

# Erie St. Clair LHIN Leads Reports

## Integrated Health Service Plan 2

### Appendix F – Part 1



# Erie St. Clair LHIN Leads Reports

## Appendix F – Part 1

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### *Cautions*

The information contained in this, the Appendices Section of the Integrated Health Service Plan 2 (HSP2), represents a wide range of support documentation to be used as companion publications to the strategic directions presented in the IHSP2 main report. Erie St. Clair Local Health Integration Network (LHIN) staff will use this information to enhance the existing planning process and in some instances to launch new projects and health care directions. Much of the information contained in the Appendices is early in development and will require additional discussion and refinement before approved plans are initiated.



## Erie St. Clair LHIN Lead Reports and Annual / 90 Day Plans

### Aboriginal

**Contact Person:** Lisa Tabobondung

**1) Describe the 'current state' for your area of responsibility including:**

- a) Relevant support data (e.g. utilization, population, service, etc. – put this into a Table format where possible distinguishing the 3 geographic areas of Windsor/ Essex, Chatham-Kent and Sarnia/Lambton)

**Table of Population Statistics – Aboriginal Communities by Geographic Area**

Geographic Region	Total Female	Total Male	Total Population
<b>Windsor/Essex</b>			
Windsor (census metropolitan area) *	2,890	2,695	5,585
<b>Chatham-Kent</b>			
Walpole Island *	930	955	1878
Delaware Nation *	235	175	412
Caldwell F.N. **	148	122	268
Chatham Kent *	1,140	1,180	2,320
<b>Sarnia/Lambton</b>			
Aamjiwnaang F.N.*			706
Sarnia city *	615	425	1,490
Kettle Point *	495	525	1020
Aboriginal Identity Population ***			14,895

\* population statistics derived from 2006 Aboriginal Profile , <http://www12.statcan.ca/census-recensement/2006/dp-pd/prof/92-594/details/page.cfm?>

\*\* INAC's Indian Register, as of December 31, 2008, Eric McGregor, Senior Analyst  
Socio-Economic and Demographic Statistics Section, Strategic Research and Analysis Directorate  
Indian and Northern Affairs Canada

\*\*\* First Nations People in Ontario: A Demographic Portrait, health Analytics Branch, January 2009

## Appendix F - Part 1: Aboriginal (cont'd)

### Services

Direct services provided by Aboriginal communities and funded through the Erie St. Clair Local Health Integration Network (LHIN) are varied. The Erie St. Clair LHIN provides financial resources to Kettle and Stony Point to provide resources for operation and maintenance of the Kettle and Stony Point, Assisted Living Centre. A new agreement with Aamjiwnaang First Nation for congregate dining for Seniors in their community commenced in 2009. The Erie St. Clair LHIN provided two vans for client transportation to Walpole Island in previous years and is currently in discussion with Walpole Island regarding the Community Health Centre deployment.

### b) Current Health Care Issues/Needs/Risks

The Current Health Care Issues/Obstacles/Needs/Risks were reported by the participants of the Aboriginal Meeting held March 25<sup>th</sup>, 2009. Common issues reported by all communities, were issues relating to responding to Mental Health and Addictions and Diabetes services. Specific, feedback gathered through the small group session identified twenty general issues/obstacles and are as follows:

1. barriers to trust and relationship building;
2. absence of human and material resources including more health practitioners;
3. transportation;
4. jurisdiction problems (federal - provincial);
5. programming problems including red tape;
6. lack of awareness of First Nations protocols;
7. cultural sensitivity;
8. absence of strategy to address prescription drug abuse;
9. lack of access to cancer treatment;
10. inadequate attention to health issues of men;
11. need for health care services for off-reserve Band members;
12. water-air pollution;
13. stigma (discrimination and racism);
14. disjointed services;
15. top-down decision-making;
16. unavailability of natural medicines;
17. lack of recognition of traditional healing by health authorities;
18. need for more education/training on traditional healing and cultural safety;
19. not enough collaboration.

### c) Current Health Care Successes (within the past 3 months)

- A new investment through the Aging at Home initiative to provide congregate dining for the senior population of Sarnia First Nation.

