care System report card and key performance indicators are now in place, providing up-to-date and ongoing data to identify opportunities for improvement and recognizing success. The report card is being reviewed against a draft provincial Rehabilitative Care System Evaluation Framework developed by the provincial RCA.

While best practice care approaches are well established and documented for the top three priority rehabilitative care populations, implementation across the ESC LHIN has been variable. Significant progress has been made through the development of standardized, cross continuum care paths for the priority patient populations of hip fracture and stroke (and a draft Geriatric Care Path is under development). Additional care paths for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and diabetes will have implications for rehabilitative care capacity. Gap analyses have highlighted areas of practice variation (and needs), which impact the ability to fully implement these care paths.

While some improvement has been made, timely access to inpatient rehabilitative care within targets continues to be an issue, contributing to acute and post-acute care ALC days and delays in recovery for patients. A predictive model for evaluation of Rehabilitative Care System capacity has been developed, and an initial assessment of bedded capacity gaps in Erie St. Clair region has been completed. This model also highlights opportunities to begin alignment of regional bedded resources to the recently approved provincial RCA Definitions Framework for Bedded Levels of Rehabilitative Care, and to implement the mandated MOHLTC Open Access initiative and Provincial Referral Standards.

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/avoidance of acute hospitalization. Evidence indicated that some patients are disproportionately admitted to CCC or LTC, where availability of rehabilitative care services is limited, while others are admitted for care in a bedded program when their goals might have been able to be realized through service in the home/community setting.

Older adults and those with medically complex needs form 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. Finalizing the Geriatric Care Path in conjunction with Senior Friendly Hospital initiatives are key objectives toward expanding capacity and enhanced service delivery to this population in Erie St. Clair region. The funding received under the MOHLTC Assess and Restore Guideline will assist with increasing knowledge in various healthcare disciplines through evaluation of learning needs, and developing a model for education on identification and management of geriatric syndromes.

As noted, the provincial RCA has completed a number of key deliverables in the past two years, which will further facilitate standardization of rehabilitative care program definitions, evaluation of system capacity and performance, and implementation of the Ministry of Health Assess and Restore Guideline in Erie St. Clair. With an extended two year mandate now approved for the RCA, the focus will be on implementation of these key deliverables in the Erie St. Clair region.

**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 utilization of inpatient rehab beds Ensure adequate access to funded outpatient and community-based rehabilitation services
Theme 2: Supporting Prevention, Activation and Self-Management	Develop an ESC LHIN-wide seniors falls prevention strategy, in collaboration with the ESC LHIN Fall Prevention Network Expand rehabilitation for the complex inpatient population – leveraging existing Activation/Ambulation Programs into a standardized Seniors Mobile Assess and Restore Team (SMART) philosophy 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, marketing, participation in research and scientific conferences Develop regional centres of excellence for the top clinical conditions

The action plans continue to 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

In the coming year, actions will also focus on reviewing and refreshing the ESC LHIN Rehabilitation System Strategic Plan in alignment with provincial RCA and MOHLTC deliverables, such as Assess and Restore, updated Quality-Based Procedure Handbooks and other emerging key priorities.

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, Assess and Restore Guideline, the RCA, and directions for CDPM			
Action Plans / Interventions:	% Completion by Year		
	2015-16	2016-17	2017-18
Develop and implement a Community Rehabilitative Team for patients with stroke ESC LHIN-wide that includes early supported discharge.	100%	-	-
Work toward implementation of the Future State Stroke Care Pathway developed in 2014 for patients with stroke that incorporates processes for access to comprehensive inpatient rehabilitation for all stroke survivors who are unable to return home from acute care within the established QBP acute care LOS target timelines.	50%	100%	-
Develop a strategy to reach the optimal rehabilitative care bed mix outlined in the ESC LHIN Rehabilitative Care System capacity report (February 2015) aligned with the approved RCA Definitions Framework for Bedded Rehabilitative Care (including rehab, CCC and convalescent care beds)	50%	100%	-
Finalize the implementation of a standardized hip fracture care pathway aligned with the best practices outlined in the Hip Fracture Handbook, ESC LHIN-wide	100%	-	-
Work with the ESC CCAC to develop and implement the Community Rehabilitative care services strategy developed in 2014 for patients with hip fracture that incorporate early supported discharge from acute/inpatient rehabilitation or convalescent care stay, and full community re-integration (Community Geriatric Rehabilitation Team)	50%	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 support the development of the ESC LHIN Senior Strategy	40%	60%	100%
Implement the Hospital Elder Life Program (HELP) ESC LHIN-wide in acute and inpatient rehabilitation care settings to support the work of the Acute Care of the Elderly teams (Seniors Mobile Assess and Restore Teams funded through the Assess and Restore initiative) in screening, preventing, recognizing and managing delirium and functional decline in frail seniors hospitalized in acute care settings.	30%	70%	100%

TEMPLATE A: PART 2: GOALS and ACTION PLANS Rehabilitative Care System (cont'd)			
Action Plans / Interventions:	% Completion by Year		
	2015-16	2016-17	2017-18
Develop and implement a community-based early screening process to identify individuals with frailty/functional decline, (which was piloted in the ED at Chatham-Kent Health Alliance) and which triggers a comprehensive geriatric assessment and navigation of patients to appropriate rehabilitative/restorative care programs and services (ESC LHIN Geriatric Care Pathway aligned to MOHLTC Assess and Restore Guideline, using the Assessment Urgency Algorithm (AUA) endorsed by the RCA))	30%	70%	100%
Develop specialized geriatric medicine/rehabilitation capacity across the Erie St. Clair region interfaced with geriatric mental health services to support the development of the ESC LHIN Senior Strategy (ESC LHIN Geriatric Care Pathway aligned to MOHLTC Assess and Restore Guideline)	40%	80%	100%
Expected Impacts of Key Action Items			
Appropriate rehabilitative system inpatient bed capacity to: • Increase access to inpatient rehabilitative care for all patients with moderate and severe stroke unable to return home from acute care • 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 based on quality based procedure (QBP) lengths of stay where applicable) • Reduce ALC days in acute care to LTC • Reduce ALC days to CCC and convalescent care • 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 (methodology for tracking patient outcomes and patient experience to be determined)			

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

What are the Risks / Barriers to Successful Implementation?

