



Annual Business Plan 2016-2017

FINAL
JULY 6, 2016

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1 Context

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

The ESC LHIN's vision is "Better Care, Better Experiences, Better Value." It is a vision that informs everything the LHIN does.

The ESC LHIN's mission is to bring people and organizations together to build a better, more sustainable health system in order to achieve better population health outcomes.

The ESC LHIN values equity, efficiency, quality, innovation, partnerships, and being client-focused.

Strategic Priorities in 2016-2017

The ESC LHIN has established eight strategic priorities for the coming fiscal year.

1. Improved outcomes in hospital emergency departments

In the Erie St. Clair region, hospital emergency departments (EDs) continue to be the default portal through which many consumers gain access to health care. The resulting congestion in the ED is an indicator of overall health system performance, telling us how effectively our primary health care, community care, mental health, long-term care (LTC) homes, and hospital programs are working collaboratively to serve patients.

2. Improved outcomes in alternate level of care management

Too often, people remain in hospital when an alternate level of care (ALC) is available and would serve them better — for instance, at home or in LTC facilities, where services can be better tailored to their needs.

Although ALC rates (i.e., the percentage of inpatient beds occupied by ALC patients) in Erie St. Clair have decreased over the most recent fiscal year, this region continues to experience significant ALC pressures from individuals who have complex special needs. At the same time, the evidence indicates that patients recover better and faster when they are transitioned from acute care to sub-acute care or back into their communities. ESC LHIN's focus, over the next three years, will be on improving the transfer of patients in a timelier manner to the right care location, including rehabilitative care, community services, and their own homes.

3. Improved outcomes in chronic disease prevention and management

Chronic health conditions are increasing the overall disease burden in the Erie St. Clair region. Compared to the province, the Erie St. Clair population has higher rates of arthritis, asthma, diabetes, hypertension, mood disorder, chronic obstructive pulmonary disease (COPD) and heart disease. Of these conditions, the largest proportion of ED visits is associated with arthritis, heart disease, and COPD.

Optimal patient outcomes occur when people are supported on their journey through the health care system and in better managing their own care. Significant benefits for both patients and the system will result from finding ways to simplify access and improve navigation processes related to chronic disease prevention and management (CDPM), as well as from ensuring more timely

access to care for persons who have a chronic disease. At the same time, patients' ability to self-manage with confidence will also improve.

4. Improved outcomes in addiction and mental health care

Addiction and mental health care have a significant impact on EDs, acute-care settings, and community resources. The prevalence of mental health and addiction disorders in the Erie St. Clair region is 18%, affecting 120,000 people. This figure is higher than the provincial average of 16%.

5. Improved outcomes in rehabilitative care

Timely access to inpatient rehabilitative care within target time periods is an important way to return patients to independence in the community. Ensuring access to and the capacity of community and outpatient rehabilitative care are critical enablers of this goal. Meeting this goal will reduce both acute and post-acute care ALC days, maximize patient outcomes, and improve patient experience.

6. Improved outcomes in hospice and palliative care

High-quality, compassionate end-of-life care helps ease the suffering of dying people and their loved ones. The Erie St. Clair region has a higher annual mortality rate per 1,000 people than the province as a whole (81.3% vs. 64.9%), with some 5,200 deaths in 2011-2012. As well, the region's population has a higher-than-average number of seniors and people with chronic diseases. Currently, areas of excellence in hospice palliative care (HPC) have been developed across the region, and the ESC LHIN will continue to build on this success.

7. Improved outcomes in Indigenous health care

Research has shown that inequities continue to exist in health outcomes for Indigenous people, including life expectancies that are approximately five to 10 years lower than for the general population, for both men and women. This reflects the effects of the social determinants of health and many other factors.

8. Improved outcomes in French-language health care

Access to and accessibility of health services in French remains limited in the Erie St. Clair region. There is a persistent shortage of bilingual health care professionals in the region and a need to continue to identify existing and new bilingual staff. There also is an ongoing need to promote awareness among health service providers (HSPs) to provide linguistically and culturally appropriate services.

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

Success was realized in a number of key current programs, activities, and strategic areas over the past three years.

ED Wait Times

- Since the implementation of the provincial ED/ALC Information Strategy in 2008, significant actions have been taken to improve and document the ED patient experience. These include:
 - establishment of the Ministry of Health and Long Term Care's (MOHLTC's) Access to Care initiative as a data-collection and monitoring organization for ED and ALC
 - regular and timely public reporting of ED and ALC performance

- the creation of Performance Lead and ED Lead positions at the LHINs
- implementation of the provincial Pay for Results (P4R) funding program
- three waves of a provincial ED Performance Improvement Program for P4R-designated hospitals
- In 2012, the MOHLTC established Primary Care Physician Leads in each LHIN in order to support timely, accessible, and effective primary care and to prevent unnecessary ED visits. In the ESC LHIN, the Primary Care Physician Lead created a Primary Care Council (PCC) to advise on improving integration and quality improvement within the region's primary health care system. The Erie St. Clair PCC's community engagement activities include efforts to reduce avoidable ED visits and improve CDPM, as well as initiatives to reduce avoidable hospitalizations.
- As a priority, the ESC LHIN continues to monitor ED wait times in the region's five hospitals for high-acuity admitted patients, high-acuity non-admitted patients, and low-acuity patients. Specifically, the wait times for a physician's initial assessment, and times to inpatient beds, where required, are monitored.
- The P4R program is assessed on a monthly basis, with the goal of reducing ED wait times. The program also monitors performance and financial accountability through quality process improvement planning, evidence-based practices, and redesigned strategies. Since the program's inception, ED wait times have progressively decreased, while the acuity and volume of patients accessing ED care has steadily increased at most local hospitals.

Alternate Level Of Care

- Although the number of patients designated as ALC in Ontario has remained fairly stable over the last two years, the percentage of ALC patients in the ESC LHIN has decreased. However, the Erie St. Clair region continues to experience significant ALC pressures, as more individuals present with complex special needs. Addressing ALC challenges continues to remain a priority within the Erie St. Clair region.
- In May 2016, the ESC LHIN ALC rate of 17.2% was ranked fifth highest in the province. As a result, the ESC LHIN, in partnership with the ESC Community Care Access Centre (CCAC), developed a regional ALC Performance Management Working Group as part of the ESC LHIN Patient Flow/ALC Action Plan. The working group promotes and supports strategies across the region to ensure that people are living in the most appropriate settings, that system capacity is optimized, and that duplication of services is avoided or reduced. Areas of focus are:
 - post-acute care programming, including rehabilitation, complex continuing care, and community-based care
 - transitional care planning for individuals waiting more than 30 days for the most appropriate discharge destination
 - the complex needs of individuals requiring special care supports (e.g., acquired brain injury [ABI], neurological, behavioural, chronic mechanical ventilation)

Chronic Disease Prevention and Management

- In June 2012, the ESC LHIN board approved its first strategic plan. A key goal in this plan was realigning 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 populations identified included those living with congestive heart failure (CHF), COPD, and other complex conditions.
- Work to advance a COPD Integrated Care Path/Model by the CDPM Physician Lead is currently underway. The main objectives are to:

- establish HSP accountability to patients through improving access to care and incorporating the patient experience into planning and care
- improve the health of COPD patients
- better manage the costs of COPD care, ensuring a sustainable system is available in the longer term
- promote innovation through best practice uptake
- continue to build capacity through quality improvement. The COPD Care Path development process has been directly linked to the work of the PCC, ensuring better access to ongoing primary care
- Progress is also continuing on the implementation of a standard central intake referral form to facilitate a smoother process for health care providers (HCPs) and patients who require diabetes care services. The ESC LHIN continues to promote the development and dissemination of key clinical pathways for diabetes care, foot care, and optometry with relevant stakeholders and primary care providers. Quality improvements through the uptake of best practices continue to be a priority focus for this population.
- A final key priority is that of improving patient care for people with CHF.

Mental Health and Addictions

- Starting in 2013-2014 and throughout 2015-2016, the ESC LHIN invested in a number of promising practices and activities designed to address key performance elements such as repeat ED visits, community wait times, capacity pressures, and avoidable admissions. Investment highlights include the following:
 - opening of the newly founded Bluewater Health Withdrawal Management Services, which is intended to reduce reliance on ED and inpatient services and provide more comprehensive care for those who require it. It currently operates on a mobile outreach and day program basis. A proposal to build a facility to include withdrawal management beds and stabilization capacity is currently being developed.
 - the Rapid Assessment Intervention Treatment (RAIT) Team began operating in Chatham-Kent and Sarnia/Lambton. It provides clinical outreach for clients with moderate mental health conditions such as depression and anxiety. Clients are referred from primary care practices and the focus is on preventing moderate conditions from increasing in acuity. The program has expanded to reach a greater number of clients, including Indigenous communities.
 - the Second Stage Relapse Prevention Program at Westover Treatment Centre has evolved from a pilot to an annualized program. It is available to clients who have received addiction treatment (residential or outpatient) and who are self-identifying as being at risk for relapse.
 - the Fast Access to Community Experts (FACE) initiative is being embedded in mental health and addiction providers' dedicated service delivery. Providers have embraced the navigation and access mechanism as a foundation, whereby clients are rapidly connected to an appropriate service provider to meet their diverse needs.
- The ESC LHIN and local addiction treatment providers have embarked on a strategic planning initiative, which will identify regional treatment gaps as well as areas of strengths and opportunities for improvement.

Rehabilitative Care

- In September 2012, the ESC LHIN board of directors approved a three-year *Rehabilitation System Strategic Plan for the Erie St. Clair Region*, along with recommendations to move the plan forward. With this support, an ESC LHIN Rehabilitation Lead and the Rehabilitative Care Committee have worked collaboratively on the strategic goals.

