



Annual Business Plan 2017–18

FINAL
July 20, 2017

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Transmittal Letter

Tim Hadwen, Assistant Deputy Minister
Health System Accountability and Performance Division
Ministry of Health and Long-Term Care
80 Grosvenor Street, 5 Floor, Hepburn Block
Toronto, Ontario M7A 1R3

Dear Mr. Hadwen:

The Erie St. Clair Local Health Integration Network (ESC LHIN) is pleased to provide you with its 2017-18 Annual Business Plan (ABP) for the fiscal year beginning April 1, 2017 and ending March 31, 2018. This plan outlines how we will improve the health care system in our region, in alignment with the second year of our fourth Integrated Health Service Plan (IHSP 4), *People First: Our Foundation for Local Health Care Change 2016-19*. It also demonstrates consistency with the recently released Local Health Integration Network (LHIN) mandate letter 2017–18 issued by the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, on May 1, 2017.

Specifically, the ESC LHIN will focus its improvement efforts on the following collective health system priorities outlined in the mandate letter:

1. Improve the patient experience within the health care system
2. Identify and address the root causes of health inequities
3. Reduce the burden of disease and chronic illness
4. Create healthy communities
5. Reduce variation in access to care
6. Ensure seamless transitions for patients between health care sectors
7. Support innovation in new models of care

Our plan continues to build on previous work and progress made toward addressing the *Patients First: Action Plan for Health Care* announced in February 2015, which highlighted these planning pillars:

- **Improving** access – providing faster access to the right care
- **Connecting** services – delivering better coordinated and integrated care in the community, closer to home
- **Informing** - supporting people and patients by providing the education, information and transparency they need to make the right decisions about their health
- **Protecting** our universal public health care system – making decisions based on value and quality, to sustain the health care system for generations to come

In advancing these initiatives, our LHIN will continue to engage local patients, the public, stakeholders and other interested parties to obtain their insights and input as we develop specific goals and action plans for improvement. We are excited about our early successes and the current transition and transformation underway within the health care system. Collectively, through hard work and a concerted, committed effort, we will achieve our goal of a high-quality, patient-centred health system that is sustainable into the future. The ESC LHIN Board of Directors acknowledges and thanks our many community partners and local residents who continue to take ownership and accountability for meaningful change in shaping their local health care system.

Sincerely,



Martin Girash
Board Chair, ESC LHIN

1. Context

Mandate and Strategic Directions

The Erie St. Clair Local Health Integration Network (ESC LHIN) is one of 14 LHINs established in 2006 by the Ontario government to plan, coordinate, integrate and fund health services at the local level. LHINs have been organized around geographic regions to facilitate system-wide planning, with a focus on identifying and addressing local needs.

The ESC LHIN's fourth Integrated Health Service Plan (IHSP 4), *People First: Our Foundation for Local Health Care Change 2016-19*, is the blueprint that will move the LHIN toward achieving its vision of "Better Care, Better Experiences, Better Value." It is a vision that informs everything the ESC LHIN does. To achieve this vision, the ESC LHIN brings people and organizations together to plan and build a better, more accessible, and sustainable health system that will result in improved population health outcomes.

The development of the Annual Business Plan (ABP) is generally guided by the IHSP and, more specifically, on a year-to-year basis by the LHIN mandate letter, which was issued by the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, on May 1, 2017. The ESC LHIN mandate letter focuses on key ministry initiatives and outlines the broad service and performance expectations for our LHIN in 2017–18. The ESC LHIN is strongly supportive of and committed to meeting the priorities of this letter, which provides the ground work for a more sustainable, efficient, and accessible health care system for future generations.

Generally, the mandate letter, aligned with the *Patients First Act, 2016*, sets out a number of "collective" priorities for the wider health care system in Ontario:

1. Improve the patient experience within the health care system
2. Identify and address the root causes of health inequities
3. Reduce the burden of disease and chronic illness
4. Create healthy communities
5. Reduce variation in access to care
6. Ensure seamless transitions for patients between health care sectors
7. Support innovation in new models of care

The mandate letter further acknowledges that 2017–18 is a transition year, as the LHINs and Community Care Access Centres (CCACs) engage in extensive (and ongoing) efforts to ensure the success of the CCACs' transfer to the LHINs. The mandate letter also differentiates between "transition" and "transformation"; the latter will be occurring for many years into the future.

At the local level, eight key strategic priorities were articulated in the IHSP 4. The priorities outlined in Table 1 are aligned with and reflect provincial directions for the health care system, as well as local feedback on how best to strengthen our capacity, commitment, and sustainability into the future.

Table 1: ESC LHIN IHSP 4 Strategic Priorities and Goals

ESC LHIN IHSP 2016-19 Strategic Priorities: Goals:	
Hospital Emergency Departments (ED)	- Reducing ED wait times - Increasing capacity and improving ED processes - Improving ED offload times for ambulances - Expanding community-based alternatives to ED services - Increasing public awareness that the ED is not the only option for people who need immediate, unscheduled care
Alternate Level of Care (ALC) Management	- Reducing the overall hospital system ALC rate - Increasing capacity for restorative/transitional care programs in the community - Continuing to promote ALC avoidance strategies (specialized geriatric rehabilitation capacity, early screening for frailty/functional decline)
Chronic Disease Prevention And Management	- Helping patients to better navigate the complex health care system - Educating patients and their families on the importance of lifestyle changes - Ensuring that care strategies are tailored toward the attitudes, beliefs, culture and preferences of clients - Continuing to promote/support self-management strategies - Providing outreach to individuals in the community setting
Mental Health and Addictions (MHA) Care	- Recognizing that mental health is essential to our quality of life - Continuing to recognize the possibility of recovery in the population served - Providing access to the right combination of services, treatments and supports, when and where people need them - Enabling people confronting MHA to be fully engaged citizens and active participants in all aspects of social and economic life - Reducing disparities in risk factors and access to MHA services, and strengthen the response to the needs of diverse communities - Reducing wait times for MHA services
Rehabilitative Care	- Ensuring that rehabilitation services and programs begin as early as possible in a patient's care journey - Continuing to advance early screening tools and processes to identify individuals with frailty/functional decline - Determining the optimal rehabilitation care/bed mix model for the ESC region - Continuing to promote/support the advancement of best practices and evidenced-based rehabilitative care
Hospice and Palliative Care	- Improving client/family, caregiver and provider experience by delivering high-quality, seamless care and support - Improving, maintaining, and supporting the quality of life and health of people with progressive life-limiting illnesses - Continuing to support/advance residential hospice/palliative care community alternatives to hospital care - Supporting efforts to ease the suffering and dying of people and their loved ones
Indigenous Health Care	- Identifying and addressing inequities that continue to exist in health outcomes for Indigenous people - Increasing knowledge of health care resources available and accessible to Indigenous people - Continuing to promote an environment of collaborative planning and relationship development - Communicating transparently and involving Indigenous people in the development, delivery and management of health care programs - Promoting holistic perspectives that help protect and promote the health, safety and well-being of Indigenous people

Table 1: ESC LHIN IHSP 4 Strategic Priorities and Goals

ESC LHIN IHSP 2016-19 Strategic Priorities: Goals:	
French-Language Health Care	- Continuing to identify the needs of our Francophone population and the gaps in accessing appropriate care - Increasing access and accessibility of health services in French across the region - Continuing to support efforts that promote awareness among health service providers (HSPs) to provide linguistically appropriate services - Continuing to support the recruitment of bilingual health care professionals across the region

Overview: Progress/Achievements 2016–17

There have been a number of local issues that impacted the planning and delivery of health services in the ESC region, including seasonal variability issues such as the flu surge, aging population, high prevalence of chronic diseases, and ongoing issues related to recruitment and retention of health care professionals. The work of the ESC LHIN has also been affected by new health system policy directions and evolving provincial priorities, such as primary care reform, the transformation of home and community care becoming a function of the LHINs, evolving models of Health Links care, long-term care (LTC) renewal, changes to eHealth and advancing technology solutions, palliative care reform, and the impact of health system reform funding on day-to-day activities and operations of providers.

Throughout this time of change and transition of the ESC LHIN, by receiving provincial direction, stakeholder feedback, and community engagement, has realized successes and improved quality in a number of areas during the past year, including but not limited to the following:

- ESC LHIN hospitals reduced their ALC patients rate from 17.3% to 15.9% over the past year
- All 36 long-term care homes (LTCHs) in the ESC LHIN achieved their 97% occupancy target in 2016, reflecting strong LTCH, CCAC, and LHIN collaboration
- The ESC CCAC achieved the shortest wait times in Ontario for admission to LTCHs
- The Chatham-Kent (C-K) Breathe Well Pulmonary Rehabilitation program improved the quality of life of 114 patients with chronic obstructive pulmonary disease (COPD) by assisting them in managing their chronic disease through education, exercise and support
- The CCAC Intensive Hospital to Home (IHH) program provided support to all ESC LHIN hospitals throughout the region. Since its inception in early 2016, the program has safely transitioned 68 complex patients from hospital to home
- Live Oculys reporting of Bluewater Health's (BWH) ED helped BWH, CCAC and the ESC LHIN work as a team to address the flu season, reducing impacts and better managing LTCH outbreaks
- The ESC LHIN introduced a new rigorous quarterly performance review process with its mental health, addictions and community support service agencies, in accordance with the provincial auditor general's recommendation
- The C-K Nurse Led Outreach Team performed 118 assessments in 3 of the 5 LTCHs in C-K, which resulted in a reduction in unnecessary ED visits and decrease in hospital admissions
- Collaborative Falls Prevention clinics installed approximately 420 grab bars
- For the first time, nurse practitioners (NPs) began working in LTC homes, thereby improving access to primary care in these facilities