- Challenges in quantifying proportions of older adults in acute care and community who might benefit from rehabilitative care and do not currently access these services (complexity of comorbidities, ICD-10 codes, etc.)
- Challenges in effectively monitoring results and impact of programs on patient experience and functional outcomes with measures in addition to 30-day hospital readmissions
- Availability of funding and ability of stakeholder partner organizations to develop innovative new models and programs of care utilizing existing funding

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, utilize the comprehensive rehabilitative system report card with key performance indicators and report quarterly to the ESC LHIN
- Close communication and collaboration with stakeholders/system partners
- Accelerate the ESC LHIN Rehab Committees work
- Introduce a sharing mechanism to support awareness, exchange and uptake of emerging practices including resources and standards developed by the provincial RCA

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

- Dedicated ESC LHIN-wide Rehabilitation Lead and Decision Support positions to support the research, analysis and process improvement initiatives across Erie St. Clair region
- 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 rehabilitative care 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 serves 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. Erie St. Clair's population shows a higher than average rate of seniors and people with chronic diseases. At least one percent of patients in a family practice setting will likely die in the next year. Quality palliative care helps ease the suffering of dying people and their loved ones. Palliative care will increasingly be required in our region. The need for HPC is increasing. HPC includes bereavement and all forms of grief (acute, chronic and anticipatory). The Canadian Hospice Palliative Care Association estimates that each death in Canada impacts the immediate well-being of an average of five other people, disrupting their lives, affecting their income, and causing grief and other psychological issues, including depression and anxiety. HPC is needed for all disease categories (including chronic diseases), and is required in all care settings where persons die. Only about 10% of care needs are met by the formal system of HPC. Any plan for a regional system of HPC needs to embrace: • all care settings where patients die • all services focused on HPC • bereavement services • informal care providers • the community at large 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 will positively impact patients, care providers, and the system and community as a whole. In February 2015, the Erie St. Clair HPC Network completed its third strategic plan for HPC in Erie St. Clair. The process was iterative, building on extensive previous work in the Erie St. Clair region. Consultations and community engagements took place during the spring, summer and fall of 2014 with key partners and stakeholders, including frontline providers and informal caregivers. The draft plan was vetted and revised through three local networks and the Erie St. Clair HPC Advisory Council in November/December 2014 and January 2015, and was submitted to the ESC LHIN in February 2015. The approach used qualitative and quantitative information to describe the desired future state, to ascertain the current state and to articulate a plan including targets and measures.

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

Goal(s):

The Erie St. Clair strategic priorities are:

1. To facilitate creative planning and implementation of a full continuum of funded and volunteer services for HPC in Erie St. Clair (this includes bereavement)
2. Encourage each organization/provider to clarify and update their internal HPC program elements and identify linkages to the system and community as a whole
3. Promote cross sector initiatives which advance a system perspective and enhance knowledge transfer and exchange regarding best practice(s)
4. Continue to develop and implement creative models to maximize human resource expertise and facilitate recruitment and training
5. Strengthen regional accountabilities and regional enabling structures, clearly defining the role of the Erie St. Clair HPC Network/Program aligned with the ESC LHIN and other regional partners
6. Work with provincial partners to advance improvements in policy, funding and education for HPC

Three overarching facilitating priorities that impact the system as a whole in Erie St. Clair are:

1. Promote ACP and health care consent (HCC) across the continuum in Erie St. Clair
2. Build public awareness and community focus
3. Advance clinical best practice

Consistency with Government Priorities:

The above goals are consistent with the priorities and action commitments outlined in the document: Advancing High Quality, High Value Palliative Care in Ontario, A Declaration of Partnership and Commitment to Action, December 2011.

Erie St. Clair has embraced the following provincial strategic priorities and has aligned with the six implementation requirements below.

1. Broaden access and increase timeliness of access
2. Strengthen caregiver supports
3. Strengthen service capacity and human capital in all care settings
4. Improve integration and continuity across care settings
5. Strengthen accountability and introduce mechanisms for shared accountability
6. Build public awareness (pg. 30 of Declaration Document)

HPC overall goal is to move to the new model of care of virtual extended inter-professional teams. This would require that the following 'implementation requirements' are in place:

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

TEMPLATE A: PART 2: GOALS and ACTION PLANS Hospice Palliative Care (cont'd)			
Action Plans/Interventions: (further details in the Erie St. Clair HPC Strategic Plan)	% Completion by Year		
	2015-16	2016-17	2017-18
Advocate for and facilitate creative planning and implementation of a full continuum of funded and volunteer services for HPC in Erie St. Clair:			
Support final stages residential hospice development Chatham-Kent and Leamington	80%	90%	100%
Support hospices across the region to become community hubs for HPC in their individual counties/catchment areas	60%	80%	100%
Advance access to bereavement services in all counties	60%	100%	-
Support volunteer programs and community development (e.g. Share the Journey Volunteer Education, Windsor Charter etc.)	60%	80%	100%
Advance paediatric palliative care education and service delivery	5%	30%	50%
Encourage each organization / provider to clarify and update its own internal HPC program elements and identify linkages to the system and community as a whole.			
All organizations are responsible for creating a viable program of HPC within their own care mandate. Each will have its own articulated initiatives which will reflect HPC values and tenets	60%	70%	80%
Network sets reporting template and schedule for reporting	80%	100%	-
ESC LHIN (working with network and provincial partners) sets accountability agreement requirements	80%	90%	100%-
Promote cross sector initiatives which advance a system perspective. Enhance knowledge transfer and exchange regarding best practice			
Continue with ESC HPC Education Collaborative and Education Strategy coordinated with other HPC educational activities	80%	100%	-
Facilitate integration of community based Palliative Care Consultation Teams (PCCT) including roles for NPs and collaboration with other community resources	50%	80%	100%
Increase linkages with chronic CDPM, Health Link etc.	60%	80%	100%
Explore and implement opportunities for enhanced integration including fostering linkages between volunteer visiting hospice programs and residential hospices	80%	90%	100%