- Significant gains have been made in the past three years toward building a coordinated system of rehabilitative care services to improve the experiences and clinical outcomes of patients who have suffered a stroke or orthopaedic condition, and of the frail geriatric population.
- A refreshed ESC LHIN rehabilitation strategic plan for 2016-2019 is in the process of approval. It will address the following key priorities:
 - strengthen rehabilitation in home and community settings, with a focus on medically complex older adults
 - improve coordination of the rehabilitative care continuum, with a focus on community programs and services
 - provide best practice rehabilitative care in all settings
 - standardize rehabilitative care across the continuum
 - enhance rehabilitation expertise and share knowledge system-wide
 - build on the collaborative capacity of the Rehabilitative Care Committee and Network
- In the past two years, standardized ESC LHIN-wide care pathways have been developed and are being adopted for patients with hip fracture and stroke, and for seniors who are frail/medically complex. These pathways will continue to promote the uptake of best practices across the continuum of care, facilitate appropriate utilization of inpatient rehabilitative care beds, and ensure access to community-based and outpatient rehabilitative care.
- The ESC LHIN Comprehensive Rehabilitation System Scorecard, developed in 2013, provides a “snapshot” of the ESC LHIN’s performance, emphasizing areas of success and those in need of improvement. This is now being transitioned into an online scorecard and dashboard system, to facilitate access to data by all system partners, and will continue to be refined and aligned to the provincial *Rehabilitation Care Alliance Rehabilitation System Evaluation Framework*, which was released in 2015.

Hospice Palliative Care

- The ESC Hospice Palliative Care (HPC) Network and the ESC LHIN continue to advance the commitments outlined in the provincial report *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action* (the “declaration document”).
- In February 2015, the *Hospice Palliative Care in Erie St. Clair – Strategic Plan* was released; this is the third formal strategic plan for HPC since the LHIN’s inception in 2006. This strategic plan builds on previous work in the region, including the many initiatives underway provincially, regionally, and locally.
- The ESC HPC strategic priorities currently being addressed are to:
 - facilitate creative planning and implementation of a continuum of services for HPC in Erie St. Clair
 - promote cross-sector initiatives that advance a system perspective and enhance knowledge transfer and exchange regarding best practices
 - continue to develop and implement creative models to maximize human resource expertise and facilitate recruitment and training
 - work with provincial partners to advance improvements in policy and education for HPC
- The process for implementation of these initiatives is through a shared accountability approach. As described in the declaration document, the ESC HPC Network is the lead structure set up to facilitate implementation and monitor progress. This network also connects to, and aligns with, the many regional and provincial initiatives underway. Evaluation is based on outcomes, provincially identified indicators, and regional measures.

- Building on past successes and promising practices, and leveraging current momentum, Erie St. Clair is well positioned to continue to advance these priorities.

Indigenous Health Care

- Over the past 12 months, work has continued with Indigenous communities within the Erie St. Clair region. This work focused on improving patients' access to care, building relationships with the communities, and health planning. Notable achievements include:
 - continuing to increase access to primary care services for the Indigenous population (including First Nations, Inuit, Métis, and urban Indigenous communities in Windsor/Essex)
 - expanding the provision of Indigenous cultural safety training for ESC LHIN staff, board members, and HSPs
 - advancing a strategy for access to traditional healing
 - developing a cultural model of care
 - continuing to foster relationships between the ESC LHIN and Indigenous leaders (including First Nations Chiefs and Councils)
 - hosting community engagement sessions with local Indigenous communities
 - participating in the Provincial Indigenous Leads Network
 - aligning local and provincial areas of focus with ESC LHIN initiatives (e.g., CDPM, mental health and addictions)

French-Language Services

- Over the past three years, several initiatives have been successfully undertaken to address the needs of Francophone communities. Some examples of new resources that have been developed or are being implemented include:
 - a French-Language Services (FLS) Toolkit
 - the French-Language Services Providers Network
 - new primary care access points in Pain Court and Windsor
 - supportive housing/assisted-living services for frail Francophone seniors at Résidence Richelieu in Windsor
 - weekly falls prevention exercise classes in Pain Court and Windsor
 - falls prevention mobile clinic for at-risk Francophone seniors in Pain Court
- The ESC LHIN continues to engage and work in collaboration with the Erie St. Clair/South West French Language Health Planning Entity to improve health outcomes for the Francophone population. A joint action plan has been developed and is updated yearly.
- Engagement with Francophone residents continues to be key to our ongoing success in this area.

Forthcoming Planning Activities and Directions

- As the ESC LHIN moves forward with the implementation of the eight strategic priorities identified in this annual business plan, which are consistent with the directions and tactics identified in *ESC LHIN's Integrated Health Service Plan 4 – 2016-2019* (IHSP), it has incorporated the following key objectives into its work:
 - access: more timely access to the right care
 - connect: better coordinated care in the community, closer to home
 - inform: support people and patients by providing the education, information, and transparency they need to make the right decisions about their health
 - protect: health care decisions based on value and quality, to sustain the system for generations to come

- Recently, the ESC LHIN has begun to incorporate a population-health approach to improving health care access and equity within the Erie St. Clair region. This has resulted in a focus that has shifted toward addressing emerging strategic priorities and plans at the local level for:
 - improving access to primary care
 - advancing a local health equity strategy
 - expanding the Health Links initiative
 - continuing to improve home and community care
 - developing a strategy for rural health care
- These strategies are aligned with the input received from the IHSP 4 community engagement with health care partners and members of the Erie St. Clair community. It is expected that these strategic priorities will become more fully operationalized through annual business planning processes as the ESC LHIN moves forward.

1.3 Assessment of Issues Facing the ESC LHIN

Population Characteristics

Erie St. Clair, the province's southern-most LHIN, comprises the municipalities of Chatham-Kent, Sarnia/Lambton, and Windsor/Essex. It is home to over 636,020 people, or 4.6% of Ontario's population. Between 2010 and 2015, Erie St. Clair's population decreased by 0.5%, while Ontario's grew by 5.1%.

The population of seniors (those aged 65+) across the Erie St. Clair region is growing faster than the province as a whole, however, the number of people under the age of 44 is decreasing. In 2015, 18.4% of the total provincial population were seniors (aged 65+), up from 16% in 2011. Compared to the rest of Ontario, Erie St. Clair has a slightly higher proportion of the population over the age of 60 and a slightly lower proportion of the population between the ages of 30 and 34. These differences in age distribution are most pronounced in the Chatham-Kent and Sarnia/Lambton communities.

Of the total Erie St. Clair population, 17% live in Chatham-Kent, 20% in Sarnia/Lambton, and the remaining 63% in Windsor/Essex. Compared to the province as a whole, Erie St. Clair has a larger percentage (5.2% larger) of its population living in rural areas. Population density is also considerably higher in Erie St. Clair: there are approximately 70 more people per square kilometre than in the province as a whole.

At the county level from 2010-15, the population declined by 4.2% in Chatham-Kent, 1.6% in Sarnia/Lambton, and 1.2% in Essex. Between 2015 and 2020, ESC LHIN the population is expected to decrease by 0.6% by 2020. During the same period, it is projected that the population of Ontario will grow by 5.3%.

In the Erie St. Clair region, 3.3% of residents identify as Francophone (i.e., claim French as their mother tongue), which is slightly lower than for the province as a whole. The Francophone population is also much older than the region's general population. Seniors represent 32% of this group, compared to 16% in the general population. Education and household income levels are also lower than for the general population. Out-migration of Francophone youth is of particular concern to the community.

The proportion of the Erie St. Clair population identifying as Indigenous has increased slightly since 2006 to 2.5%, which is about the same percentage as for the province as a whole. Eighteen percent of the ESC LHIN's Indigenous people live in Chatham-Kent, 39% in Sarnia/Lambton, and 43% in Windsor/Essex.

Although there has been a slight increase across the province in the proportion of the population who are immigrants or visible minorities, Erie St. Clair continues to be notably less diverse than Ontario as a whole. Within the ESC LHIN, Windsor/Essex consistently has a greater proportion of immigrants (2.2%) and visible minorities (10.8%) than do other areas.

Economic Challenges

The current economic challenges, which date back to the 2008 global recession, have resulted in a disproportionately high unemployment rate in Erie St. Clair compared to the rest of the province. From June 2014 to May 2015, the unemployment rate in Erie St. Clair was 9.3%, compared to 6.8% for all of Ontario. Unemployment was highest in Windsor/Essex (10.2%) and lowest in Sarnia/Lambton (7.2%).

Overall, the economic challenges of the past few years have had a significant 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 as well as mental health and addiction services.

Health Status and Chronic Conditions

Based on self-reported health status surveys, Erie St. Clair residents believe that they are healthier than they actually are. Information from the MOHLTC Health Analytics Branch shows that they have a lower life-expectancy rate, a higher age-standardized mortality rate, and a higher potential years-of-life-lost rate than do other people across the province (MOHLTC, *Environmental Scan, 2016-2019 Integrated Health Service Plans*, 2015).

Poor health practices correlate to an increased risk of chronic disease, mortality, and disability. Relative to the rest of the province, the residents of Erie St. Clair report higher rates of smoking, alcohol consumption, and obesity, along with lower rates of physical activity and healthy eating (Statistics Canada, 2011 Census Information on the *Canadian Community Health Survey* [CCHS]). These factors place the residents of Erie St. Clair at a higher risk for developing chronic conditions, especially diabetes.

The CCHS data further indicate that life expectancy among the region's residents is lower than for Ontarians overall. While overall female and male life expectancy at birth increased by 0.2 years for both Erie St. Clair residents and for residents in the province as a whole between 2006 and 2011, Erie St. Clair residents still have a lower life expectancy than their provincial counterparts. Indeed, the life expectancy for females is 1.2 years less; for males, it is one year less.

In Erie St. Clair, chronic conditions account for six in 10 deaths, one in four acute hospital admissions, and three in 10 acute hospital days. 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. Slightly more than 40% 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.