## Appendix F - Part 1: Aboriginal (cont'd)

- Walpole Island in discussions to obtain workstation through Community Health Centre deployment.
  - Opportunities to Increase cultural competence for Erie St. Clair LHIN Board and staff through the Aboriginal engagement.
  - First Nation Control and self determination are key principles to establishing a meaningful systems approach to inclusive Aboriginal health planning.
  - A Handbook for Aboriginal Communities was developed to increase awareness and understanding of the Erie St. Clair LHIN process.
  - Regular meetings with Erie St. Clair LHIN staff and Aboriginal Health Care providers to provide support for reporting, building relationships and information gathering for Community Profiles.
  - Community profiles developed for each of the Aboriginal Health Care Providers for the purpose of increasing understanding of community health system needs and to increase cultural competence and identify priorities of the community.
  - A Local Aboriginal Health Planning Entity (LAHPE) held three meetings since May, 2009.
  - The LAHPE is planning two Community Engagement sessions focused on Mental Health and Addictions and Diabetes. The sessions will be held in November 2009 and February 2010.
- 2) **Describe the ‘future state’ (in 3 years) and indicate the improvements/goals that will have the greatest impact on addressing: a) current needs and issues as well indicate how the goals will address b) Erie St. Clair LHIN priorities, specifically (if applicable): Reducing Emergency Department (ED) volumes and wait times, Alternate Level of Care (ALC)/Hospital flow issues, and any impact on cost, or improved patient experience.**

The “future state” in three years for the Aboriginal communities will consist of Aboriginal health leaders that are engaged with the Erie St. Clair LHIN, their needs and priorities are reflected within the Integrated Health Service Plan 2 (IHSP2), and a meaningful Aboriginal health planning process will ensure the healthcare inequities experienced by Aboriginal people are addressed.

Essentially, the future state for Aboriginal Health will involve improved integration of health systems, improved access to health services, Health programs and services that are better suited to Aboriginal peoples and increased participation of Aboriginal peoples in the design, delivery, and evaluation of health programs and services.

The goals that will have the greatest impact on addressing current needs and issues include defining an Aboriginal health planning process, i.e. Local Aboriginal Health Planning Entity (LAHPE). Other goals necessary to impact current needs and issues include increasing cultural competence across the system, increase investments to address priorities of Aboriginal communities, and effective service delivery. Current priorities identified by Aboriginal communities include high incidence of Diabetes, multigenerational impact of colonization and the resulting mental health and addictions issues.

Appendix F - Part 1: Aboriginal (cont'd)

The goals will address Erie St. Clair LHIN priorities as investments are made to address priorities of Aboriginal health providers. The priorities include the need to develop culturally appropriate healing programs for clients. Clients will utilize culturally appropriate healing programs, traditional healing practices and reduce the number of visits to emergency departments (EDs), and therefore reduce Alternate Level of Care (ALC) hospital flow issue and reduce costs. Through strategic deployment of Primary Health Care resources such as Community Health Center satellites, i.e. Walpole Island, the number of clients utilizing the Wallaceburg ED will decrease. Primary health care in all Aboriginal communities is necessary.

**3) Describe the specific ‘targets and actions’ that will be implemented to get to the future state for the ‘next year’ and priority actions for the ‘next 90 Days’ (beginning April 1, 2010 – Integrated Health Service Plan – IHSP2 Implementation Date):**

**a) Annual (12 month) Plan:**

<b>Target (milestones)</b>	<b>Key Actions</b>	<b>Lead</b>
Increase cultural competency	Cultural training for Erie St. Clair LHIN staff. Cultural training for physicians and other health workers. Review existing policies to ensure culturally appropriate.	<b>Lisa Tabobondung</b>
Increase investments in Aboriginal Health.	LHAPE to provide oversight to AHTF funds. LHAPE to provide oversight to CE funds. LHAPE to discuss funding initiatives available through Erie St. Clair LHIN.	<b>Lisa Tabobondung</b>
Increase engagement with Aboriginal Communities.  Meaningful engagement with Aboriginal communities. Better more sustainable health policy decisions.	Develop aboriginal committee (LHAPE) terms of reference and work plan. Plan and implement aboriginal gatherings through committee. Develop cultural curriculum. Develop community profiles for all aboriginal communities.	<b>Lisa Tabobondung</b>
Increase effective service delivery.  LHAPE identifying service priorities and patient navigation needs.	Improved client transition strategies. Examine innovative approaches to fill gaps in services. i.e. services for men, environmental contaminants. Increase access to primary health care for aboriginal clients.	<b>Lisa Tabobondung</b>

Appendix F - Part 1: Aboriginal (cont'd)

**b) 90 Day Specific Priority Action Plan (where to start):**

<b>Target (milestones)</b>	<b>Key Actions</b>	<b>Lead</b>
Increase community engagement through meaningful communication and appropriate mechanism.	Review and ratify terms of reference. Develop, and ratify annual work plan for LAHPE. Refine process of LAHPE meetings.	Lisa Tabobondung  Ralph Ganter
Ensure Aboriginal Health Plan and priorities are included within IHSP2.	Plan and Implement Aboriginal Community Engagement session for Diabetes. Review current findings of IHSP2 process with Aboriginal Health Service Providers.	Lisa Tabobondung