- CareLink, the ESC LHIN regional health transit collaborative comprising eight agencies, bought seven new replacement vans to better address the transportation needs of people seeking health care
- Fourteen of the ESC's 36 LTCHs have been designated by the MOHLTC to upgrade older sections of their facilities to a new Class A standard
- Implementation of a cross-continuum hip fracture care pathway has supported 111 more patients with hip fractures to access inpatient rehabilitation, a 45% increase since 2012, and now nearing its target of 60%
- A Community Rehabilitation Outreach Team (CRRT) launched in Windsor/Essex at Hôtel-Dieu Grace Healthcare (HDGH) provided specialized in-home rehabilitation for 45 patients with stroke, resulting in shorter hospital lengths of stay (LOS) for these patients
- The Southwest Ontario Aboriginal Health Access Centre expanded into the ESC LHIN region. The Centre provided primary care services to 490 patients, child and youth MHA services to 88 patients, and traditional healing services (individual and group sessions) to 140 patients
- The Diabetes Central Intake process has been successfully implemented in the ESC region
- The Victorian Order of Nurses (VON) Immigrant Health Clinic served 900 refugees/immigrants, providing service in 53 languages, with an 85% referral rate to a primary care provider
- Chatham-Kent's Rapid Assessment Intervention Treatment Team (RAIT), an integrated mental health access model that includes direct linkages with primary care, served 319 individuals, 93% of whom were seen within a target time of 72 hours. The RAIT program had a dramatic, positive effect on repeat ED visits
- Crisis telephone supports for after-hours coverage were consolidated ESC LHIN-wide, resulting in greater efficiencies and ensuring that "hand-offs" back to the local provider occur in the next business day
- A Transitional Stability Centre day program for individuals with mental health and addiction issues was established in Windsor/Essex County. It served 428 individuals
- The Behavioral Supports Ontario (BSO) program was expanded to four ESC LHIN hospitals; they now have specialized behavior navigators to assist with transitions back to LTCHs or elsewhere in the community. Recent funding increases provided enhanced internal champions for all 36 LTCHs in the region
- Over 1,200 health care providers and palliative care volunteers received palliative care education within the past year
- Two new hospice residences (20 additional hospice beds) were added to the system; the service is now available ESC LHIN-wide
- The eShift program provided through the ESC CCAC helped more than 380 end-of-life clients receive care in their own homes during their palliation. The average number of patients supported every month through this program was 28, with an average LOS of 11.5 days
- Assisted Living Southwestern Ontario (ALSO) expanded and now provides assisted living/supportive housing services in French to Francophone seniors living at Résidence Richelieu in Windsor
- Telehomecare services were expanded ESC LHIN-wide and served 554 clients this year. In Windsor/Essex, clients with congestive heart failure (CHF) and COPD experienced significantly fewer ED visits after joining the Telehomecare program

Environmental Scan

Population:

The ESC LHIN is the province's southernmost LHIN, and is home to 627,633 people in the regions of Sarnia/Lambton (S/L), Windsor/Essex (W/E) and Chatham-Kent (C-K). W/E comprises 63.5% of the population; S/L, 20.2%; and C-K, 16.3%. Compared to the province as a whole, ESC has a larger percentage (5.2% larger) of its population living in rural areas. Population density is also considerably higher in ESC; there are approximately 70 more people per square kilometre than in the province as a whole. Table 2 outlines the region's population breakdown and demographics.

Table 2: ESC LHIN Population and Demographics

		ESC LHIN	Comparisons with the Province
Population		627,633	ESC LHIN's population represents 4.7% of the entire province's population
Population Growth		1.4%	Population growth between 2011 and 2015 shows that the ESC region is growing slower than the province as a whole (4.6%)
Immigration		112,700	ESC is notably less diverse (18.1% of population are immigrants) than Ontario as a whole (28.3% of population are immigrants). However, within the ESC LHIN region, W/E has a much greater proportion of immigrants (22.3%) and visible minorities (14%) than do other areas
Seniors 65+	2011	15.6%	Compared to the rest of Ontario (16.1% of population 65+), ESC has a slightly higher proportion of the population 65+
	2015	18.4%	
Children 0-4		5.33%	5.47% of the province's population is between 0-4
Language		1.3%	There are 1.3% of residents who do not speak either English or French in ESC. The rate for the province as a whole is 2.3%
Francophone		3.3%	Francophones (those who have French as their mother tongue) make up 4.4% of Ontario's population
Indigenous		2.5%	In 2011, 2.4% of the population of Ontario was Indigenous. In 2011, 30.2% of the ESC LHIN's Indigenous people live in C-K (2,905), 20.7% live in S/L (1,990) and 49.2% live in W/E (4,735)

Health Service Providers (HSPs):

There are 83 HSPs in the ESC region, including:

- Five hospitals
- One CCAC
- Four community health centres (CHCs)
- 37 other community HSPs
- 36 LTCHs
- Two Canadian Mental Health Associations (CMHA)

Health Profile:

Table 3: Health Status of ESC Residents Compared to the Province (Source StatsCan 2015)

Health Status Measures:	ESC LHIN	Ontario
LIFESTYLE:		
Obesity rate (%)	22.8	18.3
Heavy drinking (alcohol consumption – 5 or more drinks per occasion at least once per month) (%)	17.9	16.9
Current smoker, daily or occasional (%)	19.8	19.2
Current smoker, daily (%)	15.6	14.4
Leisure-time physical activity, moderately active or physical activity (%)	51.6	53.8
Fruit and vegetable consumption, 5 times or more per day (%)	34.1	38.9
DISEASE:		
Rate of COPD (%)	5.8	3.8
Rate of CHF (per 100,000 population)	113.9	86.9
Rate of arthritis (%)	20.8	17.2
Prevalence of high blood pressure (%)	20.6	17.6
Prevalence of asthma (%)	6.7	7.9
Prevalence of diabetes (%)	9.3	6.6
Prevalence of mood disorders (%)	8.0	7.6
Cancer incidence (per 100,000 population)	412.1	398.8
Colon cancer incidence (per 100,000 population)	49.2	47.8
Lung cancer incidence (per 100,000 population)	53.7	49.2
UTILIZATION:		
Hospitalization rate due to mental illness (per 100,000 population)	400	442
Hospitalization rate due to injury (per 100,000 population)	415	409
Rate of premature mortality injury (per 100,000 population)	279.2	239.0
Hospitalized stroke event rate (per 100,000 population)	133	119
Hospitalized acute myocardial infarction event rate (per 100,000 population)	233	198
30-day acute myocardial infarction (AMI) in-hospital mortality (rate)	8.0	7.6

Table 3: Health Status of ESC Residents Compared to the Province (Source StatsCan 2015)

Health Status Measures:	ESC LHIN	Ontario
Hospitalized hip fracture event rate (per 100,000 population)	479	479
Ambulatory care sensitive conditions (per 100,000 population)	303	269
Proportion of population with a regular doctor (%)	92.5	91.1
OTHER:		
Life expectancy at birth (years)	80.3	81.5
Life expectancy at age 65 (years)	19.6	20.3
Unemployment (%)	8.9	7.8
Youth unemployment, aged 15 to 24 (%)	17.9	15.8

LHIN Sub-Regions

The *Patients First Act, 2016*, provides guidance to the LHINs to establish smaller geographic sub-regions within each LHIN, in order to help better understand and address patient needs at the local level. The premise is that by looking at care patterns through a smaller lens, LHIN staff will be better able to identify and respond to community needs and ensure that patients across the region will be able to access the care they need, when and where they need it. The ESC LHIN has identified six sub-regions:

Table 4: ESC LHIN sub-regions

ESC LHIN Sub-regions:	Description:
Windsor	- Population: 210,091 232 primary care providers 16 CHCs - One acute hospital - One tertiary hospital
Tecumseh Lakeshore Amherstburg LaSalle	- Population: 108,355 59 primary care providers 16 CHCs
Essex South Shore	- Population: 71,927 39 primary care providers 16 CHCs - One acute hospital
Chatham City Centre	- Population: 69,036 49 primary care providers 15 CHCs - One acute hospital
Rural Kent	- Population: 32,648 14 primary care providers 15 CHCs - One acute hospital
Lambton	- Population: 126,199 102 primary care providers 12 CHCs - One acute hospital

ESC LHIN Sub-region Map



Access to Appropriate Levels of Care:

Emergency Department (ED) Length of Stay (LOS)

The Ministry LHIN Accountability Agreement (MLAA) includes two ED wait time indicators, one for complex visits and the other for non-admitted minor visits, which have set targets of eight hours and four hours, respectively. In the first three quarters of 2016–17, the ESC LHIN performed at 9.4 hours for 90th percentile complex LOS, or 9% better than the Ontario wait time. The ESC LHIN is performing close to the Ontario rate for the non-admitted low acuity LOS, at 4.1 and 4.2 respectively, but is still not within the four-hour target. ESC LHIN results indicate that the W/E EDs have much higher wait times than those at Chatham-Kent Health Alliance (CKHA) and BWH.

In addition to the MLAA indicators, the ESC LHIN also monitors the five pay-for-performance ED LOS-related indicators that span the patient journey, from their emergency medical services (EMS) wait times to their wait times for an acute bed. One of the biggest variances over the last few years has been the time to physician initial assessment (PIA), for which the ESC LHIN has scored poorly against other LHINs and the provincial average.