For Erie St. Clair residents aged 65+, more than 50% have two or more chronic conditions. Compared to Ontario, Erie St. Clair had higher rates of the following chronic conditions in 2013: arthritis, hypertension, diabetes, asthma, heart disease, and COPD. For all age groups, arthritis and hypertension are the most common chronic conditions.

Service Utilization

For almost all patients, the first point of access to the health care system is through a primary care physician. In the Erie St. Clair region, there are a total of 83 HSPs, including:

- five hospitals
- one CCAC
- four community health centres
- 37 other community HSPs
- 36 LTC homes

Opportunities exist to improve both access to and appropriate utilization of EDs. ED services are available in all but one of the five hospitals in Erie St. Clair (Hôtel-Dieu Grace Healthcare [HDGH], in Windsor).

In 2013-2014, patients who were assessed using the Canadian Triage and Acuity Scale (CTAS) at less urgent and non-urgent levels nevertheless continued to present at the ED for various reasons. For the 90th percentile ED length of stay (LOS), Erie St. Clair was just above the provincial average (8.1 hours compared to 8.0 hours).

From a patient-flow perspective, ESC LHIN efforts to provide better care, better experiences, and better value for the health care system resulted in improvements during 2014-2015. However, challenges remain. During 2014-2015, ALC rates continued to affect patient flow and patient experience. While the ALC rates for 2014-2015 declined across all four quarters, reaching 18.2% in the final quarter, they were still well above the provincial target rate of 12.7%. Several initiatives have been launched to improve this situation, including prioritizing implementation of the Home First program and exploring opportunities to repurpose idle LTC beds with restorative-type programming for frail individuals.

In 2014-2015, hospital statistics demonstrated that Erie St. Clair patients with COPD accounted for the largest proportion of acute care and ALC-patient days. Erie St. Clair had the largest proportion of ALC patients in the province discharged to complex continuing care facilities. (The top three diagnoses for ALC cases in Erie St. Clair were dementia, ischemic events, and heart failure.)

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

2.1 Emergency Department

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN

IHSP Priority Description/Current Status

In the Erie St. Clair region, hospital EDs continue to be the default portal through which many patients gain access to health care. The resulting ED congestion is therefore an indicator of overall health system performance, and a way in which the ESC LHIN can identify opportunities for health system improvement in primary health care, community care, and mental health care.

In the Erie St Clair region:

- nine out of 10 people with complex conditions requiring more time for diagnosis, treatment, or admission to a hospital bed spent 9.5 hours in the ED (currently, the 90th percentile of high acuity in Ontario is approximately seven hours; the low acuity is approximately four hours)
- nine out of 10 people with minor/uncomplicated conditions spent 3.8 hours in the ED (provincial target is four hours)

The ESC LHIN continues to focus on monitoring ED wait times in all five hospitals for high-acuity admitted patients, high-acuity non-admitted patients, low-acuity patients, physician initial assessment, and time to inpatient beds. In general, hospitals with a higher percentage of complex CTAS patients (levels 1 and 2) had a higher overall ED LOS (in the 90th percentile).

The ESC LHIN Quarterly Summary Report (the *Stocktake Report*) for the first quarter of 2015-2016 noted ED volumes of 74,493 patients, with an ED demand of 117 visits per 1,000 people. ESC LHIN volumes decreased by 4% compared to the previous year. The average quarterly volumes over the last nine quarters were 75,065. The majority of ED visits came from high-volume community sites, representing approximately two-thirds (62.6%) of the ESC LHIN's total ED volumes for the quarter.

Overall, the ESC LHIN has seen 5.3% of provincial ED volumes in the first quarter of 2015-2016. To date, mid-level CTAS level 3 patients contributed the most to ESC LHIN volumes (42.7%), followed by less serious CTAS level 4 patients (32.3%). Overall, 82.2% of ED patients were discharged back to their homes or places of residence (e.g., LTC home, retirement home, etc.), while 11.5% were either admitted to an inpatient bed or transferred to another facility.

PART 2: GOALS AND ACTION PLANS

Goals, Objectives, and Priority Populations

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
- develop an influenza surge plan across the region

- continue to develop recruitment and retention initiatives for the ED
- continue with the Home First philosophy and complex discharge review planning
- improve interfaces between care settings
- utilize ALC Performance Monitoring Team to improve patient flow strategies and accountabilities

Objectives

- establish and implement focused, high-impact patient-flow improvement action plans
- use the Ambulance Offload Time (AOT) tool to ensure that EMS resources are quickly redirected into the community instead of being held up in the ED awaiting a bed
- reduce avoidable re-hospitalization for key diagnosis
- launch a mandatory Return Visits Quality program to assess patients returning to the ED and admitted to hospital (within 72 hours for general cases and one week for high-risk cases)
- reduce ED visits and re-admission for chronic disease-management patients
- improve transitions, care coordination, and intensive case management
- institute a “one-number-to call” system in which Critical Care Ontario coordinates services between land ambulance and ORNGE air transport, in order to organize optimal patient-transport options
- enhance coaching, education, and support for patient self-management
- streamline mental health and addictions services between community providers and the hospital
- improve primary care access (after-hour and weekend coverage)
- improve access to primary care assessments in LTC homes for episodic care and follow-up and ongoing care
- increase use of Nurse-Led Outreach Teams (NLOTs) in LTC homes
- increase use of transitional care programming (e.g., convalescent care programs)
- improve patient flow from ED registration to inpatient admitted bed using the provincial standardized electronic Triage Acuity Scale (eCTAS)

Priority populations within the ED

- admitted patients
- high ED users
- high-risk seniors aged 65+
- frail elderly people
- individuals with behavioural and ABI special needs requirements
- chronic ventilation population
- individuals with multiple chronic diseases
- mental health and addictions patients who use ED services
- Indigenous people not attached to a primary care provider
- Francophones not attached to a primary care provider
- individuals and/or families living with a progressive, life-limiting illness

Consistency with Government Priorities

The MOHLTC and the ESC LHIN are aligned through a wide range of key strategies, aims, and measures that have been built upon various key recommendations from leading reports, the Ontario senior strategy report, *Living Longer, Living Well* (Sinha, 2012), and the *Assess & Restore Guideline* (2014).

Action Plans and Interventions	Percentage Complete by Year		
	2016-17	2017-18	2018-19
Explore ways to better manage those conditions that could be best managed outside the ED	50	60	70
Explore opportunities to improve acute care patients' access to a physician within seven days of discharge	50	60	70
Continue to expand P4R and Performance Improvement Plan strategies to reduce wait times in the ED, with a focus on the admitted population	30	50	70
At point of discharge, develop mechanisms that promote auto-referrals to a nurse practitioner or primary care provider	50	100	
Launch a mandatory Return Visits Quality program whereby the cases of patients returning to the ED and admitted to hospital (within 72 hours for general cases and one week for high-risk cases, such as myocardial infarction) must be reviewed by the hospital	60	100	
Develop strategies to support improved admission and discharge policies and processes to enhance and improve transitions in care (e.g., rollout of a provincial standardized eCTAS)	60	100	
Develop improved communications, customer service, and patient-satisfaction strategies for patients waiting in the ED	50	60	70
Explore opportunities to support ED-diversion strategies with HSPs (including emergency medical services, primary care, LTC homes, and CCACs), and rollout of an AOT monitoring system	50	100	
Review ED physician recruitment and retention strategies to ensure adequate continued coverage for the Erie St. Clair region	50	80	100

Expected Impacts of Key Action Items

- provide care in the most appropriate settings, thus reducing the rate of ED visits by 5% for those who would be best seen and managed elsewhere in the community
- increase the percentage of acute care patients who have had a follow-up with a physician within seven days of discharge by 25%
- reduce ED visits ESC LHIN-wide from 1,247 to 944 within three years for individuals with COPD aged 35+ (rate per 100,000 people)
- reduce ED visits ESC LHIN-wide from 456 to 362 within three years for individuals with CHF aged 35+ (rate per 100,000 people)
- reduce 30-day repeat visits to the ED by 5% within three years for people with mental illness and addictions
- divert 10% of current hospital mental health visits to the community sector for care management and support
- reduce palliative care visits to the ED to reach the 10th percentile of provincial performance
- increase the percentage of Francophone people attached to a family physician/primary care provider in a culturally safe primary care setting by 20%

- increase the percentage of Indigenous people attached to a family physician/primary care provider in a culturally safe primary care setting by 20%

Risks to Successful Implementation, Mitigation Plan, and Key Enablers

Risks

- varied access to timely primary care
- higher than provincial rates of chronic conditions (e.g., arthritis, asthma, diabetes, hypertension, mood disorder, anxiety disorder) driving ED visits
- opportunity for capacity and expertise enhancement in the community sector to effectively manage high-needs populations (e.g., behavioural, ABI, chronic ventilation needs)
- need to improve ED capacity during times of system overload
- continued undersupply of ED physicians in the ESC LHIN

Mitigation plan

- aligning and engaging ESC PCC goals and objectives to improve access to a primary care provider and/or NPs in the Erie St. Clair region
- develop and support improved 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 to support transitions of care for high-need populations
- refine surge-capacity plans to better manage hospital overcrowding
- continue to advance a community-wide ED physician-recruitment strategy
- work with hospital administrations to better manage and respond to bed availability and staffing issues that affect patient flow in the ED

Key enablers

- standardized approach to health promotion, CDPM, prevention, and self-management strategies that support best practices and knowledge translation through the Erie St. Clair region
- patient flow across the continuum of care for bedded patients
- the expansion of Health Links
- Behavioural Supports Ontario (BSO) capacity within Erie St. Clair
- a regional approach for ED diversion and episodic care for LTC homes
- a current and future-state ED-coverage inventory
- an ED physician-recruitment and retention plan

2.2 Alternate Level of Care

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN

IHSP Priority Description/Current Status

ALC challenges remain a priority within the Erie St. Clair region and are recognized as the symptom of a larger capacity issue across the entire continuum of care. Although the number of Ontario ALC patients has remained somewhat stable over the last two years and the number of ED patients waiting for an inpatient bed has declined, the patient populations are becoming more complex.