## Regional Infection Control

**Contact Person:** Nora Boyd

### 1) The 'current state' for Infection Prevention and Control in Erie St Clair:

The Regional Infection Control Networks (RICNs) have been designed to:

- Develop a strong, cooperative network of providers committed to improving infection prevention and control within and between health care organizations
- Integrate the distinct infection prevention and control activities of acute and non-acute care organizations, public health programs, and community care agencies
- Promote standardization of these activities in health care facilities across Ontario

#### RICNs:

- Link professionals to the most advanced-information and thinking on infection
- Foster collaboration among these front-line professionals
- Work as networks in their communities and as a network of networks throughout the province

Erie St. Clair Infection Control Network (ESCICN) works with three Public Health Units, five Acute Care Hospitals, 37 Long-Term Care (LTC) homes and numerous primary care facilities and health care clinics.

#### **Current Health Care Issues/Needs/Risks**

- Acute care facilities are crowded with Alternate Level of Care (ALC) patients (25-100 patients per facility) who are vulnerable to healthcare acquired infections such as C difficile, Methicillin-resistant Staphylococcus Aureus (MRSA) and Vancomycin-Resistant Enterococci (VRE) which lengthen their stay and deteriorate their health status and capacity to return home, requiring further placement or support in the community. Possession of these organisms delays transfer due to shortage of appropriate placement options and need for further medical care to stabilize or rehabilitate the patients. Outbreaks in LTC homes further restrict transfers during winter. LTC homes are not comfortable accepting patients with Antibiotic-Resistant Organisms (AROs) and are concerned their facility cannot manage these clients. They require extra care but with no extra funding. There needs to be better resources for LTC to enhance their infection prevention and control programs to limit outbreaks and improve their capacity to manage clients with AROs.
- Mandatory Patient Safety Indicators: seven of eight are related to infection control. Hospitals are required to report this information publicly. The RICN has provided a forum to support acute care in meeting these deadlines. See below for March 2009 data.

Appendix F - Part 1: Regional Infection Control Network (cont'd)

**Mandatory Patient Safety Indicators March 2009 Data**

Hospital	%Hand hygiene before care annual	C Difficile per 1000 pt days monthly	VAP Per 1000 pt days quarterly	CLP BSI per 1000 line days quarterly	% SSI prophylaxis On time annual	MRSA BSI Rate per 1000 pt days quarterly	VRE BSI per 1000 pt days quarterly
<b>Ontario</b>	69	0.39	3.51	1.56	85.19	0.02	0
<b>HDGH</b>	69	0.34*	11.96Δ	0.82*	30Δ	0*	0
<b>WRH-Met</b>	92*	0.87Δ	3.07	0*	94.74*	0.04Δ	0
<b>WRH-Western</b>	94*	0.41	0	0	0	0*	0
<b>WRH-Malden Park</b>	97*	0.76Δ	0	0	0	0*	0
<b>LDMH</b>	48	0	0	0	0	0	0
<b>CKHA-Chatham</b>	76*	0.99Δ	0*	0*	95.24*	0*	0
<b>CKHA-Sydenham</b>	89*	0*	0	0	0	0*	0
<b>BWH-Mitton</b>	68	0*	0*	0*	73.68♦	0*	0
<b>BWH-Russell</b>	74	0*	0	0	100*	0*	0
<b>BWH-CEE</b>	63*	0*	0	0	0	0*	0

\*Above provincial standards

Δ Below provincial standards

♦Almost below provincial standards

- Infection prevention and control professionals require education and support to develop expertise over time. The Ministry of Health and Long-Term Care (MOHLTC) has increased the number of Infection Control Programs (ICPs) in acute care so the staff are all in their first three or less years of practice. Day to day support from the RICN helps the beginning professional. Certification in Infection prevention and control through the Certification Board of Infection Control is the standard for an educated ICP (a stand alone exam). Courses are available through Queens University and Centennial College and for non acute facilities through the RICN plus Certification in Infection Control (CIC) study courses to assist in prepping for this exam.

#### Appendix F - Part 1: Regional Infection Control Network (cont'd)

- Community Health Facilities and Long-Term Care lack expertise in cleaning, disinfection, and sterilization of medical devices. Two education conferences have been offered and resources created to standardize this complex process for these groups. Foot care is an important health care procedure and needs to meet standards.
- Maternal Infant infection control guidelines are needed to standardize and reduce neonatal intensive care unit (NICU) outbreaks to reduce risk to newborns.