TEMPLATE A: PART 2: GOALS and ACTION PLANS Hospice Palliative Care (cont'd)			
Action Plans/Interventions: (further details in the Erie St. Clair HPC Strategic Plan)	% Completion by Year		
	2015-16	2016-17	2017-18
Continue to develop and implement creative models to maximize human resource expertise and continue to facilitate recruitment and training			
Support physician “recruitment events”/Learning Essential Approaches to Palliative End-of-Life Care (LEAP)	60%	70%	100%
Encourage and support enhanced primary care role and shared care continuum models	60%	70%	100%
Support Windsor Charter Project and facilitate “spread”. Support community hub concept	60%	80%	100%
Strengthen regional accountabilities and regional enabling structures, clearly defining the role of the Erie St. Clair HPC Network/Program aligned with the ESC LHIN and other regional partners			
Pursue accountability priorities as outlined in the provincial document “Declaration of Partnership and Commitment to Action”, including formalizing the Regional HPC Program/Network structure, role, accountabilities and evaluative framework. Establish a sustainability plan	90%	100%	-
Work with provincial partners to advance policy/funding/educational advancements in HPC.			
Active participation on all relevant provincial committees	70%	90%	100%
Support initiatives to improve core curriculums to help address deficiencies in professional training	70%	90%	100%
Promote Advanced Care Planning and HCC across the continuum			
Advance proposal for a more robust roll out of an ACP Regional Program. In the interim, continue with ACP/HCC regional strategy under the sponsorship of the HPC Education Collaborative	50%	70%	100%
Build Public Awareness and Community Focus			
Update communication plan including website	75%	100%	-
Advance clinical best practice			
Update asset map insuring that the role of each care setting is clearly articulated and understood including admission criteria, discharge criteria, etc.; update system care paths accordingly	90%	100%	-
Monitor progress at the provincial level with a view to the creation of an Erie St. Clair Network Clinical Council. In interim, continue to promote identified best practice	80%	90%	100%

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

Expected Impacts of Key Action Items

Key impacts include:

- Less suffering for patients, family and the community as a whole
- More sustainable system
- Improved system level triple aims of:
 - Quality
 - Population Health
 - Sustainability

Through implementation of the Erie St. Clair HPC Strategic Plan, the aim is to improve patient care and system outcomes.

Consistent with the Declaration Document progress will be measured in terms of:

- Faster, easier access to palliative care
- Improved client and family experience and
- Better clinical outcomes, such as improved pain and symptom management

Erie St. Clair's performance will be evaluated using:

- provincially identified measures and
- specific regional measures

Success will be measured via achievement of process targets and through narrative reporting.

1. Provincially identified Measures

In September 2014, the Provincial Steering Committee members approved the following six priority indicators to measure palliative care in the province:

1. Home support for discharged palliative care patients
2. ED visits in the last two weeks of life
3. Percentage of palliative care patients discharged from hospital that were seen in the ED within 30 days
4. ESC CCAC home care wait times
5. Outpatient palliative care wait times (Regional Cancer Centres)
6. Hospital readmission within 30 days for palliative care patients

These indicators, along with those currently under further development, will support ESC LHIN in achieving a 10% reduction in the total number of hospital days that are attributed to palliative care. (Discussion about this indicator – It is generally understood that patients in hospital are more appropriately identified as “palliative” this number will initially increase not decrease. This 10% reduction will occur only after a stabilized baseline is achieved. Currently coding of patients as palliative in hospitals across Ontario is increasing as hospitals become more aware of HPC patient needs.

Additionally, HPC/EOLC indicators for the cancer population are published by the Cancer Quality Council of Ontario.

The Erie St. Clair's target related to these provincial indicators is:

- Improvement will be evident in all of the six indicators within the first year of measurement
- Erie St. Clair will be equal to or better than the provincial average

2. Specific Regional Measures

As indicated above, all initiatives described in this strategic plan will impact these high level system outcomes.

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

What are the Risks / Barriers to Successful Implementation?

Risks /Barriers include:

- 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, NP as well as other team members
- Need for improved data collection methodologies to allow HPC evaluation at a system level (e.g. National Ambulatory Care Reporting System (NACRS) to capture increased use of ED by persons who require palliative care)
- Few resources in LTCH to support increased staffing requirements that may be needed to handle complex palliative care needs (especially for midnight and evening shifts)
- 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)
- Inadequate support for and poor uptake of PC education for physicians and others in all sectors
- Lack of HPC education for physicians and others in all sectors

Mitigation strategies for above stated risks include:

- 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 the implementation strategy include data reporting to the Erie St. Clair HPC Advisory Council from the ESC LHIN and from providers
- Work with provincial level data groups
- Include LTCHs in mandate of PCCT. Work with partners in LTCHs (e.g. Registered Nurses Association of Ontario (RNAO) Best Practice, Palliative Pain and Symptom Management Consultation Program (PPSMCP), NPs in homes, palliative medicine physicians and hospices, etc.)
- Include ED in ACP education and other HPC education
- As HPC resources become available deploy them to ED as well as 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?

Key opportunities include the following:

- 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
- Enhanced HPC network structure and role will help break down silos between sectors
- Strategic planning “refresh” will help focus and prioritize actions going forward

2.7 Aboriginal

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY PRIORITY: Aboriginal Health Care Access
Integrated Health Services Priority:
Patient-Centered Health Access for Aboriginal Populations
IHSP Priority Description:
The priorities for the next 12 months are centred on identifying and assessing local and regional Aboriginal communities' health care needs. Needs assessments will be undertaken with the understanding that each Aboriginal community (rural and urban) has their own unique challenges and obstacles related to accessing and navigating the health care system. The needs assessments will be guided with the purpose of understanding localized primary and acute health care issues, and determining health system barriers. Regional priorities will be ascertained from the individual community health care needs assessments, and will form the basis for the development of a three year strategic plan. After completion of the community needs assessments and the strategic plan, the information will be presented back to each community through a comprehensive engagement process for review and additional input. Through the needs assessments and the strategic plan, the ESC LHIN will have better insight of where to make targeted investments that will positively respond to identified needs with specific emphasis on enhancing and augmenting the Aboriginal patient journey through the health care system. In aiming to improve the Aboriginal patient journey, it will be necessary to establish a collaborative model of care that recognizes and promotes cultural practices and traditions as essential elements to overall health and wellbeing and sets out to: • Improve service integration, accountability and communications between First Nation health agencies, the ESC LHIN and mainstream HSPs across Erie St. Clair • Improve leadership and interfaces between care settings (hospital, NP, primary care, and specialists) • Streamline coordination across service providers

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

Current Status

Locally, regionally, and nationally there is a significant data deficit in determining Aboriginal specific health related information. Health information related to Aboriginal people is often scattered among several area disciplines and therefore, there is not a current and/or single source of data that can be drawn from. These challenges are particularly evident within the ESC LHIN as information pertaining to Aboriginal patients is not documented in a formal or consistent manner across the various HSPs within the region.