The Erie St. Clair region's population is aging, and its growth rate will double over the next 20 years. In particular, the number of residents aged 85+ and 90+ will quadruple during that time.

PART 2: GOALS AND ACTION PLANS

Goals, Objectives, and Priority Populations

Goals

- continue to support and enhance Home First philosophy and the *Assess & Restore Guideline* (2014)
- continue to support a coordinated approach to discharge process
- support best practice interventions to optimize recovery and outcomes
- focus on prevention and risk reduction
- advance standardized cross-continuum care paths
- identify earliest rehabilitation opportunities to restore functioning
- facilitate appropriate use of post-acute care options (e.g., rehabilitation, mental health, CCC, convalescent care, supportive housing, assisted living)
- identify high-needs population contributing to long waits
- enhance the primary care role in managing end-of-life patients
- initiate the use of early-warning risk-assessment tools

Objectives

- improve outcomes for ALC patients through dissemination and integration of evidence-based practices
- enhance restorative programming to reduce hospital-acquired functional decline
- reduce hospital utilization incidence rate for identified high-risk users
- reduce avoidable admissions and re-admissions on selected case mix groups
- continue to improve access to acute care capacity (medical, surgical, and critical care) through process improvement
- develop community care and discharge options
- improve time to LTC home placements for hospital inpatients and those in the community
- improve time to admission from acute to all levels of post-acute rehabilitative care
- continue to improve outcomes of implemented falls prevention program in institutions and homes
- create effective standardized educational programs for seniors with respect to services, supports, and programs available to assist them
- reduce acute LOS for chronic disease populations

Priority populations for ALC

- ALC patients in need of rehabilitation inpatient and community services
- high-risk frail seniors aged 65+ and especially 75+
- stroke patients
- fractured-hip patients
- assisted-living patients currently in complex continuing care (CCC) and/or convalescent beds
- individuals and/or families living with a progressive, life-limiting illness
- chronic ventilation patients
- ABI individuals
- top 1% and 5% of high ED-services users
- special-needs populations experiencing mental health and neurological issues

Action Plans and Interventions	Percentage Complete by Year		
	2016-17	2017-18	2018-19
Increase capacity for restorative/transitional care programs (e.g., convalescent care)	50	60	70
Continue to advance ALC-avoidance strategies and monitor for improved patient flow	40	50	60
Promote an assess and restore philosophy for the seniors population	50	60	70
Implement the ALC Resource Matching and Referral Program	80	100	
Explore the redesign of the complex-discharge review process across the Erie St. Clair region for long and exceedingly long waits	80	100	
Develop and implement community rehabilitative care services for patients with hip fracture	90	100	
Develop and implement a community-based early screening process to identify individuals with frailty/functional decline	90	100	
Increase capacity for restorative/transitional care programs (e.g., convalescent care)	50	60	70

Consistency with Government Priorities

These 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.

Expected Impacts of Key Action Items

- reduce the percentage of acute ALC to provincial target of 9.5% (ESC LHIN was 15.4% in the third quarter of 2015-16)
- reduce overall ALC rate to provincial target of 12.7% (ESC LHIN was 17.2% in the fourth quarter of 2015-16)
- maintain ALC throughput ratio at or above provincial target (i.e., greater than one)

- reduce the need for hospital acute services (inpatient discharges) within the next three years, from 500 to 350 acute patient days per 100,000 population
- increase community patient days by 150 per 100,000 population within the next three years
- meet the target of 7,250 new patient days (equal to 20 beds) for assisted living in Chatham-Kent, Sarnia/Lambton, and Windsor/Essex
- reduce hospitalization rate due to falls from 12% to 11.2% (per 1,000) for those aged 65+ within three years
- strive for a 5% reduction in readmission rates for frail elderly with chronic conditions within the next three years

Risks to Successful Implementation, Mitigation Plan, and Key Enablers

Risks

- ability to transition patients effectively to the most appropriate care setting with Home First philosophy
- ability to generate accurate ALC data analysis by site
- effective uptake on best practices in discharge planning
- growing elderly (aging) population with higher acuity needs and chronic disease
- behavioural/ABI populations

Mitigation plan

- ensure that the resident assessment instrument is completed within the acute care sector to improve transitions of care and restorative potential opportunities in the most appropriate setting
- education and performance tied to best practice implementation
- better uptake on self-management strategies for elderly
- LTC homes' education, supports, and resources for high-intensity needs for BSO, geriatric conditions

Key enablers

- ensure access to primary care and follow-up for the senior population
- Resource Matching and Referral initiative
- the provincial Rehabilitation Alliance Definitions Framework
- Assess & Restore project (SMART Program)
- use of quality-based procedures (QBP) for specific conditions
- Health Links

2.3 Chronic Disease Prevention and Management

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN

IHSP Priority Description/Current Status

The best patient outcomes occur when people are supported in better managing their own care. In the Erie St. Clair region, COPD care path development and implementation are currently underway in Chatham-Kent, and there is an opportunity to build on and expand this work. In addition, evidence-based discharge protocols exist and need to be used consistently across all hospital sites. Finding ways to simplify the access and navigation processes related to CDPM and ensure more timely access to care for persons with a chronic disease, while also improving patients' ability to self-manage with confidence, will lead to significant benefits for both patients and the health care system.

PART 2: GOALS AND ACTION PLANS

Goals, Objectives, and Priority Populations

Goals

- continue to improve CDPM population health
- provide quality care for individuals who have a chronic illness/condition
- achieve a lower per-capita cost for service provision to this population
- improve service coordination in the CDPM sector
- develop and implement ESC LHIN-wide standardized care paths
- develop an ED/hospital standardized discharge toolkit for COPD and CHF
- implement a centralized intake (single point of access for high-end users of the health care system)
- advance more culturally based models of care
- advance a CDPM strategic/implementation strategy for the Erie St. Clair region

Objectives

- simplify access to care through a single point of access/centralized intake mechanism
- standard assessment and discharge processes
- effective care transition points on the patient's care path
- improved patient flow across the care continuum ("right place at the right time")
- shared/collaborative care
- uptake on best practices (evidenced-based care models)
- clear, agreed-upon roles and accountabilities for all HSPs
- continue to provide alternatives to the ED/hospital
- strong performance and reporting mechanisms (including performance-target setting and advancement of standardized measures of success)

Priority populations for CDPM

- individuals with COPD
- individuals with CHF
- individuals who have suffered a stroke
- individuals with complications/high needs due to diabetes
- individuals with complications due to digestive disorders
- Indigenous people with a chronic disease and comorbidities

- Francophones with a chronic disease and comorbidities
- individuals and/or families living with a progressive, life-limiting illness

Consistency with Government Priorities

These goals are consistent with MOHLTC directions for CDPM.

Action Plans and Interventions	Percentage Complete by Year		
	2016-17	2017-18	2018-19
Advance and implement an ESC LHIN-wide standardized COPD care path	50	60	70
Initiate a heart failure care path development process (beginning in Windsor/Essex)	30	40	50
Advance and implement an ESC LHIN-wide care path for diabetes	80	90	100
Advance and implement a standard ED and hospital discharge protocol for better management of COPD and CHF patients	100		
Implement a centralized intake process ESC LHIN-wide for diabetes, based on the Windsor/Essex model (expanding first to Chatham-Kent)	90	100	
Advance/link with more culturally based models of health care	50	60	70
Formalize CDPM planning by developing comprehensive strategic and implementation strategy	90	100	

Expected Impacts of Key Action Items

- reduce 30-day readmissions from 24.5% to 12% within three years for individuals with COPD aged 35+
- reduce 30-day readmissions 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 rates from 19.7% to 17.7% within three years and reduce the daily or occasional smoking rate within three years from 22.2% to 18.9% (rate per 100,000 population)
- achieve a 2% reduction in ED diabetes visits
- achieve a 2% reduction in LOS for hospitalized diabetes-related complications
- place 90% of complicated CHF, COPD, and diabetes patients on a multidisciplinary care path
- place 100% of admitted CHF and COPD patients on a standardized hospital discharge protocol that links directly to CCAC and appropriate community supports

Risks to Successful Implementation, Mitigation Plan, and Key Enablers

Risks

- residents not adopting better lifestyle choices
- limited uptake on self-management support options
- opportunity for a preventative approach to health care management
- limited use of standardized community care paths (COPD, CHF, stroke, diabetes)
- a limited ability to effectively measure the impact of programs on patient outcomes; especially within Francophone and Indigenous communities where data is not as readily available
- establishing linkages with primary care for ongoing maintenance and prevention
- reliance on hospital EDs for after-hours and weekend health care service

Mitigation plan

- focus on health promotion, education, and self-management strategies as a response to longer-term health care improvement and positive lifestyle change
- formalize and operationalize linkages with primary care through care paths and program/protocol development
- develop and implement standard coordinated care paths/logic models for high-end users of the health care system (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 practices (linkages and targets) for connecting with primary care after a discharge from hospital and other critical primary care support components
- advance and/or extend models of after-hour care and crisis management within community settings

Key enablers

- development and implementation of coordinated care paths through LHIN-based networks
- focus on the uptake of best practices within the ESC LHIN's regions
- continued ESC LHIN leadership in developing tools to accurately measure and report on health system performance (and return on investment)

2.4 Mental Health and Addictions

PART 1: IDENTIFICATION OF THE INTEGRATED HEALTH SERVICES PLAN

IHSP Priority Description/Current Status

The prevalence of mental health and addiction disorders in ESC LHIN is 18.2%, or nearly 120,000 people, which is higher than the provincial average of 16%. One measure of how the system is performing is the number of repeat ED visits within 30 days. In 2013-2014, the Erie St. Clair region was the best performer in the province for the least repeat visits for substance abuse, but ranks third highest in the latest figures. The number of patients in this category revisiting the ED has also increased since the second quarter of 2013-2014 by 28.2% (from 142 to 182 visits). During 2014-2015, the figure is starting to increase, with notable changes from alcohol use to more complex, poly-substance use.