#### **Current Health Care Successes (within the past 3 months)**

Over the past year, two CIC study courses have been offered and three new ICPs from acute care have achieved their CIC. This doubles the number of ICPs certified in Erie St Clair LHIN to seven. The non-acute course offered by the RICN graduated three health care professionals through a 12 month course on infection prevention and control. To complete the CIC requires usually two years of practice before writing the certification exam.

The Mandatory patient safety indicators standardize surveillance in acute care facilities and provide comparator information from across the province. Ontario has taken a North American lead in patient safety with public reporting on health care acquired infections. The patient safety indicators include *C difficile* rates, MRSA and VRE bacteremia rates, ventilator associated pneumonia rates, Central line bacteremia rates, hand hygiene rates and surgical site prophylaxis rates.

Thirty professionals attended the workshops lead by world class experts in sterilization and disinfection. Our experts participated in the Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practice on Disinfection/sterilization and sits on Canadian Standards Association (CSA) Board.

A RICN sponsored a Canadian Standards Association course on Infection Prevention and Control during Construction/Renovation and Maintenance was attended by 18 Health Care Providers from infection control, facilities planning and maintenance. This has never been offered in this area before now.

Education and resources created for LTC on hand hygiene and glove use, use of PPE to standardize education content to Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practice documents. There are two DVDs: Superbugs, A Nightmare on Your Hands; and, The Grand Prix of PPE (Personal Protective Equipment) for use in health care facilities plus a hand hygiene campaign was held in 35 of the 37 LTC homes December-April using social marketing to drive commitment to hand hygiene for staff and visitors.

## Appendix F - Part 1: Regional Infection Control Network (cont'd)

**2) Future State:**

- a) Mandatory patient safety Indicators reporting has been a big success and MRSA/VRE/C difficile numbers are reduced by 40%. Intensive Care Unit (ICU) infections are rare. Antibiotic stewardship programs have been implemented across Ontario and have impacted the number of AROs.
- There is a reduction in ALC days as patients move easily between facilities due to low numbers of AROs (we don't have current rates at RICN) and outbreaks have been contained faster(health units have the current data) to improve capability to flow patients to right bed at right time.
- Primary care systems manage chronic illness so elderly patients aren't managed in acute care beds and ALC days are reduced. Primary care offices use standardized infection control systems (prevention, containment, contingency).
- Integrated network for infection prevention and control exists across the province.
- e-Mentorship program for infection control professionals and champions developed by ESCICN to enhance movement of professionals from novice to expert in specific skill acquisition for Infection prevention and control and other fields and used province wide.

Appendix F - Part 1: Regional Infection Control Network (cont'd)

**3) April 1, 2010 – Integrated Health Service Plan – IHSP Implementation Date):**

**a) Annual (12 month) Plan:**

Target (milestones)	Key Actions	Lead
Standardization of environmental cleaning according to PIDAC Best Practices (BP)	Create DVD of standardized training for Acute, LTC and Community	Nora Boyd
Antimicrobial Stewardship pilot in Erie St. Clair LHIN	Partner with the Institute for Safe Medication Practices (ISMP) and Windsor Hospital to participate in Ontario Pilot	Dr Quan, Christine Donaldson Nora Boyd
Surveillance Toolkit for LTC	Complete evaluation and feedback to develop second round of tools	Nora Boyd
Routine Practices and Additional Precautions PIDAC BP rolled out across the Erie St. Clair LHIN	Evaluate roll out process- effectiveness and efficiency	Laura Fraser
Provide 10 education on demand through use of e-health initiatives: standardized education sessions available via desktops and video-conferences	Needs survey Focus groups Develop library of articulate presentation for use on demand available on the web site <a href="http://www.ricn.on.ca">www.ricn.on.ca</a>	
Pilot e-mentorship program through non acute care students	Create e-mentorship program to develop communities of practice for non acute care students with possibilities for CIC study groups and ICP orientation	Nora Boyd/ Sara Dalo
Provide resources to community health care providers including primary care and homecare	Needs survey Develop resource toolkit Develop community of practice with home health care providers/ community health centres/ primary care centres	Nora Boyd