Therefore, the following health data has been gathered from the “Our Health Counts” (OHC) Urban Aboriginal Health Database Project (2011) and First Nations Regional Health Survey 2008/10. The OHC report is specific to Hamilton and selected because it is the geographically closest and most recent health data source for Aboriginal people in Southwestern Ontario. The First Nations Regional Health Survey is a near national overview of the health of Aboriginal people in 10 First Nation regions spanning all provinces and territories with the exception of Nunavut. This report was selected because it is the closest to a national snapshot of the health of Aboriginal people across Canada.

OHC - Aboriginal adult data:

- Diabetes rate is 15.6% (more than three times the rate among the general Hamilton population)
- Fifty-three percent of First Nations population in Hamilton reported at least one visit to the ED over the past two years for acute problems compared to 20% of the Ontario population
- Ten percent reported six or more ED visits in the previous two years compared to 1.5% of the Hamilton and Ontario populations respectively

First Nations Regional Health Survey 2008/10 (FNRHS)- Aboriginal adult data:

- Sixty-two percent of First Nations reported being diagnosed with at least one chronic health condition
- Co-morbid health conditions increase by age, by age 60 approximately half of First Nations adults have been diagnosed with four or more chronic conditions
- Most common chronic health conditions in First Nations include:
 - High blood pressure - 21.8%
 - Arthritis - 19.9%
 - Diabetes - 16.2%

The top five percent of First Nations with chronic health conditions seeking treatment:

- Diabetes - 89.7%
- Thyroid - 82.1%
- Heart disease - 80.1 %
- High blood pressure - 78.8%
- Asthma - 70.5%

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

Current Status

Prevalence rates of chronic conditions in Erie St. Clair (2009):

- Arthritis - 21.9% (comparatively- OHC rate -30.7%; FNRHS rate -19.9%)
- Hypertension - 19.9% (comparatively- OHC rate -25.8%; FNRHS -21.8%)
- Diabetes - 7.75 (comparatively- OHC rate -15.6%; FNRHS -16.2%)
- Forty-one percent of Erie St. Clair residents have chronic conditions and 17% have multiple conditions
- Mortality and hospitalization rates for all chronic conditions, except asthma, are higher than provincial rates
- Diabetes prevalence is higher than the provincial average
- Erie St. Clair residents has the fifth highest CCC active cases rate in the province
- Erie St. Clair hospital CCC active cases increased by 3.8 % between 2006-2011

Aboriginal people in Ontario have poorer overall health status and are not receiving a proportionate level of primary care support or culturally safe care

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

Goal(s):

Aboriginal Health Access Overall Goals:

- Conducting needs assessments in the following five First Nation communities: Aamjiwnaang First Nation (Sarnia), Delaware Nation at Moraviantown; Caldwell First Nation; Chippewas of Kettle and Stony Point First Nation; and Bkejwanong Territory (Walpole Island). A needs assessment will also be conducted with the urban Aboriginal population in Windsor
- Development of an Aboriginal focused three year health strategic plan
- Creation of a collaborative model of health care premised on the recognition that cultural practices and traditions are essential to overall health and wellbeing aimed at:
 - Improving integration, accountability, and communication between First Nation health agencies and mainstream HSP's through education and information sharing
 - Improving leadership and interfaces by developing partnerships between local/regional First Nation, Metis, Inuit communities and health care stakeholders
 - Streamline service coordination across service providers by building on existing strengths and relationships between Aboriginal and local and regional health services to provide better coordinated care

Consistency with Government Priorities:

The above undertakings support and advance the MOHLTC Patients First: Action Plan for Health Care which aims to:

- Improve access – providing faster access to the right care
- Connect services – delivering better coordinated and integrated care in the community
- Support people and patients – providing the education and information they need to make the right decisions about their health

TEMPLATE A: PART 2: GOALS and ACTION PLANS Aboriginal Health Care Access (cont'd)			
Action Plans / Interventions:	% Completion by Year		
	2014-15	2015-16	2016-17
Develop Aboriginal health utilization data for Erie St. Clair	30%	50%	100%
Conduct health needs assessments in five First Nation communities and one urban community	80%	20%	100%
Develop a three year Aboriginal Health Strategy	70%	30%	100%
Conduct six community engagement sessions to review needs assessments and strategic plan	70%	30%	100%
Identify health care access points/care path	20%	60%	100%
Creation of collaborative model of care	20%	70%	100%
Expected Impacts of Key Action Items			
• Development of a collaborative model of care for Aboriginal patients • Aboriginal patients will have better access to health services • Improving the patient's overall experience during their journey through the health care system • Improved health care service integration and collaboration between a patient's different health care providers			

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

What are the Risks / Barriers to Successful Implementation?