ED Visits Best Managed Elsewhere

The ESC LHIN improved on this indicator by reducing the rate of ED visits for conditions best managed elsewhere by almost 50%, from 8.1 in the third quarter of 2014–15 to 4.3 in the second quarter of 2016–17. As of the second quarter of 2016–17, the ESC LHIN is performing approximately 25% better than the Ontario rate of 3.2. Through an analysis to help inform the sub-region geographies, the LHIN found that the outliers in the region are tied to areas with lower areas of primary care access, predominately the rural areas of S/L and C-K.

Primary Care Per Capita

The ESC LHIN has approximately 30% fewer primary care physicians per capita than does Ontario. The provincial rate per 10,000 is 11.2. The equivalent rate within the ESC LHIN varies from 3.4 in south Chatham to 13.2 in Windsor West.

Alternate Level of Care (ALC) Rates

After a period of decline, the ESC LHIN ALC rate for all inpatient services experienced two consecutive quarterly increases, in the second and third quarters of 2016–17. At the end of the third quarter, the rate was 16.5%, slightly above the provincial rate of 15.6% and substantially above the provincial target of 12.7%. Major contributors to these increases were BWH's acute care services HDGH's post-acute care services.

ALC Patients

For open cases designated ALC in acute care, data to the end of December 2016 show that the top three discharge destinations in the ESC LHIN were 22% for rehab services, 21% for home with CCAC services, and 13% for complex continuing care. By comparison, for the province as a whole, the corresponding percentages were 12% for rehab services, 15% for home with CCAC service, and 10% for complex continuing care.

For open ALC cases designated ALC in post-acute care, the top three discharge destinations in the ESC LHIN were 29% for LTCHs, 22% for patients at home with community services, and 18% for patients at home with CCAC services. By comparison, for the province as a whole, 65% were waiting for a LTCH, less than 5% were at home with community services; and 5% were at home with CCAC services.

Wait Times

At the end of December 2016, for open cases in ESC LHIN in acute care waiting to be discharged to rehab, the median wait time was 8 days, while for those waiting for home with CCAC services, it was 32 days and for complex continuing care it was 29 days. For the province as a whole, the median wait time for rehab was also 8 days, for a home with CCAC it was 14 days, and for complex continuing care it was 16 days.

For open cases in post-acute care, the longest median wait times in the ESC LHIN were for LTC (221 days) followed by home with community care services (67 days). By comparison, for the province as a whole, the median wait time for LTC placement was 144 days, and for home with CCAC services it was 33 days.

Issues Impacting the Local Health Care System:

Aging Population

An increase in the aging population across Ontario and within ESC, has resulted in an increasing number of seniors who require more health services. As the population continues to age, the ESC LHIN strives to invest in programs and supports to promote healthy aging, a comprehensive continuum of health services to provide optimal care and support to older Canadians, and an environment and society that is “age friendly.”

Poor Lifestyles

Based on self-reported health status surveys, ESC residents believe that they are healthier than they actually are. Information from the MOHLTC Health Analytics Branch shows that ESC residents 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, 2016-19 IHSPs, 2015).

Relative to the rest of the province, ESC residents report lifestyles that include higher rates of smoking, alcohol consumption, and obesity. In addition, ESC residents reported lower rates of physical activity and healthy eating compared to Ontario overall. These factors place ESC residents at a higher risk for developing chronic conditions, especially diabetes.

Disease Prevalence and Complexity

Chronic health conditions are rapidly increasing the overall disease burden in the ESC region. Compared to the province, the ESC population has higher rates of arthritis, diabetes, hypertension, mood disorder, COPD, and heart disease. Of these conditions, the largest proportion of ED visits is associated with arthritis, heart disease, and COPD.

In the ESC LHIN, chronic conditions account for six in ten deaths, one in four acute hospital admissions, and three in ten 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 ESC residents (aged 12+) have a chronic condition, and 17% have multiple conditions. The prevalence of multiple chronic conditions increases dramatically with age.

Unique Populations

Currently in the ESC LHIN, there is a lack of available data and information on the health care needs and issues facing the Francophone and Indigenous populations within the region. ESC LHIN staff continue to work with and engage these populations to better understand patients' experiences and advance unique solutions that will result in better planning and better health care outcomes. As part of this work, an equity planning model and action plan are in the development stages.

Declining Population in Certain Regions

At the county level, from 2011 to 2016, the population declined by 2% in C-K. In S/L there was a slight increase in the population of 0.4%, and in W/E there was a net population increase of 2.6%. Ministry of Finance population projections indicate that between 2015 and 2020, the population of the ESC LHIN is expected to decrease by 0.6%. During the same period, it is projected that the population of Ontario will grow by 5.3%.

The ability to delivery health care services in rural settings closer to home is very challenging, especially in areas where the population is declining. The declining population in these areas also presents special problems vis-à-vis health care human resource recruitment and retention.

2. French Language Services (FLS)

Through various community engagement activities, the ESC LHIN has acquired a good knowledge of the general health of its Francophone population. This knowledge has helped inform the development of a Joint Action Plan with the French Language Health Planning Entity (FLHPE). The plan sets priorities and guides the work of both the ESC LHIN and the FLHPE.

The ESC LHIN has a collaborative relationship with the FLHPE. Regular meetings are held to share information, discuss progress, and plan future activities. The FLHPE is also involved in various committees, including the ESC LHIN FLS Providers Network, the HDGH FLS committee, and the ESC CCAC FLS committee. Community engagement with the larger Francophone population has been ongoing. Focused engagement activities are planned to help better understand the needs of specific population groups, such as Francophones living in Sarnia and frail Francophone seniors and their caregivers in the Lakeshore area of W/E.

The ESC LHIN has adopted a two-fold strategy to address the needs and concerns of the local Francophone community. First, the ESC LHIN works with its FLS providers to develop FLS plans and implement an active offer of FLS. Second, it works with its providers to develop specific initiatives to address gaps in service delivery, such as the expansion of supportive-housing/assisted-living services in French to frail Francophones. To this strategy, the LHIN strives to apply a Francophone lens in all its planning activities. The addition of planning/engagement structures by sub-regions will help to identify and address the needs and concerns of specific Francophone communities.

With the integration of home and community care, the ESC LHIN will continue to strengthen the delivery of FLS, based on the principle of an active offer. A review of processes in place will be conducted to ensure the linguistic identity of patients/clients and staff, and that processes are consistently and appropriately determined. A human resources plan that includes designated positions will also be developed, and a work plan to address remaining gaps will be established.

The ESC LHIN continues to provide FLS in compliance with the *French Language Services Act*, including local FLS obligations in service accountability agreements of its FLS-identified and designated providers. Following approval of its updated FLS plans by the LHIN Board, the ESC LHIN will monitor providers' progress through quarterly email updates and/or regular meetings.

3. Indigenous People

The ESC LHIN has been working closely with Indigenous leaders as well as Indigenous communities and organizations to build long-term relationships that honour the right to health determination and the principles of shared control, health equity, cultural inclusion, and holistic health.

The ESC LHIN's Indigenous Health Planning Committee (IHPC) comprises representatives from local First Nations communities, Indigenous Friendship Centres, Métis groups, and Indigenous organizations, and is responsible for identifying and addressing the priority health care needs of Indigenous communities within the ESC region. In January 2016, the IHPC completed a three-year strategic plan focused on:

- Reducing health inequities for Indigenous people
- Improving Indigenous patients' access to health and prevention services
- Improving health system support to Indigenous people with chronic diseases
- Expanding the availability of MHA services for Indigenous people
- Enhancing the quality and availability of reliable health planning information and data

The IHPC has also outlined specific activities and tactics for addressing the above strategic directions to be implemented by the ESC LHIN and monitored by the group. Finally, the ESC LHIN has offered Indigenous cultural awareness and sensitivity training to HSPs, ESC LHIN staff, and the ESC LHIN Board.

4. Operationalizing the Priorities

Summary of Priorities Consistent with Mandate Letter

As previously indicated in this document, the ABP is guided by the ESC LHIN mandate letter, which outlines the collective priorities for the wider health care system in Ontario, as well as specific priorities for 2017–18. Integrated planning and responsible fiscal management are the key principles supporting this work.

The ESC LHIN has integrated committees in place for certain sectors (e.g., hospice palliative care, MHA, Indigenous, etc.). Going forward, efforts will focus on uniting these committees/groups into a wider network (for each sub-region) consisting of primary care providers, hospitals, public health, mental health and addictions, and home and community care. As this work progresses, these networks will be responsible for advancing a more seamless patient care experience while also increasing the efficiency of administration, thus ensuring savings are reinvested into frontline care. The remainder of this section focuses on the specific priorities outlined in the mandate letter and a description of the initial efforts of the ESC LHIN to address these areas.

Transparency and Public Accountability

- The LHINs are to continue to be accountable for outcomes and reporting on progress toward achieving health system performance targets to be reported publically
- The LHINs will effectively manage all operational, strategic, and financial risks encountered by the LHINs while ensuring alignment with government priorities and achievement of business objectives

Toward this end, ESC LHIN staff will report regularly to the Board on the health system level stocktake indicators and performance achievements. This information is also reported to the public through public board meetings, the IHSP 4, and the ESC LHIN *Annual Report*. The ESC LHIN also prepares a risk summary report (and mitigation strategies) that is shared with its Board on a regular basis. Furthermore, it is anticipated that, in the future, the ESC LHIN will develop a cycle for public reporting on the progress of strategic planning objectives for the ESC LHIN and its sub-regions.