Similarly, in 2013-2014, the Erie St. Clair region ranked 11th in the province for repeat ED visits for mental health conditions. Since then, the region has reduced such visits by 14.2%, or 259 fewer visits. As a result of these gains, the ESC LHIN ranked third best in 2014-2015. The greatest opportunity to maintain and affect the repeat ED overall measures is in the Windsor/Essex area, where repeat mental health visits remain an issue.

PART 2: GOALS AND ACTION PLANS

Goals, Objectives, and Priority Populations

Goals

- in alignment with the MOHLTC's Mental Health Pillar Framework and the Provincial Mental Health and Addictions Leadership Advisory Council, the ESC LHIN's five goals are to:
 - promote resiliency and well-being in Ontarians
 - ensure early identification and intervention
 - expand housing, employment supports, diversions, and transitions from the justice system
 - provide the right care, at the right time, in the right place
 - fund based on need and quality

Objectives

- reduce addiction wait times and ED visits
- complete back-office integration for mental health peer-support agencies
- increase community-based counselling capacity
- conduct a refreshed local current-state analysis of mental and addiction services and the services' impact
- determine the current service-delivery model for older adults with responsive behaviours
- determine the optimal need of housing options and supports within housing and transitional-care options
- address service needs for police/mental health services
- build upon transitional-aged youth investments
- continue to advance community and bedded strategies to address high-risk, high-cost, complex ABI, dual diagnosis, mental health, addictions, and/or concurrent disordered clients
- monitor and report results quarterly

Priority populations

- high users of the ED and the overall system
- transitional-aged youth
- Indigenous people with mental illness and addictions
- Francophone people with mental illness and addictions
- patients who are opiate-dependent
- older adults with responsive behaviours

Consistency with Government Priorities

The ESC LHIN's investments align well with the MOHLTC pillars' framework (the foundation for the province's mental health and addictions strategy, *Open Minds, Healthy Minds*) and build upon prior investments. At a high level, the new investments are clustered under the respective pillars.

Action Plans and Interventions	Percentage Complete by Year		
	2016-17	2017-18	2018-19
Mental Health			
Refresh the Mental Health Priority Directions Plan and integrate with the Addiction Strategic Plan	60	70	80
Establish an Erie St. Clair core mental health basket of services	40	60	80
Continue to improve the effectiveness of the ESC BSO Geriatric Mental Health Model for Older Adults with Responsive Behaviours	70	80	90
Implement the FACE Initiative	90	100	
Implement and monitor the impact of promising practices for mental health and addiction patients	60	70	80
Continue to advance quality-improvement measures	50	60	70

Addictions			
Implement phase one of the Addiction Strategic Plan: redesign assessment, referral, and system navigation; and address community-capacity needs for enhanced community-based treatment options	50	60	70
Plan and implement housing investments	20	30	40
Spread the second-stage relapse prevention model ESC LHIN-wide	60	80	100
Advance the addicted pregnant women service partnership with child welfare services	80	100	
Continue to refine the withdrawal management-service partnership work in respective communities	80	100	
Increase program-retention rates and treatment options for people with substance misuse	60	70	80
Implement a monitoring mechanism for neonatal abstinence syndrome babies	80	100	

Expected Impacts of Key Action Items

- increased utilization of withdrawal management services/decreased use of ED or acute care for substance abuse management by 10%
- increased utilization of community-based addiction services by 10%, resulting in a 10% decrease in ED repeat visits rate
- reduce admissions to inpatient services by 5%
- increased knowledge, self-reported by the public (by 20%), of where to go for help (centralized assessment and referral)
- 10% increase in satisfaction rates reported by mental health and addictions clients through the perception-of-care measures
- increase the rate of mental health and addictions clients receiving follow-up from primary care providers within seven days of discharge by 10%
- increase the number of new mental health clients from priority populations previously not served by 5%

Risks to Successful Implementation, Mitigation Plan, and Key Enablers

Risks

- increased utilization of withdrawal management/addiction services may result in wait lists
- shared-care models may result in a greater number of people with moderate mental health and addiction issues requiring service
- psychiatry and specialized mental health and addiction human resources may not be able to keep up with demand

Mitigation plan

- Addiction Strategic Plan will introduce strategies to manage increased demand
- access to psychiatry will be expanded through telemedicine/telepsychiatry programming models

Key enablers

- ESC LHIN Addiction Strategic Plan aligned with the provincial Mental Health and Addictions Strategy
- telemedicine/telepsychiatry
- Ontario Telemedicine Network (OTN) equipment
- extensive engagement with communities prior to establishing mental health and addiction housing
- ongoing community engagement/public education on the overall mental health and addictions context

2.5 Rehabilitative Care System

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN

IHSP Priority Description/Current Status

Best practice care approaches are well established and documented for the top three priority rehabilitative care populations, and implementation across the Erie St. Clair region has been ongoing. 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 with a draft geriatric care pathway. Additional care paths for CHF, COPD, and diabetes patients will have implications for rehabilitative care planning.

Although significant progress has been made, a current-state assessment has shown that timely access to inpatient rehabilitative care continues to be an issue in some settings, 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 provided an initial assessment of bedded capacity gaps in the Erie St. Clair region. This model further highlights opportunities to begin aligning regional bedded resources to the recently approved provincial Rehabilitative Care Alliance (RCA) Definitions Framework for Bedded Levels of Rehabilitative Care and to implement the mandated Rehab/CCC Open Access initiative and Provincial Referral Standards.

The availability of community and outpatient rehabilitative care that is of sufficient intensity and duration contributes to delays in discharge from inpatient programs, as well as early intervention opportunities and potential avoidance of acute hospitalization. Evidence indicates that some patients are admitted to CCC or LTC disproportionately often when the 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 met through service in the home/community setting.

PART 2: GOALS AND ACTION PLANS

Goals, Objectives, and Priority Populations

Goals

- ensure all planning and implementation activities are in alignment with the provincial RCA strategic directions and deliverables
- identify and implement best practices for the top three rehabilitation clinical conditions
- facilitate the appropriate utilization of inpatient rehabilitative care beds (i.e., rehabilitation, complex continuing care, convalescent care)
- develop a continuum of outpatient and community-based rehabilitation services
- determine and address rehabilitation needs for medically complex frail seniors
- promote a self-management philosophy with residents and families in each program
- continue to advance standards for rehabilitation expertise for professional development
- promote public/health care professional understanding of rehabilitative care

Objectives

- refresh/advance a new three-year rehabilitation strategic plan for the Erie St. Clair region
- continue to improve the health of the population, enhance the patient experience, and reduce the per-capita cost of care
- provide opportunities that support specialized expertise and ensure that rehabilitation service providers work to their full scope of practice at all stages of care

- advance best practice interventions to optimize access, recovery, and outcomes
- develop standardized cross-continuum care paths
- continue to support equitable, timely access to care
- ensure that care transitions are being managed in a smooth and timely manner
- continue to promote prevention and risk reduction
- incorporate self-management within patient/client capabilities
- identify earliest rehabilitation opportunities to restore function

Priority populations

- patients with stroke
- patients with orthopaedic conditions, including hip fracture
- frail and medically complex older adults

Consistency with Government Priorities

These goals are consistent with the MOHLTC Seniors Strategy, *Assess & Restore Guidelines*, the provincial Rehabilitation Care Alliance, and directions for CDPM.

Action Plans and Interventions	Percentage Complete by Year		
	2016-17	2017-18	2018-19
Refresh the three-year rehabilitation strategic plan to determine priority directions	100		
Identify system gaps in specialized geriatric medicine/rehabilitation capacity in the Erie St. Clair region	90	100	
Determine the optimal rehabilitative care bed mix for the Erie St. Clair region	90	100	
Develop a geriatric care pathway	80	90	100
Implement a risk-screening mechanism for frail seniors in ED, primary care, and home care settings	80	100	
Develop an in-home model of rehabilitative care for frail seniors with restorative potential	60	80	100
Develop and implement a community-based, early screening process to identify and respond to individuals with frailty/functional decline and falls risk	90	100	

Expected Impacts of Key Action Items

- increase access to inpatient rehabilitative care for patients with hip fracture for up to 60% of those who lived in the community prior to injury
- reduce the incidence of functional decline by 50% for patients 65 and older admitted to acute care settings
- reduce by 15% or eliminate ALC days by 15% in acute care for patients waiting for inpatient rehabilitation
- reduce ALC acute care days by 10% for those waiting for LTC
- reduce ALC days to CCC and convalescent care by 5%
- reduce the rates of patients with stroke, hip fracture, and frail seniors admitted to LTC by 5%
- reduce LOS in acute and inpatient rehabilitative care by 5%

- reduce 30-day readmissions for priority populations by 5%
- increase ALC discharges to home with support by 5%

Risks to Successful Implementation, Mitigation Plan, and Key Enablers

Risks

- ability to identify the older adults' population, in both acute care and the community, that might receive the most benefit from rehabilitative care
- ability to effectively monitor results and impact of programs on improving patient functional outcome
- ability to continue to advance innovative models and programs of rehabilitative care within existing resources

Mitigation plan

- monitor progress of senior-friendly hospital implementation, particularly identification of hospital-acquired functional decline; this will inform data on the rehabilitation population in need
- to better assess the impact of change, develop and implement a comprehensive rehabilitative system-performance report card and online dashboard
- develop a sharing mechanism/process to support the awareness, exchange, and uptake of emerging innovative practices, including resources and standards developed by the provincial RCA

Key enablers

- ESC LHIN Rehabilitation Lead and decision-support position
- ensuring a collaborative decision-making approach about rehabilitative care with all health system partners
- formal data-collection tools and processes agreement from HCPs on performance targets and measures
- predictive models for rehabilitation utilization and growth of programs for the top three populations/diagnoses over the next 10 years
- system map and inventory of rehabilitation services representing the full continuum of care

2.6 Hospice Palliative Care

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN

IHSP Priority Description/Current Status

Erie St. Clair has a significantly higher mortality rate per overall population than the province as a whole (81.3% versus 64.9%), with 5,200 deaths in 2011-2012. The region's population also includes a higher-than-average number of seniors and people with chronic diseases. At least 1% 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. The need for palliative care will increasingly become more important in the Erie St. Clair region.