Anticipated barriers to the completion of the above goals include:

- Difficulty in sourcing a consultant to undertake the needs assessments and develop the strategic plan within the specified time period
- Delays in completing the needs assessments and subsequently the strategic plan due to consultant and community availability
- Limited community participation in the needs assessments
- Inaccurate or short sighted strategic actions
- Resistance and lack of willingness on the part of the Aboriginal and HSP stakeholders to jointly develop the collaborative model of care

In light of the anticipated barriers all efforts will be made to mitigate these challenges by:

- Thoroughly detailing the request for proposals guidelines and contract terms with specific timeframes and deliverables being attached to financial remuneration
- Local Aboriginal Health Planning Committee members representing each community has direct involvement in promoting and scheduling the needs assessments and the engagement sessions
- Ensuring the Local Aboriginal Health Planning Committee has direct and continuous oversight of the entire project including the screening, approval, and monitoring of the consultant hired to conduct the needs assessments and the strategic plan
- Once the needs assessments are complete, local HSPs will be identified as existing or potential stakeholders and partners. Early and continuous engagement of these parties will be critical in the development and implementation of the collaborative model of care

2.8 French Language Services

TEMPLATE A: PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN PRIORITY: French Language Services	
Integrated Health Services Priority:	
French Language Services (FLS)	
IHSP Priority Description:	
The ESC LHIN includes a number of designated areas under the French Language Services Act. Francophones are mostly located along the shorelines of Lake St. Clair, from Windsor, to Stoney Point to the former Dover Township all the way to Sarnia. It is to be noted that although not a designated area, Sarnia is home to a significant Francophone population. According to data provided by the Health Analytics Branch of the MOHLTC and based on the 2011 Census, the Francophone population in the ESC LHIN counts approximately 22,000 people. This figure takes into account the new inclusive definition of Francophones, which includes those persons whose mother tongue is French, plus those whose mother tongue is neither French nor English, but have a particular knowledge of French as an Official Language and use French at home. The Francophone population is generally older than the general population. Average age is 51 in comparison to 40 in the general population. The proportion of 45-year old and over is 67% in comparison to 45% in the general population. The Francophone population is mostly composed of white Canadian-born individuals. The face of the Francophone community is however becoming more diverse in Erie St. Clair, particularly in the Windsor-Essex area, as immigration from French-speaking countries continues to increase. Due to the age of the Francophone population and the higher prevalence of chronic diseases among seniors, priorities for improvement of access to and accessibility of services in French are services to seniors and chronic disease prevention and management services. Mental health services are also considered a priority by the community.	

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

Current Status

Access to and accessibility of health services in French remain limited in the ESC LHIN despite the identification of 28 HSPs for the delivery of services in French and the partial designation of two HSPs. This is partly due to a shortage of bilingual health care professionals, a lack of awareness of the need to provide linguistically and culturally appropriate services, and the many benefits of doing so not only for the patients but also for the providers. As well, HSPs must comply with many requirements, and FLS is often perceived as a lesser priority.

Planning and delivery of services in French are complex and success is measured in small steps.

FLS Planning Objectives Considered

- Need to build the system's capacity to deliver FLS
- Need to understand the existing human resource capacity
- Need to build the awareness of the system regarding the delivery of linguistically and culturally appropriate services
- Need to promote the existing availability of FLS
- Need to develop services to serve specific needs of Francophones
- Needs of the Francophone population, based on age distribution and expressed needs through previous engagements

TEMPLATE A: PART 2: GOALS and ACTION PLANS French Language Services (cont'd)
Goal (s)
The overarching objective of all FLS initiatives is to improve access to and accessibility of health services in French. <u>FLS Overall Goals:</u> • To ensure French language service capacity for key service functions (case management, counselling, crisis response, treatment, tier/bedded capacity, maintenance, family services, and support) • To enhance and/or build on services for the management and prevention of chronic diseases, in person or through OTN • To help seniors reach and maintain the greatest level of independence no matter where the person lives • To enhance French language services capacity across the system The action plans will focus on the following priority populations and stakeholders: • Francophones living with mental health issues • Francophones living with chronic diseases • Francophone seniors • Identified and designated HSPs
Consistency with Government Priorities:
The French Language Services Act (FLSA), R.S.O. 1990, guarantees an individual's right to receive services in French from the Government of Ontario ministries and agencies in 26 designated areas. In the ESC LHIN, designated areas include the City of Windsor, the towns of Belle River and Tecumseh, the townships of Anderdon, Colchester North, Maidstone, Sandwich South, Sandwich West, Tilbury North, Tilbury West, Rochester, as well as the town of Tilbury and the townships of Dover and Tilbury East. As crown corporations of the Government of Ontario, LHINs are subject to the FLSA, and must ensure that their services and the services they fund are available in French to the Francophone population. The above goals are consistent with the government's priority to improve access to and accessibility of health services in French to the Francophone population across the province. Although these cannot be measured at this time, they will also contribute in reducing ED visits, hospital admissions and readmissions as well as ALC rate.

TEMPLATE A: PART 2: GOALS and ACTION PLANS French Language Services (cont'd)			
Action Plans / Interventions			
Action Plans / Interventions:	% Completion by Year		
	2015-16	2016-17	2017-18
To continue working with identified and designated HSPs to develop FLS and build their capacity to provide FLS	20%	40%	60%
To continue working with HSPs to support the development of services to serve specific needs of Francophones	20%	40%	60%
To continue working with HSPs to ensure appropriate promotion of existing FLS	20%	40%	60%
To do an inventory of French-speaking health professionals	75%	100%	-
To continue raising awareness about the needs of the Francophone community and the importance of providing linguistically and culturally appropriate services	20%	40%	60%
To develop a recommended linguistic and cultural competency training approach and tools for ESC LHIN and HSP staff and board members	50%	75%	100%
Expected Impacts of Key Action Items			
- Increased providers' and staff awareness of requirements regarding FLS - Increased integration of FLS into day-to-day business of providers - Increase responsiveness of providers to the needs of the Francophone population - Improved patient satisfaction - Increased awareness of available services in French by the Francophone population - Increased availability of FLS - Greater awareness and commitment from stakeholders to the provision of culturally and linguistically sensitive services			
What are the Risks / Barriers to Successful Implementation?			
- Lack of commitment from providers - Lack of human and financial resources needed to meet the goals - Competing priorities For each risk/barrier describe the plan to mitigate risk. - The ESC LHIN risk management plan, in regards to FLS, is primarily based on increased education for providers on the need to embed FLS as part of the day-to-day operations and the importance of providing linguistically and culturally appropriate and safe services. Consequences of language barriers on the patients/clients and the health care system are also highlighted. To better respond to this need, the ESC LHIN is planning to develop linguistic and cultural competency training and tools.			