Improve the Patient Experience

- Establish and engage Patient and Family Advisory Committee(s) to ensure patients and families are involved in health care system decision-making
- Work toward improving transitions for patients between different health sectors so that patients receive seamless, coordinated care and only tell their story once
- Support patients and families by implementing initiatives that reduce caregiver distress

The ESC LHIN has begun to make strides and invest in strategies that address caregiver burden. Plans going forward will involve advancing early detection mechanisms (such as the EMS Paramedicine Program) in order to head off crisis situations due to caregiver burnout. Earlier intervention will comprise the screening of high-risk clients and the provision of home supports and respite options for the patient and families most in need, thus potentially reducing ED visits and hospital admissions. As well, the ESC LHIN is engaged with the University of Waterloo and interRAI to help identify community-based caregivers at risk. The objective will be to understand caregiver burden and support identifying opportunities for improvement to the quality of life for caregivers in their crucial roles.

Build Healthy Communities Informed by Population Health Planning

- With input from patients, caregivers, and partners, assess local population health needs, patient access and wait times, and the capacity of health providers to serve the community
- Through sub-regional (community level) planning, identify how providers will collaborate to address health gaps and improve patient experience and outcomes

As the sub-region approach to planning becomes more formalized, the ESC LHIN focus will shift to population health needs planning. Initially, to support this direction, the ESC LHIN will establish a network of providers that will work as a collaborative team (similar to the medical home concept) to improve care and health outcomes in the sub-regions. A key provider (and member of the team) that will inform this work and build health communities is the health unit(s). As per the *Patients First Act, 2016*, the ESC LHIN will be creating a regional Patient and Family Advisory Committee. Since a rich tapestry of similar groups exist among health service providers in the region, a regional model will support community level engagement in a collaborative strategy to address system gaps and support improvements to health outcomes.

Equity, Quality Improvement, Consistency and Outcome-Based Delivery

- Enhance existing and develop new performance and quality measurement frameworks to address regional priorities
- Implement quality standards in partnership with Health Quality Ontario (HQO)
- Promote health equity and recognize the impact of social determinants of health to reduce or eliminate health disparities and inequities in the planning, design, delivery, and evaluation of services by:
 - Identifying high-risk populations and working to improve access to appropriate and culturally sensitive care, and improved health outcomes for these groups
 - Ensuring engagement with Indigenous leaders, providers, and patients to guide investments and initiatives
 - Assessing the capacity and the extent to which Francophone citizens are provided with an active offer of health services in French in the region, and developing a plan to strengthen health services in French

Recently, the ESC LHIN established a health system Quality Network, an Equity Committee, in order to improve overall equity and quality across the health care system and the LHIN's ability to measure successes in these areas. Additionally, the ESC LHIN, in collaboration with local Indigenous communities, has an active Indigenous Health Strategic Plan, which is supported by the IHPC.

Primary Care

- Continue to build primary care as the foundation of the health care system and work with health care providers to develop sub-region plans that:
 - Use an equity lens to assess the number and proportion of primary care providers, based on the needs of the local population
 - Improve access to primary care providers, including family doctors and NPs
 - Facilitate effective and seamless transitions between primary care and other health and social services
 - Improve access to inter-professional health care providers to ensure comprehensive care
- As a priority, develop and implement a plan with input from primary care providers, patients, caregivers, and partners that embeds care coordinators and system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services as required
- Support the integration of Health Links into sub-regional planning, with input from primary care providers

Work is underway to support these directions through the Primary Care Council (which is assessing both equity and access needs at the sub-region level) and the CCAC/LHIN, which is in the process of advancing a new care coordinator approach, thereby placing home and community care coordinators on-site at selected locations (e.g., family health teams (FHTs), CHCs, etc.) in order to improve communications with primary care practitioners and enhance their ability to respond to patients' needs in a more timely manner. It is expected that, through this new model of care, timely system navigation and care transitions will be greatly improved.

Health Links will be established in sub-regions within the year (a total of four covering the entire ESC LHIN region) and a Regional Health Link Network, based on a strong governance model, has been set up in order to promote the successful spread and scaling of best/promising practices and advance a standard care model that integrates primary care as the centre of care for high-need populations within the ESC LHIN area. The success of this work will be tracked and measured using sub-region scorecards.

Hospitals and Partners

- Work with system partners to improve how people move through the health system, in order to avoid unnecessary hospital stays; reduce the length of time people must spend in hospital, including the ED; and reduce the number of people who are waiting in a hospital bed for the right level of care
- Support hospitals to enable the adoption of innovations in patient care, (e.g., bundled care)

As the sub-region planning approach is initiated, the networks will work together to create bundled care recommendations that benefit all involved parties, ensuring that resources within the sub-region are being maximized. The LHINs are also in the process of advancing an ALC strategy aimed at enhancing patient flow generally to a more appropriate care options/settings.

The stocktake quarterly review meetings with hospitals and wider community partners identify short-term priorities (90-day cycles) on how to improve care and avoid unnecessary hospital stays, and reduce the length of hospital stays and ED utilization; this is an ongoing effort. As the sub-region networks are established, a more comprehensive review of the quality based procedures (QBPs) will be initiated (within each sub-region) so that system solutions and innovative approaches (outside of the hospital walls) can be initiated.

Specialist Care

- To improve access to specialty care, work with providers to further reduce wait times and drive appropriate care utilization starting with people suffering from musculoskeletal (MSK) pain, and those suffering from mood disorders
- Support enhanced connections and communications across networks of providers to drive more effective and appropriate specialist referrals

Preliminary work has started at a LHIN-wide level to advance a central intake, assessment, and referral model/mechanism intended to enhance connections between primary care providers and specialists. These mechanisms will ensure that appropriate care is provided in an expeditious and equitable manner to everyone who needs it. The MSK population and the mental health system (focusing on those with mood disorders) will be prioritized. Over time, it is expected that this central intake model will be extended to other populations most in need (diabetes, heart failure, COPD, etc.).

Home and Community Care

- With input from patients, caregivers, and partners, reduce wait times and improve the coordination and consistency of home and community care so that clients and caregivers know what to expect
- Continue to implement the initiatives in *Patients First: A Roadmap to Strengthen Home and Community Care*
- Complete and consolidate the CCACs' transition to the LHINs

Considerable attention over the past six months has been placed on the successful transition of the CCACs to the LHINs. It is expected that there will be no disruption or change in patient services on or after the transition date. The ESC LHIN is working closely with patients and their families through its advisory council to ensure that home and community care coordination and quality are improving. Changes recommended by *Patients First: A Roadmap to Strengthen Home and Community Care* continue to be addressed.

Mental Health and Addictions

Based on the advice from Ontario's Mental Health and Addictions Leadership Advisory Council, work on the following priorities is underway:

- Expand access to structured psychotherapy and supportive housing
- Establish referral networks with primary care providers
- Make access to community mental health services a priority for sub-region planning, in collaboration with community and social service providers and partners
- Support the provincial opioid strategy, and provide support to connect patients with high- quality addictions treatment

For more information on this work, see "Mental Health and Addictions – Part 2: Goals and Action Plans" on page 26 of this report.

Innovation, Health Technologies and Digital Health

- Champion Ontario as a leading ecosystem to adopt and scale new and innovative health technologies and value-based processes
- Support the MOHLTC's Digital Health Strategy, once published, including but not limited to:
 - Ensuring that any hospital information system (HIS) renewal decisions are consistent with HIS Renewal Advisory Panel clustering recommendations, and that they reflect a commitment to reducing the overall number of HIS instances in the province

- Implementing or expanding existing virtual models of care or digital self-care models that are consistent with existing provincial initiatives
- Supporting the delivery of digital solutions to improve patient access and navigation as well as referrals to specialists, and further expand online consultation between primary care providers and specialists

Work is underway in this area through the sub-region planning structures, Health Links, and the uptake of directions from the Ontario Telemedicine Network (OTN). Integration of regional digital and patient information systems will continue, in support of the eHealth roadmap and the work currently underway at Connecting South West Ontario. As well, the ESC LHIN has implemented virtual care models for palliative and rehabilitative care. Opportunities to expand these models will be explored.

Success Measures

This year, the ESC LHIN is focusing on three key health system indicators as measurements of success, ultimately determining if there was integrated/coordinated improvement across the system:

- Readmissions (7-day and 30-day intervals)
- Occupancy rates (optimized occupancy rates as per defined targets for service priorities such as hospice, LTC, convalescent care, residential addictions programs, etc.)
- Disposition measures (discharge rates to homecare, convalescent care programs, MHA high case-mix groups accessing care in the community, etc.)

Table A below provides more details on priority projects for 2017–18, as well as each project's expected results across these three key health system indicators.