Hospice Palliative Care (HPC) includes bereavement and all forms of grief care (acute, chronic, and anticipatory). The Canadian Hospice Palliative Care Association estimates that each death in Canada affects 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 has been shown to improve the quality of life for persons with a life-limiting illness and for their caregivers, as well as improving resource utilization.

Despite the demonstrated benefits of palliative care, avoidable palliative admissions to acute care remain, individuals continue to die in locations that are not of their choice, necessary palliative visits to the ED continue, and referrals to palliative care do not occur or are not timely.

PART 2: GOALS AND ACTION PLANS

Goals, Objectives, and Priority Populations

Goals

- facilitate creative planning and implementation of a continuum of services for HPC in Erie St. Clair
- promote cross-sector initiatives that advance a system perspective and enhance knowledge transfer and exchange about best practice(s)
- continue to develop and implement creative models to maximize human resource expertise and facilitate recruitment and training
- work with provincial partners to advance improvements in policy and education for HPC

Objectives

- ensure timeliness of access to services
- continue to develop caregiver supports
- improve coordination and continuity across care settings
- introduce mechanisms for shared accountability
- promote advance care planning (ACP) and health care consent (HCC) across the continuum in Erie St. Clair
- build public awareness and community focus
- advance clinical best practices

Priority populations

- HPC is needed for all disease populations/categories, including chronic diseases, and is an approach required in all care settings where patients die

Consistency with Government Priorities

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

Action Plans and Interventions*	Percentage Complete by Year		
	2016-17	2017-18	2018-19
Align regional palliative care planning with the work of the provincial governance structure of the Ontario Palliative Care Network (OPCN)	50	60	70
Promote and increase the uptake on advance-care planning ESC LHIN-wide	30	40	50
Conduct and assess the impact of a family health team (FHT) HPC pilot project aimed at educating patients and their families on advance care planning	80	100	
Continue to advance an HPC education strategy across the region	60	70	80
Facilitate the coordination of community-based Palliative Care Consultation Teams (PCCTs) with other community resources	80	100	
Define and formalize HPC linkages with CDPM planning and Health Links	60	70	80
Strengthen linkages between volunteer visiting hospice programs and residential hospices	80	90	100
Support physician recruitment for HPC	60	70	80
Continue to improve data and reporting capabilities in the HPC	80	90	100

*Further details can be found in the Erie St. Clair Hospice Palliative Care Network and Local Health Integration Network's *Hospice Palliative Care in Erie St. Clair Strategic Plan* (February 2015).

Expected Impacts of Key Action Items

Priority indicators to measure palliative care success in the province include the following:

- provide appropriate HPC home support for 100% of discharged palliative care patients
- reduce unplanned ED visits by 15% in the last two weeks of life for those who have completed advance care plans
- decrease the number of palliative care patients seen in the ED within 30 days of discharge from the hospital by 20%
- aim for 40% of the patients in the FHT HPC pilot to have completed advance care plans
- reduce hospital readmissions within 30 days for palliative care patients by 20%

Risks to Successful Implementation, Mitigation Plan, and Key Enablers

Risks

- public misconceptions about the meaning of palliative care and its benefits
- poor uptake of HPC education for physicians
- failure to collaborate amongst/across health care sectors
- recruitment issues for specialist-level palliative care physicians, nurse practitioners (NPs), and other team members
- need for improved data collection
- continued use of the ED as the default position for HPC

Mitigation plan

- continue to provide HPC education to the public and HCPs across the care continuum
- strengthen accountability/collaborative structures as described in the declaration document
- implement “grow your own experts” recruitment strategies
- formalize HPC system performance reporting to the ESC HPC Advisory Council
- include ED in HPC education plan
- set up direct admissions processes for patients who clearly require admission, thereby bypassing ED

Key enablers

- ongoing provincial-level work on HPC
- cross-sector local community-based networks and groups working together
- enhanced HPC network structure and role
- strategic plan refresh will help focus and prioritize actions going forward
- recent addition of the Leamington and Chatham hospices

2.7 Indigenous Health

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN

IHSP Priority Description/Current Status

At present, there are approximately 3.3 million Indigenous people living in Canada, of whom about 61% are First Nations, 34% Métis, and 5% Inuit. These three groups all have unique geographic and linguistic heritages, cultural practices, and spiritual beliefs. More than one-half (55%) of Indigenous people live in urban areas, some with strong ties to their communities of origin and others who identify with those urban communities.

Research has shown that there are inequities in Indigenous health outcomes, including life expectancies for both men and women that are approximately five to 10 years lower than for the general population. The impact of the social determinants of health is prevalent.

Those determinants include poverty, overcrowding, and unemployment. In 2001, 41% of Indigenous children under the age of 14 were living in poverty, which was three times the national rate; 35% of these children were being raised by a single parent; and one in four single Indigenous mothers reported an annual income of less than \$10,000. In 2006, 11% of Indigenous people lived in overcrowded conditions (defined as greater than one person per room), which is four times higher than for the general population. As noted by the National Collaborating Centre for Aboriginal Health, *An Overview of Aboriginal Health in Canada, 2013, Report*, “First Nations, Inuit, and Métis peoples continue to experience considerably lower health outcomes than non-Aboriginal Canadians”.

PART 2: GOALS AND ACTION PLANS

Goals, Objectives, and Priority Populations

Goals

- continue to enhance service accountability and communications between First Nations health agencies, the ESC LHIN, and mainstream HSPs across Erie St. Clair
- support leadership and interfaces between care settings (hospital, NPs, primary care, and specialists)
- ensure coordination across service providers
- support people and patients by providing the education and information needed to make informed decisions about their health

Objectives

- conduct needs assessments of the following five First Nations 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), as well as the urban Indigenous population in Windsor
- develop a three-year Indigenous strategic health care plan
- develop and advance a collaborative model of health care premised on the recognition that cultural practices and traditions are essential to overall health and well-being

Priority populations

- Aamjiwnaang First Nation (Sarnia)
- Delaware Nation at Moraviantown

- Caldwell First Nation
- Chippewas of Kettle and Stony Point First Nation
- Bkejwanong Territory (Walpole Island)
- the urban Indigenous population in Windsor/Essex

Consistency with Government Priorities

These goals and directions are consistent with the MOHLTC direction.

Action Plans and Interventions	Percentage Completed by Year		
	2016-17	2017-18	2018-19
Advance a regional Indigenous care-planning process focusing on mental health and addiction	60	70	80
Ensure that Indigenous patients have increased access to primary care and other health services	50	60	70
Increase the utilization of telemedicine and telehomecare services within Indigenous communities	50	60	70
Advance collaborative models that will result in improved health care service quality	40	50	60

Expected Impacts of Key Action Items

- increase access to mental health and addiction services for the Indigenous population in need by 2%
- increase access to primary care by 2% for priority Indigenous populations
- improve the self-reported patient experience with the health care system by 10%
- increase uptake of telemedicine and telehomecare for populations in need by 5%

Risks to Successful Implementation, Mitigation Plan, and Key Enablers

Risks

- limited community participation in the planning process
- resistance and lack of willingness on the part of Indigenous and HSP stakeholders to jointly develop the collaborative model of care

Mitigation plan

- Indigenous Health Planning Committee members will promote the importance of participating in the planning process
- advance culturally sensitive community engagement methods
- ensure the Indigenous Health Planning Committee has continuous oversight of the project
- early and continuous engagement of all involved parties will be a critical success factor in the development and implementation of a collaborative model of care

Key enablers

- Indigenous Health Planning Committee
- formalizing the community engagement process
- preparing an outline needed to complete the strategic plan

2.8 French-Language Services

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PLAN

IHSP Priority Description/Current Status

Access to and accessibility of health services in French is an ongoing need in the Erie St. Clair region. Although more than 30 HSPs have been identified for the delivery of services in French, there remains room for improvement in order to meet the intentions of the *French Language Services Act*.

The effort to increase awareness and recognition of the need to provide linguistically and culturally appropriate services, and their benefits for patients and providers, continues to be part of the ESC LHIN planning process.

PART 2: GOALS AND ACTION PLANS

Goals, Objectives, and Priority Populations

Goals

- continue to improve access to and accessibility of health services in French
- ensure French-language service capacity in mental health and addictions is available in a timely manner (case management, counselling, crisis response, treatment, tier/bedded capacity, maintenance, family services, and support)
- enhance and/or build on services for the management and prevention of chronic diseases
- help Francophone seniors reach and maintain the greatest level of independence no matter where they live

Objectives

- continue to enhance the health care system's capacity to deliver French-language services
- foster awareness and availability of linguistically and culturally appropriate services

Priority populations

- Francophones living with mental health and addictions issues
- Francophones living with chronic diseases
- Francophone seniors
- French language-identified and designated HSPs

Consistency with Government Priorities

The above goals are consistent with the intentions of the *French Languages Services Act*.