## Appendix F - Part 1: Regional Infection Control Network (cont'd)

**b) ESCICN 90 Day Action Plan for April 1, 2010:**

<b>Target (milestones)</b>	<b>Key Actions</b>	<b>Lead</b>
Antimicrobial stewardship- support hospital participation in ISMP pilot project	Education Standardized treatment protocols Monitoring and feedback	Dr Quan
Release Environmental Cleaning DVD	Marketing and distribution across Ontario and Canada	ESCICN Staff in partnership with CAEM
Develop primary healthcare Infection Prevention and Control (IPAC) interest group	Develop toolkit and Education program	ESCICN Staff
Expand relationship with first nations southern zone nursing stations	Assist with education and policy development for nursing stations	Nora Boyd
Increase Certified ICPs by 50% in ESCICN	Offer CIC study course and e-learning for content Market certification	Laura Fraser
Standardized surveillance toolkit for LTC	Standard definitions and surveillance process	ESCICN LTC Group
Pilot e-Mentorship program	systematic review of evidence; Develop curriculum; Build e-learning program	Sara Dalo

## Critical Care

Contact Person: Dr. Eli Malus

1) Describe the ‘current state’ for your area of responsibility including:

a) Relevant support data (e.g. utilization, population, service, etc. – put this into a Table format where possible distinguishing the 3 geographic areas of Windsor/ Essex, Chatham/Kent and Sarnia/Lambton)

- Population served is the critically ill patient in any level 2 or 3 intensive care unit in Erie St. Clair.
- Support data is through the Critical Care Information System (CCIS) which is in place in all level 2 and 3 Intensive Care Units (ICU's) in Erie St. Clair Local Health Integration Network (LHIN).
- This system provides real time detailed information on all ICU's across the province.
- Level 3 is the highest acuity bed type capable of full life support
- Level 2 provides care for less sick patients not requiring full life support (e.g. stepdown)

	ICU	Level 3 beds	Level 2 beds	Specialty Services
Windsor/ Essex	<b>HDGH ICU</b>	20		<ul style="list-style-type: none"> <li>• Trauma</li> <li>• Neurosurgery</li> <li>• Vascular Surgery</li> <li>• Thoracic Surgery</li> <li>• Dialysis</li> </ul>
	<b>HDGH CCU</b>	9		<ul style="list-style-type: none"> <li>• Angioplasty</li> </ul>
	<b>WRH ICU</b>	14		<ul style="list-style-type: none"> <li>• Oncology</li> <li>• Pediatrics</li> </ul>
	<b>WRH CCU</b>	4		
	<b>LDMH</b>		2 (flex to 3)	
<b>Total</b>		<b>47</b>	<b>2</b>	
Chatham/ Kent	<b>CKHA</b>	10	12	
<b>Total</b>		10	12	
Sarnia/ Lambton	<b>Bluewater</b>	14	8	
<b>Total</b>		14	8	
<b>Erie St. Clair Total</b>		<b>71</b>	<b>22</b>	<b>Full range of critical care services are offered except for cardiac surgery and advanced burn care</b>

## Appendix F - Part 1: Critical Care (cont'd)

**b) Current Health Care Issues/Needs/Risks**

- Critical care capacity for neurosurgery is jeopardized by the lack of level 2 resources at Hôtel Dieu Grace Hospital (HDGH). The need for more level 2 capacity for Erie St. Clair (ESC), specifically at HDGH to support Neurosurgery and Trauma is needed. There is an urgent need for investment in building level 2 capacity, run by Intensive Care Unit (ICU), but accessible to neurosurgery and the other priority programs (mainly surgical and trauma).
- Critical care response teams. The only funded team in ESC is at HDGH, as they are the only ICU meeting Ministry of Health and Long-Term Care (MOHLTC) criteria for full funding. The need for a Critical Care Response Team (CCRT) at Windsor Regional needs to be formally evaluated, with potential for funding from the Erie St. Clair LHIN.
- Intensivist led capacity. Bluewater will move to an Intensivist led ICU within the next 6 to 12 months. Funding to recruit a candidate may be an issue. The transition to closed model may require investment in leadership.

**c) Current Health Care Successes (within the past 3 months)**

- Leamington District Memorial Hospital (LDMH) has followed the recommendations based on detailed analysis Critical Care Information System (CCIS) for their level 3 ICU. They have closed two beds and moved to a level 2 unit to better support their current case mix. HDGH and LDMH are integrated for level 3 capacities.
- An on call rotation for telephone ICU consultation with LDMH and HDGH is being created
- An integrated Medical Director of Critical Care has been appointed at LDMH (the same party as HDGH)
- HDGH is examining the creation of a level 2 unit adjacent to their current level 3 ICU. Neurosurgery has informally agreed with the plan put forth by the Medical Director of ICU at HDGH.
- Lean methodology is being used to examine processes at both integrated ICU's in LDMH and HDGH.
- Bluewater has agreed to recruit a medical director with training in critical care, outside their internal medicine group.
- Bluewater has agreed to move to closed access for ICU and a combined medical / surgical ICU with a fixed on call group of physicians.