Part 1 – Table A: Summary of Priority Projects for 2017–18—Readmissions, Occupancy & Patient Transitions

Key Objectives	Plan for 2017-18	This Will Result In
Reduce Readmissions:		
Palliative and end-of-life care education to health care providers	Learning Essential Approaches to Palliative Care (LEAP) education to be delivered in all three counties targeting LTCHs and primary care teams	Reduction in readmissions through strengthening the knowledge base, thus elevating the confidence of providers to support palliative and end-of-life patients in community settings
Reinforcement of informal community capacity as integral care providers	Ramp up the W/E Compassion Care Community initiative to a full-scale application	Reduction in admissions/readmissions by building non-formal community care capacity supports enabling people to stay longer in their homes safely with supports (W/E)
Telehomecare/Telemedicine	Continue to expand Telehomecare and increase enrolment/service in both program areas	Proven to decrease ED revisits/admissions and 30-day readmissions for specific populations (COPD and CHF)
Institute a seven-day follow up protocol for all discharged patients (C-K)	Chatham Kent Health Alliance (CKHA), with its community partners (primary care, including FHTs, CHCs, and public health units), will establish a working group in order to increase follow-up for all discharged patients	Decreased ED visits and 30-day readmissions, and potentially result in fewer ALC admissions (C-K)
Improve access to primary care, MHA supports in domiciliary (dom) hostels (W/E)	In Q4 2016–17 the ESC LHIN funded one full-time equivalent (FTE) NP through the Street Health program to provide dom hostel with on-site primary care. Continue to measure impact/results of this program in 2017–18	Reduced use of ED and fewer admissions (readmissions) of those in dom hostels in W/E
Provide more community supports for people in need of opioid and alcohol withdrawal supports	Implement and spread the Rapid Addiction Assessment Medicine (RAAM) program and methadone clinics region-wide	- Reduced repeat ED visits and admissions for people with opioid and alcohol addictions - Improve peoples' experience with the addiction sector through the "right" service provider - Reduce overdose fatalities
Improve Occupancy:		
Reduce ALC days for acute care patients targeting hip fracture and stroke QBPs	Enhance/refine intake and admission processes for inpatient rehabilitation for patients with stroke. Assess reasons for ALC designation of patients with stroke and hip fracture	Potential savings of 2,500 (hip fracture) and 1,900 (stroke) conservable acute-care days by reducing acute-care occupancy toward targets based on 2015–16 data

Part 1 – Table A: Summary of Priority Projects for 2017–18—Readmissions, Occupancy & Patient Transitions

Key Objectives	Plan for 2017-18	This Will Result In
Increase utilization of the Convalescent Care Program (CCP)	- Expanded provider education on admission criteria for all bedded levels of rehabilitative care. - Implement a referral decision tree (Rehabilitation Care Alliance tools) to ensure that frail seniors are accessing the most appropriate bedded rehabilitation care	- Patients accessing the right level of rehabilitative care at the right time, resulting in better health outcomes - Support CCP partners in meeting the 80% MOHLTC target for occupancy by December 31, 2018
Expand access to supportive-housing/assisted-living services in French	Expand services offered in French at Résidence Richelieu to frail Francophones seniors living in proximity (neighbourhood of care)	- Maximize occupancy for FLS residents - Improved patient satisfaction - Better health outcomes for FLS residents
Simplify and standardize the Diabetes Central Intake process	Transition current local intake processes to a region-wide electronic referral system managed by CCAC	- Increase the number of patients referred to Diabetes Education Programs (DEPs) - Maximized DEP services ensuring access to this program closer to home - Reduced diabetes patients returning to hospital for care
Create a regional “viewer” of bedded system occupancy/utilization	Advance a system occupancy dashboard and review occupancy metrics daily to ensure appropriate flow and maximization of resources across all bedded settings	- Better management of available bedded resources region-wide - Better patient flow and outcomes promoting the right care at the right time - Overall system efficiencies
Advance a regional “viewer” on community service wait times/wait lists	Advance a system dashboard for community services that keeps track of wait times for specific programs/services	- Goal is to increase access to services - Better assess occupancy as an indicator of community need - Better coordinate scarce services ESC LHIN-wide
Creation of a bedded surge protocol (ESC)	Work with hospitals, CCACs, LTCHs, public health units, and others to create surge protocol (e.g., for influenza outbreaks)	- Mitigate system-flow issues, resulting in improved bed-management capabilities - Avoid cancellation of surgeries - Help to ensure occupancy does not exceed 100%
Improve Patient Care Transitions/Flow:		
Ensure that the optimal rehabilitative care bed mix exists in the ESC LHIN	Review and update rehabilitative care bed capacity plan from 2014 with current system functioning, patient access, and ALC trends	- Reduce ALC days for those patients waiting for rehabilitation or complex continuing care - Improved care transitions between bedded services

Part 1 – Table A: Summary of Priority Projects for 2017–18—Readmissions, Occupancy & Patient Transitions

Key Objectives	Plan for 2017-18	This Will Result In
Determine capacity needs for community-based rehabilitative care services (for stroke, hip fracture, and frail seniors)	Conduct a review (current and future state) of outpatient and community-based rehabilitative care in the sub-regions	Improve patient transitions to community as measured by discharges to home and reduced ALC days (acute and post-acute)
Build FLS capacity ESC LHIN-wide	- Continue working with designated HSPs to build their FLS capacity - Provide linguistic-competency training to providers	- Increased number of providers with an FLS plan - Increased availability of FLS - Increased patient satisfaction - Smooother patient transitions between HSPs
Improve access to primary care and mental health specialized trauma care for immigrants	VON clinical team provides coordination of available resources and navigation for newcomers and immigrants in need of primary care/mental health supports	Improved patient care transitions/patient experience and cross-sectoral system coordination
Strengthen and standardize transition processes across system of care	- Examine discharge processes and flow between care settings and across care providers - Modify processes, forms, structures as needed - Provide education in order to facilitate timely care transitions	- Improved patient care transitions - Improved patient satisfaction and recovery - Better system coordination and maximizing care efficiencies
Improve Hospital Discharge Planning for CHF and COPD Patients	- Implement a standard discharge checklist that includes QBPs - Develop driver diagrams across each site (hospitals and CCAC) to guide effective use of the checklist and to address any implementation challenges	- Enable CHF/COPD patients to receive timely and appropriate access to community supports - Reduce ED visits, readmissions into acute care, and ALC days - Greater system efficiencies, including the potential to reduce hospital LOS for target groups
MRI/CT (magnetic resonance imaging/computed tomography) advancement of radiology protocols (C-K)	Standardize MRI protocols and address staffing fluctuation in CT to be more efficient	Increase patient flow capacity to reach the provincial target of 90% of cases completed for MRI/CT (C-K)
Extending MHA hours of service (access) on weekends starting with S/L and adopting for C-K and W/E	- Initiate diversion plans from mental health ED visits to community mental health services on weekends - Create care pathways for police or other providers, (e.g., EMS), where appropriate	- Direct patients away from ED on weekends by offering a community support alternative - Improve mental health patient flow, access and care options within community sector

Part 1 – Table A: Summary of Priority Projects for 2017–18—Readmissions, Occupancy & Patient Transitions

Key Objectives	Plan for 2017-18	This Will Result In
Implement Personal Support Service Regulatory Amendments and Policy	• Initiate a process to identify community support service agencies to provide care coordination/stratification and personal support services for lower-need clients, thereby freeing up the ESC CCAC to focus on moderate- and higher-needs clients	• Improved access to home care and reduced ED visits and hospitalizations • Cross-sector common standards, tools, and processes, including assessment, intake, and wait-time management

Emergency Department

PART 2: GOALS and ACTION PLANS

Goal(s):

- Provide care in the most appropriate settings, thus reducing the rate of ED visits
- Lambton Kent CMHA to extend hours on weekends which is expected to decrease the number of mental health ED visits at BWH
- Implement the Transitional Stability Centre (TSC) as a mechanism for ED avoidance for mental health repeat visitors
- Implement short stay units ESC LHIN-wide by January 1, 2018
- Implement the “Choosing Wisely” philosophy and conduct preliminary analysis of impact by April 1, 2018
- Ensure optimal uptake of Detection of Indicators and Vulnerabilities for Emergency Room Trips (DIVERT) ESC LHIN-wide

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, including the Ontario Senior Strategy Report, *Living Longer, Living Well* (Sinha, 2012) and Assess and Restore (A&R) Guideline (2014).

Action Plans/Interventions:	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Rapid Assessment Zone or similar models across the ESC LHIN to improve time to physician initial assessment LOS	In progress	30	In progress	50	Complete	20
Programs in the community for ED diversion/avoidance: CMHA weekend hours, TSC, DIVERT assessment	In progress	30	In progress	30	Complete	40
Pull strategies – mental health short stay unit	In progress	30	In progress	40	Complete	30
Choosing Wisely: Appropriate clinic treatment protocols; diabetes insipidus (DI), lab/tests	In progress	30	In progress	30	Complete	40

LHIN Measured Successes

- Care provision in the most appropriate settings will result in a reduction of ED visit rates 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 visit rate for ESC LHIN-wide for individuals with COPD aged 35+ (rate per 100,000 people)
- Reduce ED visit rate for ESC LHIN-wide 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
- 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 primary care setting by 20%
- Increase the percentage of Indigenous people attached to a family physician/primary care provider in a primary care setting by 20%

Risks/Barriers:

- CMHA: Patients may continue to use the ED despite CMHA extended hours, due to entrenched behaviour/dependency on the ED. Also, ability to sustain extended hours is dependent upon P4R stable performance and funding
- Short Stay Unit: Access to psychiatry consultants to enable referral to Short Stay Unit
- TSC: Changing behaviour and effectively directing patients from ED to TSC and socialization of program to non-allied health
- Choosing Wisely: Concern regarding physician liability in leveraging diagnostics for confirmation of diagnosis as well as patient/family demands for specific tests to be performed

Mitigation of Risk:

- P4R: Hold hospitals accountable to P4R performance by working with ED chiefs and physician champions
- DIVERT: Education of CCAC a success, with diversion programs to hospital stakeholders
- Short Stay Unit: Continued engagement of ED physicians on leveraging on-call schedule for psychiatry consultation
- TSC: Educating public and stakeholders, sustainability of in-kind resources for the multi-disciplinary care team
- Choosing Wisely (a tool related to the appropriateness of recommending imaging tests): Educating physician outcomes associated with implementation; specific to adverse events

Key Enablers:

- Stakeholder engagement, education and enhanced regular communication

Alternate Level of Care

PART 2: GOALS and ACTION PLANS

Goal(s):

- Continue to support and enhance Home First philosophy and A&R philosophy across the care continuum restorative potential
- Continue to support a coordinated approach to the 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 function
- Facilitate appropriate use of post-acute care options (e.g., rehabilitation, mental health, complex continuing care, convalescent care, supportive housing, assisted living)
- Identify high-needs population contributing to long-wait ALC volumes
- Enhance the primary care role in managing end-of-life patients
- Initiate the use of early warning risk assessment tools
- Develop surge ESC LHIN-wide protocol

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.