Action Plans and Interventions	Percentage Complete by Year		
	2016-17	2017-18	2018-19
Build capacity to provide French-language services with designated HSPs	60	70	80
Increase access to health services in French	70	80	90
Continue to promote existing French-language services	70	80	90
Continue to enhance data-collection methods specific to the Francophone population	80	100	
Advance a human resources strategy (including an inventory) aimed at enhancing French-speaking health professionals	60	80	100
Develop and implement a linguistic and cultural competency training approach	70	100	

Expected Impacts of Key Action Items

- increase number of identified and designated HSPs that can actively provide FLS by 5%
- increase the number of Francophones self-reporting that they are very satisfied with the health services they receive by 10%
- increased awareness of available services in French by the Francophone population by 10%

Risks to Successful Implementation, Mitigation Plan, and Key Enablers

Risks

- maintaining the ongoing commitment from providers amongst competing priorities
- French-language human resources and other enabling resources are limited

Mitigation plan

- development of an ESC LHIN French-language services risk-management plan, providing increased education for providers on the need to embed FLS into their day-to-day operations
- provision of linguistic and cultural competency training and tools within the health care system

Key enablers

- a comprehensive French-language services education strategy
- a constantly renewed French-language services risk-management plan
- development of a community resource bank of French-language assets

3 ESC LHIN Operations and Staffing Templates

3.1 ESC LHIN Operations Spending Plan

Template A: 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	3,164,300	3,227,586
HOOPP	272,398	338,860	304,990	311,090
Other Benefits	356,560	328,800	370,600	378,012
Total Employee Benefits	628,958	667,660	675,590	689,102
Transportation and Communication				
Staff Travel	75,119	93,520	86,400	80,000
Governance Travel	10,825	20,000	16,000	15,000
Communications	60,116	53,900	45,000	45,000
Other Benefits	2,464	6,010	5,000	5,000
Total Transportation and Communication	148,524	173,430	152,400	145,000
Services				
Accommodation (includes Insurance)	299,559	323,990	332,310	335,000
Advertising	0	10,000	5,000	3,000
Community Engagement	37,172	50,000	50,000	40,000
Consulting Fees	53,954	51,100	44,300	25,500
Equipment Rentals	19,992	30,000	25,000	25,000
Governance Per Diems	63,425	86,150	99,000	90,000
LSSO Shared Costs (includes LHINC)	451,162	458,500	429,500	429,500
Other Meeting Expenses	46,730	51,210	50,000	45,000
Other Governance Costs	128,780	50,770	33,540	30,000
Printing & Translation	28,536	36,000	30,000	28,912
Staff Development	53,365	68,230	60,050	45,000
Total Services	1,182,675	1,215,950	1,158,700	1,096,912
Supplies and Equipment				
IT Equipment	32,480	30,000	32,000	30,000
Office Supplies and Purchased Equipment	32,826	33,960	35,610	30,000
Capital	22,528	0	0	0
Total Supplies and Equipment	87,834	63,960	67,610	60,000
LHIN Operations: Total Planned Expense	5,181,256	5,236,300	5,218,600	5,218,600
Annual Funding Target	5,236,300	5,236,300	5,218,600	5,218,600
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.

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 B: LHIN Staffing Plan (Full-Time Equivalents)				
Position Title/Classification	2014/2015 Actuals as of March 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	8	9	9
Lead	3	3	4	4
Analyst	4	5	5	5
Executive Assistant	1	1	1	1
Coordinators	3	2	2	3
Admin Assistant	8	7	7	7
Receptionist	1	1	1	1
Total FTEs	34	32	34	34

4 ESC LHIN Annual Business Plan Integrated Communications Strategy

4.1 Objectives

Supporting Business Goals

The ESC LHIN's communication strategies support its business goals through communications plans created for the implementation of the IHSP 4 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."

This year marks the launch of the ESC LHIN's fourth IHSP, a document that is designed to make strategic improvements to the local health care system. The IHSP 4, 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 2016 to 2019 and is the basis for this Annual Business Plan.

Through the IHSP, the ESC LHIN continues to build on previous successes and the efforts already underway, with a focus on the following key strategic priorities:

1. improved outcomes in EDs
2. improved outcomes in ALC management
3. improved outcomes in chronic disease prevention and management
4. improved outcomes in mental health and addictions care
5. improved outcomes in rehabilitation care
6. improved outcomes in hospice and palliative care
7. improved outcomes in Indigenous health care
8. improved outcomes in French-language health care

Communication Objectives

1. **Become more visible and vocal within the community.** The ESC LHIN must be more proactive about communicating messages that support its leadership position, and become more available to media and others in the community.
2. **Provide better health care system information and education.** As leaders, the ESC LHIN needs to help Erie St. Clair residents gain a better understanding of the health care system, how it works, and how they can make the most of the services available to them. Education must better target the system's users and service providers.
3. **Uphold the ESC LHIN's commitment to be open, transparent, and accessible to the public on LHIN priorities and initiatives.**

We want our communication strategies and tactics to:

- positively influence health behaviours to improve the health of local residents
- influence the public's opinion of LHINs, build trust in the work being done at the local level, and 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 experiences, and better value

The ESC LHIN's core communications activities include:

- **Better communications on priority initiatives:** Support the development of communications and resources aimed at educating the ESC LHIN's audiences about its key initiatives and role.
- **Better support for education/navigation:** Support the development of communications and resources aimed at educating and helping health care users to better access services and manage their health.
- **Better connection to the community through public affairs and issues management:** Support the development of communications and resources aimed at educating and helping health care users to better access services and manage their health.
- **Better media engagement:** Maximize protocols and practices for engaging media as a key audience and an essential vehicle for improving the ESC LHIN's leadership presence in the community.
- **Better use of multi-platform communications:** All communications should be developed in a way that facilitates distribution through multi-platform media.
- **Other tactics:** Support ongoing communication efforts for integration activities, provincial programs, and capital redevelopment projects as required. A number of major projects requiring communications activities will be rolled out this year, as identified in this plan. Specific communications plans will be created to support these projects as required.

Through extensive and ongoing interaction with the public and stakeholders, the ESC LHIN is able to inform its planning processes to improve health care locally. By ensuring that the planning is patient-focused, the ESC LHIN can be confident that it is improving the system in ways that make the patient experience better, at a lower 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* (see Section 5).

Provincial Context

The MOHLTC and the province of Ontario have developed future-focused plans to create a better health care system for all residents. The ESC LHIN supports putting patients at the centre of the health care system, with the aim of improving their overall health care experience.

4.2 Context

The ESC LHIN brings people and organizations together to build a better, more sustainable health care system in order to achieve better population health outcomes. The ESC LHIN's values are to be client-focused, equitable, and efficient, and to promote quality, innovation, and partnerships.

The ESC LHIN serves approximately 636,020 people in the regions of Chatham-Kent, Sarnia/Lambton, and Windsor/Essex. Although these regions are independent and each has unique qualities, they also share many commonalities, such as being surrounded on three sides by the Great Lakes. The area's urban-rural mix is economically dependent upon the agricultural, petrochemical, and automotive industries. As well, the region's American neighbours not only influence the local economy and trade, but also affect the use and perception of health care.

Windsor/Essex comprises 62% of the population; Sarnia/Lambton, 20%; and Chatham-Kent, 18%. The population includes immigrants (18.1%), seniors (18.4%; those aged 65+), Francophones (3.3%), and Indigenous people (2.4%) (*ESC LHIN 2014-2015 Annual Report*).

Erie St. Clair has a growing seniors' population, and is aging faster than the province as a whole, while our younger population — those aged between 0 and 44 years — is decreasing. In 2015, 18.4% of

the population were seniors (aged 65+), an increase from 16% in 2011. 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 vision is "Better Care, Better Experiences, Better Value." The ESC LHIN believes that 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

LHINs are the "local lens" for the provincial health care system; they regionalize the directions set by the MOHLTC to improve care for residents. The specific activities and areas of involvement through which the overall corporate strategies are being executed include the following:

- provincial strategies, initiatives, and programs
- IHSP 4
- the ESC LHIN 2015 Strategic Plan
- Governance Advisory Council
- Regional Transportation Strategy
- Chronic Disease Prevention and Management Care Paths
- Mental Health Strategic Plan
- Addictions Strategic Plan
- Community Capacity Plan
- Rehabilitation Strategic Plan
- Primary Care Strategy
- Indigenous health care
- integration activities
- hospice palliative care
- 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 from these strategies/activities for both the local and pan-LHIN roles.

4.3 Target Audiences

Primary

- consumers/patients of the health care system
- the general public
- the media
- HSPs
- elected officials

- MOHLTC
- ESC LHIN board
- ESC LHIN staff

Secondary

- partner organizations and stakeholders (e.g., Ontario Medical Association, Ontario Health Association, Ontario Association of CCACs, Association of Ontario Health Centres)
- physicians and allied health care 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

The ESC LHIN must be more proactive about communicating messages that support its leadership position. The ESC LHIN needs to be more available to media and others that act as interfaces between the ESC LHIN and the community. In alignment with its strategic direction of bold, focused leadership, the ESC LHIN will communicate the leadership decisions that will ultimately create a more tightly integrated, better aligned, and sustainable health care system in which people receive the best care possible.

Provide Better Health Care System Information and Education

As a health care leader, the ESC LHIN needs 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 system users and service providers. For example, by providing clear, understandable, and publicly available information on the programs and services available, the ESC LHIN will help improve health outcomes for all Erie St. Clair residents while also improving overall system navigation.

Support the LHIN's Leadership Role by Being More Vocal about Accomplishments, Successes, and Challenges

The ESC LHIN must do a better job of internally communicating its successes so that front-line spokespeople have a richer reservoir of stories from which to draw. The ESC LHIN must also be more willing to openly discuss plans, the issues that arise in their implementation, and the ways in which it is adapting to changing circumstances.

The ESC LHIN wants to show the residents of Erie St. Clair the work that is being done to improve patient care in their community. The communication of successful ESC LHIN initiatives and investments will improve the knowledge people have of LHINs and what services are available locally. If changes in health behaviour and metrics tied to the ESC LHIN's strategic goals and IHSP 4 are achieved, the ESC LHIN will have also met its communication objectives.