## Appendix F - Part 1: Critical Care (cont'd)

**2) Describe the 'future state' (in 3 years) and indicate the improvements/goals that will have the greatest impact on addressing: a) current needs and issues as well indicate how the goals will address b) Erie St. Clair LHIN priorities, specifically (if applicable): Reducing Emergency Department (ED) volumes and wait times, Alternate Level of Care (ALC)/Hospital Flow issues, and any impact on cost, or improved patient experience.**

a)

- The future state for critical care in Erie St. Clair LHIN revolves around several key issues and priority programs
- Bed open model for level 3 patients.
  - The level 3 ICU's in Erie St. Clair should always be able to take local critical acuity by working as one large ICU, with a revolving on call rotation. Specific case mix by subspecialty with have to be addressed by allowing sites that care for more complex cases the bed capacity to accept these cases. HDGH being the regional trauma, neurosurgery, dialysis, vascular and thoracic centre has to be "always open" for this case mix. Investment in capacity at HDGH should allow 8 to 10 level 2 beds. The need for level 2 capacity at HDGH seems to be the most pressing issue for critical care capacity in Erie St. Clair.
  - Having an open level 3 bed at all times for Erie St. Clair will decrease emergency department (ED) wait times for critically ill patients and improve patient flow within Erie St. Clair by decreasing extra Erie St. Clair LHIN transfers.
- Chronic ventilator capacity needs to be looked at from a provincial standpoint. Erie St. Clair may need to develop its own strategy if none is in place globally. This will require a capital investment and Windsor Regional is well placed to lead this initiative. An independent, non hospital based, centre to deal with this patient population needs to be created.
- Investment in critical care rapid response teams at Intensivist led level 3 ICU's to improve patient outcomes and resource utilization needs to be completed. The hospitals having closed model ICU's could be considered for a LHIN based funding model, overseen by the Erie St. Clair LHIN lead for their program development and accountabilities.
- Standardized best practice and order sets across Erie St. Clair ICUs. Having standard admission orders that incorporate current best practice guidelines allows for seamless patient transfer and guarantees best patient care regardless of which ICU a patient is located in.

b)

- Reducing ED Wait Times
  - Open level 3 bed strategy allows faster transfers out of ED to ICU across ESC
  - Improved Chronic Ventilator Capacity improves ICU capacity and will decrease wait times from ED to ICU.
- ALC Hospital Flow
  - Chronic Ventilator Capacity improvement allows chronic patients to be moved out of acute care settings

Appendix F - Part 1: Critical Care (cont'd)

- Improved Cost
    - Using Level 2 capacity for neurosurgical cases previously designated as Level 3 allows for a large cost savings (more than 50 percent less)
    - This will also decrease length of stay, allows for a substantial decrease in cost per weighted case
    - Standardized best practice across ESC Intensive Care Units will decrease length of stay and improve outcomes, which will decrease overall cost per case.
  - Improved Patient Experience
    - Rapid response teams have shown to improve nursing and patient morale across hospitals in North America and Europe. Patient and their families benefit from increased access to specialized care and more interactions with the health care team
    - Increased access to ICU beds by opening up Level 2 capacity (for neurosurgery as an example) allows decreased surgical wait times.
- 3) Describe the specific ‘targets and actions’ that will be implemented to get to the future state for the ‘next year’ and priority actions for the ‘next 90 Days’ (beginning April 1, 2010 – Integrated Health Service Plan – IHSP2 Implementation Date):**

a) Annual (12 month) Plan:

Target (milestones)	Key Actions	Lead
Windsor Regional (WRH)	Implement an alternate model rapid response team	Dr. Dhar
Hotel-Dieu Grace Hospital	Open at least four level 2 beds that will service neurosurgery and other surgical priority programs	Dr. Malus
Bluewater will move into their new combined medical / surgical ICU	Hire a medical director with formal ICU training. Move to closed access with assistance of Erie St. Clair LHIN Lead and the new Medical Director.	Dr. M. Lees Dr. Malus

b) 90 Day Specific Priority Action Plan (where to start):

Target (milestones)	Key Actions	Lead
Level 2 Unit at HDGH for Neurosurgery, Trauma and the Surgical Programs.	Architectural drawings, Funding request to CCS and MOHLTC.	Dr. Eli Malus
Leamington District Memorial Hospital (LDMH) to begin transfer of level 3 capacity to HDGH	On call ICU rotation provided by HDGH. SLA for repatriation back to LDMH. ED early identification of patients requiring level 3 care.	Dr. Eli Malus John Norton
Chatham-Kent Health Alliance (CKHA) will transition to closed access model	ED doctors will not be able to admit to ICU without involvement of on call Internist covering ICU	Dr. P. Letarte