Action Plans/Interventions:	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
CCP: Increase occupancy ESC LHIN-wide	In progress	50	In progress	30	Complete	20
Ensure optimal utilization of CCAC IHH program	In progress	30	In progress	30	Complete	40
Ensure appropriate utilization and occupancy of bedded rehabilitative care	In progress	30	In progress	30	Complete	40
Advance an effective standardized surge protocol (ESC LHIN-wide)	In progress	50	In progress	40	Complete	10
Rent supplements and support services to expand the MOHLTC's seniors supportive housing program	In progress	40	In progress	30	Complete	30

LHIN Measured Successes:

- Reduce the post-acute ALC rate to provincial target of 12.7% (ESC LHIN was 19.2% in the fourth quarter of 2016-17)
- Maintain acute ALC rate below provincial target of 12.7% (ESC LHIN was 12.3% in the fourth quarter of 2016-2017)
- Maintain ALC throughput ratio at or above provincial target (i.e., greater than one)
- Achieve at least 90% occupancy in CCP, in all homes in ESC LHIN, by December 31, 2019
- Increase number/percentage of referrals to CCAC before discharge from hospital for IHH for appropriate cases April 1, 2018
- Decrease percentage of discharges acute care to LTC, and increase the percentage who need lower intensity home care

Risks/Barriers:

- Occupancy of CCP: Supply and demand for CCP beds. Eligibility criteria, complexity of clients they accept (barrier), availability to book in advance for orthopedic patients
- IHH: Uptake of referrals, family/patient concerned with reduced services after 30-day stay, impact of community wait list for LTC, family concern for patients going home waiting in crisis if they do not get a LTC bed within time expected
- Surge: Institutions accepting role in surge and implications of ALC patients (both acute and post-acute care hospitals)

Mitigation of Risk:

- CCP: Ongoing collaboration between stakeholders to identify capacity and appropriate patients, making hospitals aware of eligibility criteria, better communication of when CCP beds become available (expected discharge dates)
- IHH: review of LOS policy for IHH, clear identification of eligibility, education to hospital providers, use of DIVERT tool to support those in community at risk of ED visits
- Surge: Funding new capacity (IHH, assisted living), surge planning process. Engagement with and collaboration between providers

Key Enablers:

- CCP: Care coordinators identifying appropriate patients and communicating capacity (expected discharge/open beds)
- IHH: Complex discharge rounds to identify appropriate patients, use of DIVERT tool
- Surge: Surge planning table, access to timely and accurate (validated) hospital data

Chronic Disease Prevention and Management

PART 2: GOALS and ACTION PLANS

Goal(s):

- Reduce the burden of disease and chronic illness in the ESC region
- Improve service coordination in the chronic disease prevention and management (CDPM) sector
- Advance a central mechanism for assessment and referral for those in need of chronic disease supports
- Improve timely access to care in this sector and across sectors
- Ensure that patients are better able to self-manage their conditions
- Improve information collection and sharing mechanisms within this sector and across sectors

Consistency with Government Priorities:

These plans are consistent with the Minister's mandate letter. The plans also align and are consistent with the directions outlined in the IHSP 4.

Action Plans/Interventions:	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Diabetes eReferral system (enhanced central intake)	In progress	50	In progress	30%	Complete	20
Implementation of a standardized discharge checklist designed to reduce unplanned ED visits and hospital readmissions for CHF and COPD patients	In progress	40%	In progress	40%	Complete	20%
Continue to implement standard care paths (in the sub-regions) for COPD, CHF, diabetes, stroke	In progress	30%	In progress	30%	Complete	40%
Development of consistent work plan objectives and measureable indicators (process and outcome) across paediatric diabetes education programs (DEPs) in ESC, designed to reduce reliance on acute care services	In progress	40%	In progress	20%	Complete	40%

LHIN Measured Successes:

- 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%
- 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/Barriers:

- Adoption of poor lifestyle choices
- Continued reliance on hospital EDs for after-hours and weekend health care service
- Limited use of standardized community care paths (COPD, CHF, stroke, diabetes)
- Limited available data/information needed to measure the impact of programs on patient outcomes
- Difficulty establishing linkages with primary care physicians for patient health ongoing maintenance and prevention

Mitigation of Risk:

- Focus on health promotion, education, and self-management strategies as a response to longer-term health care improvement and positive lifestyle change
- Advance and/or extend models of after-hour care and crisis management within community settings as an alternative to ED utilization
- Develop and implement standard coordinated care paths/logic models for high-end users of the health care system (COPD, CHF, stroke, diabetes)
- Advance sub-region scorecards to measure the impact of specific programs on population health
- Formalize and operationalize linkages with primary care through care paths and program/protocol development
- Directly connect patients with a primary care provider after a discharge from hospital

Key Enablers:

- Implementation of coordinated care paths through ESC LHIN-based networks
- Promotion of the uptake on best practices within the ESC LHIN's sub-regions
- Having tools to accurately measure and report on health system performance (and return on investment)

Mental Health and Addictions

PART 2: GOALS and ACTION PLANS

Goal(s):

- 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
- Funds based on need and quality

Recently, the MOHLTC and all 14 LHINs adopted three overarching priorities as a means of system transformation:

- Promote, prevent and intervene early across the life span
- Close critical service gaps for youths, addictions, psychotherapy, and supportive housing
- Build foundations for system transformation

Consistency with Government Priorities:

The ESC LHIN's current focus is consistent with the MOHLTC Care Open Minds Strategic Plan, including its foundational pillars.

Action Plans/Interventions:	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Refresh the mental health priorities and align with the Addictions Strategic Plan and provincial directions (e.g., core services and new benchmark targets for Multi-Sector Service Accountability Agreement (MSAA))	In progress	50	Complete	50		
Implement and monitor prior investments /promising practices, including benchmarks and system level targets	In progress	50	Complete	50		
Continue to improve the effectiveness of ESC LHIN BSO through LTCHs and cross- sectorial transitions	In progress	60	In progress	30	Complete	10
Finalize the implementation of a strong peer-support model with a back-office function for efficiency. Move to monitoring stage	In progress	75	In progress	15	Complete	10
Advance state of readiness for adopting HQO standards: cognitive behaviour training (CBT) embedded within clinical practice for major depression, responsive behaviours, and psychosis	In progress	75	Complete	25		
Advance the health outcomes for vulnerable population groups who are homeless, at risk for homelessness or residing in domiciliary hostels or transitioning from hospital or incarceration with no fixed address	In progress	30	In progress	50	Complete	20
Implement investments for phase one of the Addiction Strategic Plan, focusing on improved and coordinated assessment and referral wait times and enhanced counselling options	In progress	30	In progress	50	Complete	20
Implement and expand community withdrawal management to Chatham and Windsor as well as refining practices for serving the young and older population groups	In progress	25	In progress	50	Complete	25
Refine and expand the S/L Rapid Addiction Assessment Medicine (RAAM) model to Windsor, Chatham, and Leamington areas	In progress	60	Complete	40		
Improve program retention rates and internal practices for residential treatment providers and withdrawal management services	In progress	25	In progress	50	Complete	25

LHIN Measured Successes:

- Increased utilization of withdrawal management services and RAAM will decrease ED visits or acute care admissions by 15%
- Increased utilization of expanded therapeutic services in the community will reduce the need for residential addiction treatment services by 10%
- Expanded hours of operation and therapeutic capacity for mental health will reduce ED visits and acute care admissions by 10% and 15% respectively
- Uptake and awareness of the Ontario Perception of Care Quality Based Tool will improve satisfaction rates for clients and family members by 35% ESC LHIN-wide
- Better integration and coordination between mental health, addiction, and primary care providers will increase the likelihood of follow-up by primary care within seven days of discharge from a schedule-one facility by 25%
- Advancing and informing provider groups about Francophone obligations and Indigenous peoples' needs will increase service delivery for priority population groups by 5% to 10%, respectively

Risks/Barriers:

- Increased shared-care partnerships will result in greater demands for counselling and treatment
- Increased withdrawal management services in the community will drive up demand for counselling and treatment and after care
- Timely access to psychiatry resources in some communities
- Increasing service demand from special population groups, such as Indigenous and/or Francophone residents

Mitigation of Risk:

- New funding through the Provincial Mental Health and Addictions Ten Year Plan and the 2017 provincial budget will be used to address needs identified in the ESC Mental Health and Addiction Strategic Plan
- New housing units funds will address population groups at risk for homelessness
- Additional certified peer support workers and expanded scope will assist with demand, flow and capacity
- Technology improvements such as Tele psychiatry and e-consults

Key Enablers:

- Establish a cohesive and standardized approach for data collection and reporting including implementing a local scorecard for MHA services across the core basket of services
- Clinical capacity building investments – CBT to enable clinical staff to meet HQO standards
- Development of clinical communities of practice led by local front line champions
- Full implementation of the Ontario Perception of Care Quality Measures (OPOC)
- Availability of newly graduated psychiatrists
- Ongoing engagement with the newly formed peer support service - People with Lived Experience (PWLE) groups
- Redesign of the MHA Network to address local needs thus ensuring greater accountability

Rehabilitative Care

PART 2: GOALS and ACTION PLANS

Goal(s):

- Ensure all planning and implementation activities continue to be aligned with the provincial Rehabilitative Care Alliance (RCA) strategic directions and deliverables
- Implement known best practices in all settings for priority patient populations (patients with stroke, hip fracture, total joint arthroplasty and frail medically complex older adults)
- Improve timely access to rehabilitation programs and services
- Advance interdisciplinary team models of care
- Better match patients to appropriate services based on level of risk and functional status
- Improved evaluation and data management for rehabilitation system monitoring

Consistency with Government Priorities:

These goals are consistent with the MOHLTC *Patients First Act, 2016, Assess & Restore Guideline* (2014), the provincial RCA, directions for CDPM, and the ESC LHIN Rehabilitation Strategic Plan (2016-2019)

Action Plans/Interventions:	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Implement the ESC LHIN Stroke Care Pathway in W/E	In progress	50	Complete	50		
Develop a model of community-based rehabilitation for patients with stroke and hip fracture	In progress	50	Complete	50		
Develop and implement a Geriatric Care Pathway (cross-continuum A&R approach for frail at-risk seniors)	In progress	50	In progress	30	Complete	20
Implement a risk screening process for frail seniors in ED, primary care, and home care settings (Assessment Urgency Algorithm – AUA)	In progress	20	In progress	30	Complete	50
Pilot an integrated community independence program (A&R) for medically complex older adults following an acute episode	In progress	10	In progress	50	Complete	40
Advance standardized access criteria for all bedded rehabilitative care programs based on RCA definitions	In progress	90	Complete	10		

LHIN Measured Successes:

- Continue to maintain 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 for patients 65 and older admitted to acute care settings
- Reduce or eliminate ALC patient count for patients waiting for inpatient rehabilitation
- Reduce or eliminate ALC days in acute care for patients waiting for inpatient rehabilitation
- 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%

Risks/Barriers:

- Ability to identify the older adult population, in both acute care and the community, that would receive the most benefit from rehabilitative care
- Ability to effectively monitor results and impact of programs on improving patient functional outcomes and discharge dispositions
- Ability to develop and advance innovative models and programs of rehabilitative care in a timely manner

Mitigation of Risk:

- Continue to actively engage organizational partners through the ESC LHIN Rehabilitative Care Committee
- Monitor progress of Senior Friendly Hospital implementation, particularly identification of hospital-acquired functional decline; this will inform data on the population in need of rehabilitative care
- Develop and implement a comprehensive rehabilitative system performance report card and online dashboard
- Support the uptake of emerging innovative practices, including resources and standards developed by the provincial RCA

Key Enablers:

- A collaborative decision-making approach about rehabilitative care with all health system partners
- Formal data collection tools, dashboards, scorecards based on agreed upon performance targets and measures with health system partners
- System map and inventory of rehabilitative care services representing the full continuum of care

Hospice Palliative Care

PART 2: GOALS and ACTION PLANS

Goal(s):

- Broaden access and increase timeliness to hospice palliative care (HPC)
- Strengthen caregiver support
- Strengthen service capacity and human capital in all care settings
- Improve integration and continuity across care settings
- Strengthen accountability
- Build public awareness

Consistency with Government Priorities:

The goals and action plans are aligned with palliative care in the context of *Patients First Act, 2016*

Action Plans/Interventions:	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Addition of two hospice beds at the Hospice of Windsor Essex County and supporting services for residents and families/caregivers	Complete	100				
Build capacity in primary care and LTC through participation in standardized palliative care education and follow-up activities to support sustainability	In progress	30	In progress	30	Complete	40

Provide education on advance care planning and health care consent to all FHTs ESC LHIN-wide	Complete	100				
Ensure access and provision of services to patients seeking medical assistance in dying (MAID) in all (appropriate) care settings across the ESC LHIN sub-regions	In progress	70	Complete	30		
Support expansion of bereavement services in S/L and C-K	In progress	50	Complete	50		
Examine, recommend and implement system changes in W/E to respond to gaps in access, integration of care, 24/7 coverage and high volumes of patients requiring palliative care	In progress	70	Complete	30		
Bring together stakeholders to develop a plan for a more integrated system of palliative care in C-K	In progress	40	In progress	40	Complete	20
Expand access to palliative care services to vulnerable and/or underserved populations in all counties	In progress	30	In progress	30	Complete	40
Develop a robust and impactful regional and local approach to health care consent and advance care planning	In progress	40	In progress	30	Complete	30
Continue to support high-quality palliative care education across the ESC region	In progress	30	In progress	30	Complete	40

LHIN Measured Successes:

- More patients having had a preferred place of death; reduction in hospital-based deaths as well as greater satisfaction with care provided patient/resident and family/caregivers through end-of-life
- Better uptake on advance care plans
- Increased public knowledge about HPC services
- Improved patient access to palliative care services

Risks/Barriers:

- The wide scope of work and time to deliver
- Involvement of all key stakeholders to plan, implement and support changes

Mitigation of Risk:

- Clear focus on addressing key priorities
- Use of tools/templates to scope and plan work
- Use of appropriate data to focus work, assess impact and course correct
- Ongoing involvement of front line people who know the issues and will be impacted by changes

Key Enablers:

- Commitment to direction and strong, effective, supportive partnerships
- Focused effort
- Metrics that provide a timely view of system and whether interventions are effective
- Quality leadership and sponsorship
- Involvement of front line people in gap assessment, planning and implementation

French Language Services

PART 2: GOALS and ACTION PLANS

Goal(s):

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

Consistency with Government Priorities:

The above goals are consistent with the intentions of the *French Language Services Act*. These goals also guide the implementation of the Joint Action Plan developed in collaboration with the French Language Health Planning Entity

Action Plans/Interventions:	2017–18		2018–19		2019–20	
	Status	%	Status	%	Status	%
Continue to work with identified and designated HSPs to build their capacity to provide FLS	In progress	40	In progress	20	In progress	20
Increase access to health services in French in targeted settings (e.g., primary care, supportive housing/assisted living, adult day programs)	In progress	40	In progress	30	In progress	10
Continue to ensure appropriate promotion of existing FLS	In progress	25	In progress	25	In progress	25
Improve data collection on the Francophone population	In progress	60	In progress	30	Complete	10
Advance a human resources strategy to improve uptake on French-speaking health professionals	In progress	10	In progress	30	In progress	40
Continue to raise awareness of the needs of the Francophone community and the importance of providing linguistically and culturally appropriate services	In progress	25	In progress	25	In progress	25
Advance a linguistic and cultural competency training approach for ESC LHIN staff and Board members and HSPs	In progress	60	In progress	20	Complete	20

LHIN Measured Successes

- Francophones are satisfied with the services they receive
- Providers have developed or updated their FLS plan and are making measurable progress

Risks/Barriers

- Maintaining the ongoing commitment from providers among competing priorities
- Limited French language human resources

Mitigation of Risk

- To continue to educate providers on the need to embed FLS into their day-to-day operations, the many benefits of doing so and the risks of not providing FLS
- To provide providers with linguistic and cultural competency training and tools
- To support providers in defining solutions to increase their bilingual staff complement

Key Enablers

- A comprehensive FLS education/awareness strategy
- Development of a comprehensive bilingual human resource strategy

Indigenous Health

PART 2: GOALS and ACTION PLANS

Goal(s):

- Enhance Indigenous patient care, support, transitions, and navigation
- Establish collaborative connections between Indigenous communities and HSPs

Consistency with Government Priorities:

- The goals and action plans are aligned with the *Patients First Act, 2016* and the strategic plan developed by the ESC LHIN Indigenous Health Planning Committee

Action Plans/Interventions:	2017-18		2018-19		2019-20	
	Status	%	Status	%	Status	%
Advance a regional Indigenous care-planning process focusing on MHA	In progress	70	In progress	15%	Complete	15
Improve access to primary care and other health and support services for Indigenous patients	In progress	60	In progress	20%	Complete	20
Increase the utilization of Telemedicine and Telehomecare services within Indigenous communities	In progress	65	In progress	20%	Complete	15
Improve diabetes support/resources for Indigenous patients	In progress	30	In progress	50%	Complete	20
Increased access and availability of hospice and palliative care options for Indigenous patients/communities	In progress	20	In progress	40%	Complete	40

LHIN Measured Successes:

- Increase the number of Indigenous people attached to primary health care provider
- Improved patient care/support by increasing the number of Indigenous people receiving/accessing health services
- Improve transitions/pathways of care for Indigenous patients
- Improve integration and collaboration between HSPs and Indigenous communities
- Improve access for Indigenous people to MHA services
- Increased utilization of community-based addiction services for Indigenous people

Risks/Barriers:

- Ongoing involvement with Indigenous and/or HSPs to jointly develop collaborative models of care
- Availability of Indigenous safety/awareness training by HSPs to build positive relationships
- Availability of health (inclusive of MHA) services/options to Indigenous/rural communities

Mitigation of Risk:

- Promotion of Indigenous Cultural Safety (ICS) as baseline training for HSPs
- Sharing and advancement and Indigenous Health Planning Committee integration models
- Early and continuous engagement of all involved parties will be a critical success factor in the development and implementation of collaboration between Indigenous communities and HSPs
- Continue to address the needs of Indigenous/rural communities