Guiding Communication Principles

- clear language
- transparent
- respectful of Canada's two official languages
- aligned to LHIN visual identity branding

Tactics

A variety of strategic communications tactics are used to reach the audiences outlined in Section 4.3. These tactics include, but are not limited to:

- traditional media products, social media, events, email, web/online, the *Community Report*, annual reports, LHINfo Minutes, the media engagement strategy, meetings, open board meetings, board highlights, open mic sessions, advance dissemination of board meeting materials and agendas, etc.
- for media use: proactive media pitches, third-party publications, availability as a health care resource, etc.
- for HSPs: the Governance Advisory Council, networks and advisory groups, memos, newsletters
- for elected officials: council meetings, one-on-one meetings, briefing notes

The ESC LHIN's communications tactics are based on local, provincial, and pan-LHIN strategies, and are in line with the International Association for Public Participation's (IAP2's) best practices for public engagement, and MOHLTC input and directives. The ESC LHIN strives to be proactive in its communications and uses a methodical, reactive approach when needed.

The LHIN's guiding principle is transparency: it is open and transparent in all communications, and its material is publicly accessible, primarily through the ESC LHIN website and other directed approaches. As well, by collaborating with HSPs and health care consumers, the ESC LHIN encourages the 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, communication pieces such as the *Community Report* are available in both official languages.

4.5 Key Messages

The ESC LHIN's messaging platform must recast its core values and mission, as well as its goals, roles, and responsibilities, in language that is easy to understand and remember. This is captured in the ESC LHIN vision: "Better Care, Better Experiences, Better Value."

What Is the ESC LHIN?

The ESC LHIN is the government agency that plans and funds health care services totalling over one billion dollars a year in the Erie St. Clair region — everything from hospitals to Meals on Wheels. The ESC LHIN's goal is to make the system better by understanding and responding to local needs and by getting health care services to work together more efficiently.

Project-Specific Key Messages

These messages are developed at the onset of the project and updated throughout the implementation phases of the communication plan.

Patients First key messaging

- Patient's First means a caring, integrated experience for patients and faster access to quality health services for all Ontarians.

- The *Patients First: Action Plan for Health Care* sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system by improving the health care experience:
 - Access
 - Improve access - providing faster access to the right care.
 - Connect
 - Connect services - delivering better coordinated and integrated care in the community closer to home; providing better home and community care.
 - Inform
 - Support people and patients - providing the education, information, and transparency Ontarians need to make the right decisions about their health.
 - Protect
 - Protect our universal public health care system - making decisions based on value and quality, to sustain the system for generations to come.
- As the next logical step in the *Patients First Action Plan*, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* proposes a path toward providing better access to care no matter where you live by better connecting health care services.

4.6 Evaluation and Monitoring

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

Media Monitoring and Analytics

Media are monitored daily for shifts in activity resulting from the ESC LHIN's 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, including Google clips, MOHLTC media clips, and Cormex Reports.

Social Media Monitoring

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

Communication Metrics

The ESC LHIN continues 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 constant sources of communication evaluation. Through both regular and planned channels, the ESC LHIN receives feedback and uses it to inform the LHIN's strategy and evaluate its effectiveness. Examples of feedback include, but are not limited to, feedback received from the public through our complaints and concern process, online feedback, open mic sessions at board meetings, meetings, surveys, and engagement sessions.

5 ESC LHIN Annual Community Engagement Plan

5.1 Introduction

All LHINs are required to publish a plan for community engagement that is updated annually. The plan is intended to provide the ESC LHIN community with an overview of activities planned within the fiscal year. The ESC LHIN's community engagement in 2016-2017 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* (LHSIA).

Key population and stakeholder groups include:

- patients of the health care system
- the Francophone community
- Indigenous communities
- newcomers and immigrants
- ESC LHIN-funded HSPs
- physicians
- allied HCPs
- public health and social service providers

The Annual Business Plan's deliverables are derived from the ESC LHIN's IHSP, a strategic document that is updated every three years. In 2015-16, the ESC LHIN began planning to update its current IHSP; this plan was presented for board approval in advance of its implementation on April 1, 2016. The writing of the IHSP is a significant undertaking that requires broad engagement with stakeholders to document and validate the current status of the local health care system, the health status of the population it serves, and opportunities for addressing the health needs of the population. As has happened in previous IHSP planning cycles, a dedicated community engagement strategy was developed to inform the creation of local strategies.

Other ESC LHIN initiatives also involved dedicated engagement plans and/or initiatives, including the following:

- Indigenous health strategy
- addictions strategy
- Behavioural 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 new community engagement opportunities during 2016-2017.

This section 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 each year or as required.

5.2 Community Engagement Activities

The following community engagement initiatives were undertaken by the ESC LHIN beginning in 2015-2016, and will extend into 2016-2017.

Indigenous Health Strategy

Through the engagement of the Indigenous Health Planning Committee (IHPC), a continued focus will be placed on improving access to culturally appropriate health care services for Indigenous people across the Erie St. Clair region. The following priority areas will be the emphasis of engagement and implementation for 2015-2017:

- conducting six community needs assessments
- developing a three-year Indigenous Health Strategic Plan
- creating a collaborative model of health care

The ESC LHIN Regional Indigenous Health Integration and Strategy Liaison will be a key support in putting this plan into action and/or collaborating with community partners on implementation. As such, working groups will be created where required to support the plan, and the IHPC will continue to guide these efforts, with the support of the ESC LHIN and the Regional Indigenous Health Integration and Strategy Liaison.

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 a phased implementation strategy completed through engagement of the Mental Health and Addictions Network.

Behavioural Supports Ontario and the Geriatric Mental Health Outreach Team Review

The ESC LHIN will undertake a review and evaluation of the Behavioural Supports Ontario's (BSO) and Geriatric Mental Health Outreach Team (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 implement the review's recommendations.

Care Path Implementation

The continued emphasis on better supporting and enabling the self-management of those with chronic conditions continues with the implementation of care paths. In 2016-2017, a significant stakeholder engagement process will also 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, and smoking-cessation care.

Complex Case Resolution Table

Increasingly, the ESC LHIN is becoming involved in facilitating the resolution of cases in which patients present with extreme and/or extraordinary health and social service needs. These are one-off

processes that HSPs are unable to manage independently and for which they seek the support of the ESC LHIN to work collaboratively across the continuum in finding unique solutions to unique circumstances.

In 2016-2017, the ESC LHIN will establish a complex case resolution table comprising 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 to and quality of care while enabling risk mitigation and ensuring that patients' right to have their information remain confidential is honoured.

French-Language Services Capacity Building

Through the leadership of the French Language Services Coordinator, the ESC LHIN 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 2016-2017 will consist of:

- ESC LHIN-wide: Establish a regional Health Links partnership table comprising Health Links lead agencies, the ESC LHIN Primary Care Lead, and other key stakeholders. This partnership table will 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 transitioning from implementation to an ongoing, sustainable entity.
- Essex County South Shore: Support the implementation of 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 East: Expand Health Links to Windsor through the required partnership/ governance structure and submit a readiness assessment to the MOHLTC.

Long-Term Ventilation Strategy

Through 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

In 2016-2017, the ESC LHIN will consider implementing the eRequest Module of Novari ESC LHIN-wide. Full implementation will be a two-phase approach over two years, and would allow for electronic requests/referrals for services from primary care to other service providers (e.g., specialists). Community engagement with key stakeholders, physicians, and HSPs will be necessary for a successful implementation. Education and ongoing change management in utilizing the eRequest Module will need to be provided.

Primary Care Council

The ESC LHIN will continue to leverage the ESC PCC in implementing CDPM strategies, the Health Links strategy, and the regional deployment of eHealth technologies slated for implementation in 2016-2017. In creating a regional steering committee for Health Links, the ESC PCC will provide expert advice in solidifying the standardization of Health Links practices.

Chatham-Kent Seniors Supportive Housing

In partnership with the local municipal housing lead, the ESC LHIN will continue its 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 the activities of daily living and the general monitoring of their health status, as a proactive way to enable them to continue living independently.

Suicide Prevention and Coordination Conference

An ESC LHIN-wide Suicide Prevention and Coordination Conference was held in 2015-2016 as a way to help educate HSPs and stakeholders and to complete the World Health Organization (WHO) environmental scan. The conference helped to identify needs in the Erie St. Clair region and outlined an engagement process with providers for moving to action.

Windsor Hospital Capital Planning

Completion of the required submissions for the development of a future single acute care hospital in Windsor, as per the MOHLTC Capital Planning Process, are continuing. Currently, the work is in phase 1B and will be finalized later in 2016 and submitted to the MOHLTC for approval.

At the same time, a community capacity plan is being prepared to determine which services may potentially transition from Windsor Regional Hospital to community providers. A robust 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 has asked each LHIN to complete a local eye vision strategy, based on the Provincial Vision Strategy Task Force report, *A Vision for Ontario: Strategic Recommendations for Ophthalmology in Ontario*. The strategy will define the communities' current and future needs through medical and surgical treatments. Key to this process will be input and feedback from patients, families, clinicians, and providers through a process to be defined.

Networks/Committees/Working Groups

Although the ESC LHIN is responsible for the planning and execution of time-limited, project-based initiatives for which 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 Mental Health and Addiction Leadership Table
- CareLink Regional Transportation Committee
- Community Analytics Steering Committee
- Data Consortium

- Decision Support Committee
- Erie St. Clair/South West French Language Health Planning Entity
- Executive Nurse/Clinical Leads Advisory Council
- FACE 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
- Rehabilitation Committee Network
- Residential Addictions Treatment Table
- Sarnia/Lambton Special Needs Working Group
- Smoking Cessation for both Windsor/Essex and Chatham-Kent
- Stocktake Review Table

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