3 ESC LHIN Operations and Staffing Templates

3.1 ESC LHIN Operations Spending Plan

Template B: LHIN Operations Spending Plan				
LHIN Operations Sub-Category (\$)	2014/15 Actuals	2015/16 Allocation	2016/17 Planned Expenses	2017/18 Planned Expenses
Salaries and Wages	3,133,264	3,115,300	3,196,428	3,196,428
HOOPP	272,398	338,860	359,428	359,428
Other Benefits	356,560	328,800	338,334	338,334
Total Employee Benefits	628,958	667,660	697,762	697,762
Transportation and Communication				
Staff Travel	75,119	93,520	60,000	60,000
Governance Travel	10,825	20,000	17,000	17,000
Communications	60,116	53,900	50,900	50,900
Other Benefits	2,464	6,010	10,000	10,000
Total Transportation and Communication	148,524	173,430	137,900	137,900
Services				
Accommodation (includes Insurance)	299,559	323,990	326,500	326,500
Advertising	0	10,000	10,000	10,000
Community Engagement	37,172	50,000	40,000	40,000
Consulting Fees	53,954	51,100	25,500	25,500
Equipment Rentals	19,992	30,000	30,000	30,000
Governance Per Diems	63,425	86,150	77,500	77,500
LSSO Shared Costs (includes LHINC)	451,162	458,500	458,500	458,500
Other Meeting Expenses	46,730	51,210	41,000	41,000
Other Governance Costs	128,780	50,770	50,250	50,250
Printing & Translation	28,536	36,000	36,000	36,000
Staff Development	53,365	68,230	45,000	45,000
Total Services	1,182,675	1,215,950	1,140,250	1,140,250
Supplies and Equipment				
IT Equipment	32,480	30,000	33,960	33,960
Office Supplies & Purchased Equipment	32,826	33,960	30,000	30,000
Capital	22,528	0	0	0
Total Supplies and Equipment	87,834	63,960	63,960	63,960
LHIN Operations: Total Planned Expense	5,181,256	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	55,044	0	0	0

- Salaries and Wages are expected to decrease in 2015/16 based on organizational structure changes.
- There remains a significant risk into 2015/16 to meet performance increase expectations given a zero percent revenue change. This will be offset by a reduction in staff if necessary.
- Significant costs in 2014/15 for Other Governance Costs relating to Expert Panel work. Costs to normalize for 2015/16.

3.2 ESC LHIN Staffing Plan

Template C: LHIN Staffing Plan (Full-Time Equivalents)				
Position Title / Classification	2014/2015 Actuals as of Jan 31/2015 FTEs	2015/16 Forecast FTEs	2016/17 Forecast FTEs	2017/18 Forecast FTEs
CEO	1	1	1	1
Senior Director	1	1	1	1
Director	3	3	3	3
Manager	9	9	9	9
Lead	3	3	3	3
Analyst	4	4	4	4
Executive Assistant	1	1	1	1
Coordinators	3	3	3	3
Admin Assistant	8	8	8	8
Receptionist	1	1	1	1
Total FTEs	34	34	34	34

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 IHSP 3 initiatives, other key local initiatives, and pan-LHIN/provincial programs. All ESC LHIN communication products support the ESC LHIN vision of *better care, better experiences, better value*, and supports our organizational strategic directions of:

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

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) care
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)

➤ 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 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 ESC LHIN provides to system transformation

- Positively shift attitudes about the ESC LHIN by demonstrating that the work of the ESC LHIN results in *better care, better experience, and better value*.
- Have ESC LHIN priorities and supportive communication objectives in line with the Patients First: Action Plan for Health Care and other provincial initiative 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 the *ESC LHIN Annual Community Engagement Plan* found in Section 5.

4.2 Context

The Erie St. Clair region, 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 is aging faster than the province as a whole, while our younger population, those between 0 and 44 years, is decreasing. In 2012, almost 16.5% of the population were seniors (aged 65+), an increase from 14.6%. Compared to the rest of Ontario, Erie St. Clair has a slightly higher proportion of the population over the age of 60 and a slightly lower proportion of the population between the ages of 30 and 34. These differences in age distribution are most pronounced in the Chatham-Kent and Sarnia/Lambton communities.

➤ ESC LHIN Business Objectives:

The ESC LHIN's Health Care Vision:

"Better Care, Better Experiences, Better Value."

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 2012/15 developed a series of directions to guide the ESC 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 IHSP 3, supports the ESC LHIN Board local Strategic Plan, by further advancing directions intended to integrate and improve the clinical and effectiveness outcomes of the local health system. The IHSP 3, which is consistent with the vision and strategic directions of the 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.

➤ LHIN/Ontario Government Initiatives or Programs:

Building on the foundation at the provincial level, LHINs look to regionalize these directions to improve care for local residents. Initiatives include:

- Premier's Mandate Letter to the MOHLTC, including priorities placed on home and community care
- The LHINs' role in delivering more efficient and coordinated care to patients, and focus on accountability, transparency, and patient experience
- Patients First: A Roadmap to Strengthen Home and Community Care
- Patients First: Action Plan for Health Care

Additionally, there are specific activities and areas of involvement through which the overall corporate strategies are being executed; including the following:

- Provincial strategies, initiatives and programs
- IHSP 3
- ESC LHIN Strategic Plan
- Leadership Council
- Regional Transportation Strategy
- Chronic Disease Prevention and Management Care Paths
- Mental Health Strategic Plan
- Addictions Strategic Plan
- Community Capacity Plan

- Rehab Strategic Plan
- Primary Care Strategy
- Aboriginal health care
- Integration activities
- Orthopaedic plan
- French Language Health Planning Entity (FLHPE)/LHIN Joint-Strategic Plan
- Capital projects
- Other planning activities as they develop

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 (HSPs)
- Elected Officials
- MOHLTC
- ESC LHIN Board
- ESC LHIN Staff

➤ Audiences, Secondary

- 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, FHTs, NP led clinics
- Universities and Colleges
- 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 users and service providers. For example, by providing

clear, understandable and publically available information on the programs and services available, we will strive towards improving the health outcomes for all of our residents while improving overall system navigation. Also in alignment with our strategic direction of Health Promotion Partnerships, we will work in collaboration with our stakeholders to deliver health promotion and illness prevention messaging.

- Support our leadership role by being more vocal about our accomplishments and successes. Be upfront about issues and how we 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.

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 behaviour and metrics tied to our strategic goals and IHSP 3 are achieved, we will have also met our communication objectives.