Key Enablers:

- Continued engagement with the IHPC
 - Development of protocol/service agreements between Indigenous communities and HSPs
 - Implementation and promotion of the service inventory/health link electronic resource within Indigenous communities
-

5. ESC LHIN Operations and Staffing Templates

ESC LHIN Operations Spending Plan

Template B: LHIN Operations Spending Plan				
LHIN Operations Sub-Category (\$)	2016-17 Actuals	2017-18 Allocation	2018-19 Planned Expenses	2019-20 Planned Expenses
Salaries and Wages	3,268,683	3,208,200	3,107,200	3,169,344
HOOPP	308,931	306,390	295,950	301,869
Other Benefits	374,795	368,300	355,750	362,865
Total Employee Benefits	683,726	674,690	651,700	664,734
Transportation and Communication				
Staff Travel	54,142	70,000	80,000	70,000
Governance Travel	15,624	20,000	30,000	25,000
Communications	41,857	43,000	45,000	45,000
Other Benefits	3,809	5,000	5,000	5,000
Total Transportation and Communication	115,432	138,000	160,000	145,000
Services				
Accommodation (includes Insurance)	323,511	335,440	348,850	362,804
Advertising	0	5,000	5,000	2,500
Community Engagement	19,183	25,000	40,000	30,000
Consulting Fees	44,866	31,200	40,000	32,500
Equipment Rentals	26,458	25,000	25,000	25,000
Governance Per Diems	81,750	102,000	115,000	115,000
LSSO Shared Costs (includes LHINC)	383,073	0	0	0
Other Meeting Expenses	22,939	45,000	55,000	45,000
Other Governance Costs	43,594	40,000	50,000	45,000
Printing & Translation	21,405	35,000	50,000	45,000
Staff Development	78,754	60,000	66,350	50,000
Total Services	1,045,533	703,640	795,200	752,804
Supplies and Equipment				
IT Equipment	19,150	30,000	35,000	27,218
Office Supplies & Purchased Equipment	43,613	34,570	40,000	30,000
Capital	3,900	0	0	0
Total Supplies and Equipment	66,663	64,570	75,000	57,218
LHIN Operations: Total Planned Expense	5,180,037	4,789,100	4,789,100	4,789,100
Total CCAC Planned Expenses		144,956,155	144,956,155	144,956,155
Total LHIN and CCAC Planned Expenses		149,745,255	149,745,255	149,745,255
Annual Funding Target	5,186,927	149,745,255	149,745,255	149,745,255
Variance	6,890	0	0	0

- Salaries and Wages are expected to decrease in 2018/19 based on organizational structure changes.

ESC LHIN Staffing Plan

Template C: LHIN Staffing Plan (Full-Time Equivalents)				
Position Title / Classification	2016-17 Actuals as of Mar 31, 2017 FTEs	2017-18 Forecast FTEs	2018-19 Forecast FTEs	2019-20 Forecast FTEs
CEO	1	1	1	1
Vice-President	0	5	5	5
Director	5	8	7	7
Manager	8	7	7	7
Lead	2	1	1	1
Analysts/Specialists	5	3	3	3
Executive Assistant	2	2	2	2
Coordinators	3	3	3	3
Admin Assistant	7	7	7	7
Receptionist	1	1	1	1
LHIN Operations Staffing	34	38	37	37
CCAC Operations Staffing	431	429	429	429
Total FTEs	465	467	466	466

6. Integrated Communications Strategy

Objectives

The ESC LHIN's communication strategies support the ABP goals through communications targeted at the eight IHSP 4 2016-19 strategic directions and the MOHLTC's *Patients First: Action Plan for Health Care* four key objectives (see the 'Mandate and Strategic Directions' section of this report).

Communication Objectives

1. Sustain trust in local health care
2. Build and sustain positive two-way communications within the community
3. Uphold the ESC LHIN's commitment to be open, transparent, and accessible to the public
4. Provide health care system information and education on services available to positively influence health behaviours to improve the health of local residents

(Refer to the *ESC LHIN Annual Community Engagement Plan* for more detail)

Provincial Context

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
- *Patients First Act, 2016*, and transition activities
- Sub-region planning
- Governance Advisory Councils
- Regional Transportation Strategy
- Chronic Disease Prevention and Management Care Paths
- Vision Care Strategy
- Mental Health Strategic Plan
- Addictions Strategic Plan
- Rehabilitation Care Strategic Plan
- Primary Care Strategy
- Indigenous Health Strategic Plan
- Integration activities
- Hospice palliative care
- Orthopaedic Strategic Plan
- French Language Health Planning Entity/LHIN Joint-Strategic Plan
- Capital projects
- BSO Action Plan
- Other planning activities

Strategic communication plans are developed and implemented from these strategies/activities for both the local and pan-LHIN roles.

Target Audiences

Primary

- Consumers/patients of the health care system
- Engaged general public
- Indigenous people and communities
- Francophone people and communities
- Media
- HSPs
- Elected officials
- MOHLTC
- ESC LHIN Board
- ESC LHIN staff

Key Messages

Provincial

- The *Patients First: Action Plan for Health Care* is Ontario's plan to transform the health care system into one that puts the needs of patients at its centre
- 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: increasing access, connecting services, informing patients and protecting our health care system
- We have made progress in all four priority areas, but we can do more to put patients first
- By putting patients first in everything we do, we will provide faster access to the care patients need today and make the necessary investments to ensure our health system will be there for patients for generations to come
- On December 7, 2016, Ontario passed the *Patients First Act, 2016*, an important step forward in the *Patients First: Action Plan for Health Care*
- Once fully implemented, changes supported by the Patients First Act will make local health care more responsive to local needs:
 - Patients will benefit from improved access to primary care, including a single number to call when they need health information or advice on where to find a new family doctor or nurse practitioner
 - Primary care providers, inter-professional health care teams, hospitals, public health units and home and community care providers will be better able to communicate and share information, to ensure a smoother patient experience and transitions. Our goal is that patients will only have to tell their story once
 - Administration of the health care system will be streamlined and reduced, with savings put back into improving patient care
 - The voices of patients and families in their own health care planning will be strengthened
 - There will be an increased focus on cultural sensitivity and the delivery of health care services to Indigenous peoples and French speaking people in Ontario
- LHINs will ensure that any changes are seamless and that they simplify and improve patient experience. There will be no added bureaucracy and financial savings will go to patient care

Pan-LHIN

- The (ESC) LHIN and its health care partners continue to bring about significant and positive change to ensure better patient outcomes
- The (ESC) LHIN is committed to making the experience of care more seamless and easier to navigate
- The (ESC) LHIN brings together health care partners to develop innovative, collaborative solutions leading to more coordinated, value-driven model that promotes wellness and a better patient experience
- The (ESC) LHIN is working with its partners to change from an old system designed to treat people once they are sick to a more coordinated, value-driven model that promotes wellness
- The (ESC) LHIN is the key organization in this region that brings together health care partners such as hospitals and community-based agencies to develop innovative, collaborative solutions that lead to improved access to high-quality care for all residents

Erie St. Clair LHIN

The ESC LHIN's key messaging aims to communicate the core values and mission, as well as its goals, roles, and responsibilities, in language that is easy to understand and remember

Strategic Approach

The ESC LHIN's core communications activities include:

- Communications on priority initiatives
- Support for education/navigation
- Connection to the community through public affairs and issues management
- Media engagement
- Use of multi-platform communications
- Other tactics

Tactics

A variety of strategic communications tactics are used to reach audiences, including:

- Traditional media products, printed collateral for patients, 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.
- Media relations: proactive media pitches, third-party publications, availability as a health care resource, etc.
- Health service providers: networks and advisory groups, memos, newsletters
- Elected officials: council meetings, one-on-one meetings, briefing notes

Guiding Communication Principles

- People-first, clear language
- Provide key communication materials in both English and French
- Openness and transparency

Communication Activity Tactics

- Communications on priority initiatives
- Support for education/navigation
- Connection to the community through public affairs and issues management
- Media engagement
- Use of multi-platform communications

Evaluation

To gauge the effectiveness of ESC LHIN's communications activities, including evaluating the success of the transition and Patients First activities, the following evaluation methods will be used:

- Media monitoring and analytics
- Social media monitoring
- Surveys
- Patient feedback
- Staff, including care coordinator, feedback
- Public feedback

7. Community Engagement

Consistent with the *Patients First: Action Plan for Health Care*, and *Patients First Act, 2016*, the ESC LHIN will formalize its engagement with patients and families by establishing a Patient and Family Committee. This Committee will be involved in all decision making as per the changes outlined in the *Act* are implemented.

Currently the ESC LHIN engages a number of established networks, committees, and working groups on an ongoing basis. Note that new groups will be added to the listing below as the transition process matures. The following is a summary of the various structures in place for which the ESC LHIN leads or is an active member:

- Governance Advisory Councils
- ALC Performance Management Working Group
- BSO/CCAC/Hospital Quarterly Working Group
- Child and Youth 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
- Identified and Designated FLS Providers Network
- Indigenous Health Planning Committee
- Local Partnership Committee
- LTC Operators Networks (Chatham-Kent, Windsor/Essex, and Sarnia/Lambton)
- Ministry of Community and Social Services/Developmental Services Ontario/ CCAC, ESC LHIN
- Mental Health and Addictions Network
- 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
- Rehabilitative Care Committee
- Residential Addictions Treatment Leadership Table
- Sarnia/Lambton Special Needs Working Group
- Stocktake Review Table

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