- Guiding Principles of Communication

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

- Tactics:

For all audiences noted above, a variety of strategic communication tactics are used. These tactics include, but are not limited to:

- Traditional media products, social media, events, email, web/online, Community Report, Annual Report, LHINfo Minutes, media engagement strategy, meetings, open Board Meetings, Board Highlights, open mic, advance dissemination of Board Meeting materials and agenda, etc.
- Additionally, for media we use: proactive media pitches, third party publications, availability as a health care resource, etc.
- Additionally for HSPs: Leadership Council, networks and advisory groups, memos, newsletters
- 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, videos, newsletters, etc. The ESC LHIN is dedicated to providing key communication materials in both English and French. For example, we ensure that communication pieces such as our Community Report are available in both official languages.

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 over a billion dollars a year in our region – 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. There are plans to ensure Ontarians have access to high quality care and a sustainable health system for years to come. By organizing the system differently and focusing on the medical evidence, Ontarians will receive better care and better value for tax dollars.

Goals:

- Putting people and patients first by improving the health care experience
- Providing information to make decisions, and tools to live healthy and stay healthy
- Providing better access to quality health services, and protecting those services for generations to come
- Patients First:
 - a caring, integrated experience for patients
 - faster access to quality health services
 - for all Ontarians at every life stage
- Access:
 - Providing faster access to the right care

- Connect:
 - Providing better home and community care
 - Inform:
 - Providing information to make the right decisions about your health
 - Protect:
 - Ensuring our universal health care system is sustainable for generations to come
- Project specific Key Messages:
- Are developed at the onset of the project and updated throughout the implementation phases

4.6 Evaluation and Monitoring

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

➤ Media Monitoring and Analytics

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

➤ Social Media Monitoring

Social media is monitored daily for outreach opportunities, communication accuracy, and impact (e.g. re-tweets, click-thru rates, etc.). Engagement decisions are based on the ESC LHIN's social media policy and best practices.

➤ Communication Metrics

We continue to refine the communication metrics used for reporting on public communication including communication outputs (e.g. news releases, interviews, media hits, 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: feedback received from the public through our complaints and concern process, online, open mic sessions at board meetings, meetings, surveys, and engagement sessions.

5 ESC LHIN Annual Community Engagement Plan

5.1 Introduction

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

Community Engagement in 2015/16 will primarily support the implementation of key improvement initiatives outlined in the Annual Business Plan.

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
- Newcomer and Immigrants
- Health Service Providers (ESC LHIN funded)
- Physicians
- Allied Health Care Professionals
- Public Health and Social Service providers

The deliverables of the Annual Business Plan cascade from the ESC LHIN's IHSP, a strategic document which is refreshed on a three year cycle. In 2015/16, the ESC LHIN will undertake planning to perform a refresh of the IHSP, which will be presented for board approval in advance of implementation on April 1, 2016. The writing of the IHSP is a significant undertaking as it will require broad engagement with stakeholders to document and validate the current status of the local health care system, the health status of the population it services, and opportunities for addressing the health needs of the population. As has happened in previous IHSP planning cycles, a dedicated community engagement strategy will be developed to inform the creation of local strategies.

Other ESC LHIN priority, areas both independent and tied to the ESC LHIN IHSP, will also involve dedicated engagement plans and/or initiatives. These include:

- Aboriginal Health Strategy
- Addictions Strategy
- Behavioral Supports Ontario and Geriatric Mental Health Outreach Team Review
- Care Path Development and Implementation
- Complex Case Resolution Table
- Family and Youth Engagement
- French Language Services Capacity Building

- Geriatric Emergency Nursing Review
- Health Links Implementation
- Long-Term Ventilation Strategy
- Seniors Supportive Housing
- Suicide Prevention and Coordination
- Windsor Hospital Capital Planning

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 2015/16.

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 2015/16, supporting our strategic objectives:

- **Aboriginal Health Strategy:** Through the engagement of the Local Indigenous Health Planning Committee (LIHPC), a continued focus will be placed on improving access to culturally appropriate health care services for Aboriginal and First Nations people in the Erie St. Clair region. The following priority areas will be the emphasis of engagement and implementation for 2015/16:
 - Conducting six community needs assessments
 - Development of a three year Aboriginal Health Strategic Plan, and
 - Creation of collaborative model of health care

The ESC LHIN Aboriginal Lead will be a key support in putting this plan into action and/or collaborating with community partners on implementation. As such, workings groups will be created where required to support the plan and the LIHPC will continue to lead these efforts supported by the ESC LHIN Aboriginal Lead.

- **Addictions Strategy:** With the completion of a broad-based community engagement initiative to determine local needs for improving access to care for those with substance abuse, the ESC LHIN will finalize and seek Board approval of a Regional Addictions Strategy. This will be followed by the development of phased implementation strategy completed through engagement of the MH&A Network.
- **Behavioral Supports Ontario (BSO) and Geriatric Mental Health Outreach Team Review (GMOT):** The ESC LHIN will be undertaking a review and evaluation of the BSO and GMOT programs with the goal of assessing transitions of care, clinical competencies in LTC, and impact on ALC. Extensive consultation with patients, families, clinicians, and providers will be completed as part of the review. Subsequently, the results of the review will be vetted through a steering committee which will also be tasked with implementation of recommendations of the review.

Care Path Implementation: the continued emphasis on better supporting and enabling self-management of those with chronic diseases continues with the implementation of care paths. In 2015/16 a significant stakeholder engagement

process will continue with a focus on developing and implementing a communication strategy and education plan. HSPs and clinicians will be the primary target of these strategies, which will seek to improve uptake and adherence to the care paths, resulting in standardization and use of best practices across the region for CHF, COPD, diabetes, stroke, smoking cessation care.

- **Complex Case Resolution Table:** Increasingly, the ESC LHIN is becoming involved in facilitating the resolution of cases where patients present with extreme and/or extraordinary health and social service needs. These are one-off processes for which, HSPs are unable to manage independently and seek the support of the ESC LHIN to work collaboratively across the continuum in finding unique solutions to unique circumstances.

In 2015/16, the ESC LHIN will be establishing a Complex Case Resolution Table comprised of key service providers from across the continuum of care. The table will provide a standardized method to bring challenging cases forward for deliberation and problem solving with the goal of improving access and quality of care while enabling risk mitigation. The table will adhere to Personal Health Information Protection Act (PHIPA), 2014.

- **French Language Services Capacity Building:** The ESC LHIN, through the leadership of the French Language Services Coordinator, will continue to work with identified and designated HSPs to support them in building their capacity to provide French language services. Additionally, targeted engagement will take place with health link steering committees to build awareness of the need to provide culturally and linguistically appropriate care to ensure the best possible patient experience.
- **Health Links Implementation:** To date the ESC LHIN has supported the establishment of partnerships and governance structures for Health Links in Chatham-Kent, Essex County South Shore, and Lambton County Lake Huron. Engagement activities for Health Links for 2015/16 will consist of:
 - **ESC LHIN-wide:** Establish a Regional Health Links Partnership Table consisting Health Link Lead agencies, ESC LHIN Primary Care Lead, and other key stakeholders. The purpose of this partnership table will be to provide leadership in standardizing Health Link practices and streamlining decision processes with respect to matters of regional scope (i.e. Care Coordination Tool adoption).
 - **Chatham-Kent:** Engage the Chatham-Kent Leadership Table in the transitioning from implementation to an ongoing, sustainable entity.
 - **Essex County South Shore:** Support the implementation of the Health Links, per the submitted business case, once approved by the MOHLTC via the Leadership Table and other working groups as required.
 - **Lambton County Lake Huron:** Support the process of the business case and identified engagement of patients, clinicians, HSPs, and other non-funded agencies.
 - **Windsor West and Windsor/Tecumseh/Lakeshore:** Expand Health Links to Windsor/Essex with the establishment of the required partnership/governance structure and submit a Readiness Assessment to the MOHLTC.

- Long-Term Ventilation Strategy: Engaging the Long-Term Mechanical Ventilation Steering Committee, the ESC LHIN will support the development and implementation of a strategy to provide better access to care for people who are mechanically ventilated. Patient and family members engagement will be required of the committee to ensure solutions put in place best meet their care and social needs.
- Novari Implementation: There will be consideration by the ESC LHIN, in fiscal year 2015/16, for the addition of the eRequest Module of Novari to be implemented ESC LHIN-wide. This would be a two-phase approach over two years to fully implement and would allow for electronic requests/referrals for services from primary care to other service providers (e.g. specialist). Community engagements with key stakeholders will be necessary for a successful implementation, including separate plans for engaging clinicians and HSPs, to their gain, commitment and inform implementation planning, and provide education and ongoing change management in utilizing the eRequest Module.
- Primary Care Council: Continue to leverage the ESC Primary Care Council (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 ESC PCC will be leveraged to provide expert advice in solidifying standardization of Health Link practices.
- Chatham-Kent Seniors Supportive Housing: In partnership with the local municipal housing lead, the ESC LHIN will continue engagement with apartments and complexes in Chatham-Kent where unofficial hubs for seniors housing exist. The goal of this dialogue is to determine opportunities to support at risk seniors in these hubs with activities of daily living and general monitoring of their health status as a proactive means to enable them to continue living independently.
- Suicide Prevention and Coordination Conference: An ESC LHIN-wide Suicide Prevention and Coordination Conference will be held in 2015/16 for the purposes of providing education to HSPs and stakeholders, as well as, completing the World Health Organization (WHO) Environmental Scan. The process will determine needs in the Erie St. Clair region and an engagement process with providers for moving to action.
- Windsor Hospital Capital Planning: In planning for the development of a future single acute care hospital in Windsor, completion of the required submissions per the MOHLTC Capital Planning Process, are continuing. Currently, the work is in phase 1B and will be finalized later this year and submitted to MOHLTC for approval.

In parallel to this work, a Community Capacity Plan which will be implemented to determine what services will potentially transition from Windsor Regional Hospital to community providers. A fulsome engagement plan will be put in place in order to effectively engage a broad base of consumers and stakeholders, and inform the transition services with the goal of improved access to care.

- Vision Care Strategy: The MOHLTC is requesting each LHIN to complete a local eye vision strategy. The strategy will define the current and future state needs for our local communities in regards to the care of medical and surgical treatment of eye diseases based on the Provincial Vision Strategy Task Force Report. Key to this process will be input and feedback from the patients, families, clinicians and providers through a process to be defined.

➤ Networks/Committees/Working Groups

While the ESC LHIN is responsible for planning and execution of time-limited, project-based initiatives where community engagement is required, a significant focus of ESC LHIN engagement activities are the result of ongoing networks, committees, and working groups. The following is a summary of the various structures currently in place for which the ESC LHIN leads or is an active member:

- ALC Performance Management Working Group
- BSO/CCAC Quarterly Working Group
- Child and Youth Leadership Table
- Care Link Regional Transportation Committee
- Community Analytics Steering Committee
- Data Consortium
- Decision Support Committee
- Domestic Violence Working Group
- Erie St. Clair/South West French Language Health Planning Entity
- Executive Nurse/Clinical Leads Advisory Council
- Fast Access to Community Experts Working Group
- Identified and Designated FLS Providers Network
- Leamington and Area Older Adults Mental Health & Addictions Working Group
- Local Aboriginal Health Planning Committee
- Local Partnership Committee
- Long-Term Care Operators Networks (Chatham-Kent, Windsor/Essex, and Sarnia/Lambton)
- Ministry of Community and Social Services/Developmental Services Ontario/Community Care Access Centre, ESC LHIN
- Mental Health and Addictions Network
- Mental Health and Addictions Quarterly Stocktake Working Group
- Mental Health and Addictions Tri-County Municipal Supportive Housing Working Group
- Primary Care Council
- Psychiatry Leadership Table
- Regional Diabetes Education Program Network
- Regional Renal Administrative Advisory Committee
- Rehab Committee Network
- Residential Addictions Treatment Table
- Sarnia/Lambton Special Needs Working Group
- Smoking Cessation for both Windsor/Essex and Chatham-Kent
- Stocktake Review Table

180 Riverview Drive
Chatham, ON N7M 5Z8
Tel: 519 351-5677 • Fax: 519 351-9672
Toll Free: 1 866 231-5446
www.eriestclairhin.on.ca