## e-Health

**Contact Person:** Stephen Banyai

### **Background**

Within Erie St. Clair there are five acute care centres, located in both urban and rural communities, which include Windsor Regional Hospital (WRH), Hôtel Dieu Grace Hospital (HDGH), Leamington District Memorial Hospital (LDMH), Chatham-Kent Health Alliance (CKHA) and Bluewater Health (BWH). In 2005, WRH and CKHA created an information technology shared services company called Consolidated Health Information Services (CHIS). The vision for CHIS was to leverage current and future technology investments between the founding members (WRH and CKHA) and to maximize the capacity of both infrastructure and human resource capital (a precious commodity) to enable the strategic visions for each founding member organization. In addition, the creation of CHIS resulted in a substantial net cost reduction for both organizations (WRH and CKHA).

The business and governance model that formed CHIS was Board-centric, with each of the member organization's CEOs and two designates becoming CHIS Board Directors. This model is unique in the province of Ontario with respect to IT services in healthcare. It was further envisioned that as a result of 'sharing' there would be substantial opportunity to consolidate traditional high cost investments such as servers, network infrastructure and support/maintenance costs associated with enterprise class software. One of the pivotal aspects that enabled the sharing of services was the single vendor solution for enterprise-wide hospital information systems; both WRH and CKHA were invested with the McKesson suite of products.

With the formation of the 14 provincial Local Health Integration Networks (LHINs) in 2006 there was a renewed emphasis put on to the regionalization and re-organization of health service delivery. In addition to the financial and accountability requirements the LHIN and health services providers would negotiate, the underlying opportunity to look at standardization across the province, and in particular standardization with respect to technology, took root. At the same time, the province continued to look at the role of e-health, and e-health initiatives that would create a single patient identifier for all Ontarians and a full electronic health record (EHR / EMR) by 2015. Other initiatives had been underway for some time, including the provincial lab information system (OLIS), provincial drug viewer, regionalized diagnostic imaging and PACS – all important pieces to the ultimate goal of creating the EHR / EMR.

The Erie St. Clair LHIN has embraced the potential for CHIS to deliver not only the priorities of its members but also to be the technology service delivery vehicle for the Erie St. Clair LHIN and e-Health. There is significant alignment within these initiatives, those of the LHIN/e-health and those of the health service providers in Erie St. Clair.

In 2008, the province approved \$4.3 billion over five years to further these initiatives and created the e-health Agency (a merger between the e-health office and Smart Systems for Health (SSHA)). As a result of these advancements and government commitment, yearly funding has been provided for the establishment and operation of a LHIN-wide Project Management Office. In the Erie St. Clair region that PMO has been incorporated in to the CHIS business model. The CHIS President and CEO is also the e-health Lead working with the province, the LHIN and the region to ensure the development of standardization and be a catalyst for regional planning initiatives by participating on provincial steering committees.

## Appendix F - Part 1: e-Health

In the summer of 2008, BWH, HDGH and LDMH entered into discussions with CHIS to join, thus bringing all five acute care centres under the CHIS umbrella for information technology and hospital CEOs to the Board table to collectively govern the policies and strategy for CHIS. The net result of the full compliment of acute care centres at the CHIS Board will increase the awareness and buy-in for continuing consolidation, cost reduction and maximizing capacity related to IT service provision and now project management.

It is anticipated that by the end of 2009, all five acute centres will have officially joined CHIS as full members.

### Current State

We are currently faced with a significant healthcare crisis, one that affects millions of Canadians and costs the healthcare system billions of dollars - chronic disease. The Ontario Quality Health Council 2007 Report indicates that:

- 16 million Canadians are living with one chronic disease
- 70% over the age of 45 are living with two or more
- Of those over the age of 65, four out of five have one chronic disease
- 70% of these individuals have two or more
- One in seven Canadians live with three or more
- 60% of Canadian adults have one or more chronic illness
- 1/3 of adults over 65 are living with three or more chronic illnesses
- Almost all of us will develop three or more chronic diseases during our lifetime
- Canadian spending on publicly funded healthcare grew from \$75 billion to \$148 billion a year
- As much as 70% of that spending is related directly to chronic disease
- Currently, Canada loses \$80 billion a year in lost productivity in the Canadian economy because of chronic disease

The Ontario Chronic Disease Prevention Alliance suggests that:

- Prevention and management of diabetes, asthma, congestive heart failure and depression could save \$200 - \$350 million annually
- 75% of deaths across Canada annually are attributable to chronic diseases
- 1/3 of Ontarians have one or more chronic diseases (Ontario Quality Health Council Report 2007)
- Almost 2/3 of Ontarians over 45 have a chronic disease
- 55% of them have two or more
- Chronic disease carries a personal financial burden of \$15,000 per year
- 60% of healthcare costs are due to chronic diseases (Ontario Quality Health Council Report 2007)

### Appendix F - Part 1: e-Health

As a result of these indicators, health services will need to be focused on strategies to reduce the overall burden chronic disease will place on patients, families, providers and the healthcare system. A significant amount of research suggests strongly that 50% of chronic disease is preventable through life style and other proactive changes. Individuals living with chronic disease utilize all healthcare services in significant quantities and persons challenged with chronic diseases need **integrated care**.

Effective integration for chronic disease management is most likely to be achieved through networks of care that are connected to each other through **robust information management systems and electronic patient records**. Lastly, individuals with chronic disease manage their own care. The reality of chronic disease is that, unlike acute illness, it is the individuals or patients themselves, and not the healthcare professionals that actually manage the disease. Studies show that the average individual with chronic disease spends 12 hours a year in direct contact with health professions; the rest of the time they are managing their own care. Therefore, they are making the decisions that have major impacts on their health outcomes – from adherence to medication protocols, to nutrition, stress management and exercise.

It is clear then, why the top priorities for the Erie St. Clair LHIN include:

- reducing the impact of diabetes;
- addressing chronic conditions;
- reducing the impact of adult mental health and addictions; and,
- ensuring appropriate access to aging supports close to home

In order for the ESC region to be successful in achievement of its priorities, CHIS, its members and community customers (which includes Family Health Teams, Long-Term Care residences, Community Mental Health Associations and others) will focus on strategic priorities for technology and information management that are aligned.

The plan will cover the next three years; the deliverables for CHIS will span the next three to five years. The deliverable for year one will include:

- Developing an inventory of existing Clinical Management Services (CMS) and utilization of physician office Electronic Medical Records (EMR).
  - The inventory will result in: the development of a plan to standardize two or three clinical management systems which can be implemented across the region, supported by CHIS.

*In year one we will review the CMS vendors established in the region, evaluate their current functionality against desired end state and determine through assessment and RFQ/RFI/RFP who will be the preferred short listed vendors for the region that CHIS can support.*

## Appendix F - Part 1: e-Health

- Developing integrated electronic clinical assessments across disciplines.
  - The development of electronic assessments, and in particular integrated assessments, will create the foundations necessary for the establishment of the electronic health record.  
*In year one, the Erie St. Clair LHIN is a pilot for a ministry funded project for the development and implementation of an integrated electronic assessment*
- Developing a comprehensive plan for implementation of a regional utilization management system for inpatient hospital beds.
  - The issue of Alternate Level of Care, or ALC, is a significant barrier which directly impacts the flow of patients, primarily from Emergency Departments to inpatient beds. Patients who are no longer acute but have not been able to transfer to complex care, rehab beds or to home care 'block' the flow and create wait times.  
  
*In year one, the Erie St. Clair LHIN will fund a portion of the costs associated with implementing a regionally shared, single software system solution for the utilization management of inpatient beds.*
- Developing a Change Management Plan to ensure readiness of providers to quickly and effectively adopt new initiatives and tools as they come on stream.
  - The development of a comprehensive Change Management Plan will result in an overall framework to guide successful adoption of e-health initiatives across the LHIN  
  
*In year one, we will develop a change management plan that identifies the key activities and resources necessary to ensure successful adoption of approved e-health initiatives within the Erie St. Clair LHIN.*
- Raising awareness of Ontario's e-health Strategy, local priorities as identified by the PMO, the need for integrated e-health systems/ tools and the demonstrated benefits to patients as a result of these tools to enhance the successful roll-out and adoption of e-health initiatives.
  - The development of a Stakeholder Engagement Strategy and a Communications Plan will help to raise awareness of and interest in e-health initiatives and their anticipated benefits to patients; build an understanding of the PMO and its priorities; and, enhance relationships between CHIS and health service providers/clinicians across Erie St. Clair – all of which will contribute to the Po's ability to identify opportunities and address issues quickly and effectively.  
  
*In year one, we will focus on engaging clinicians and health service provider organizations about the benefits of adopting e-health solutions as well as the benefits of implementing solutions that are supported by CHIS's PMO. We will also showcase local successes including the EMR Interface with Hospitals Initiative that integrated electronic records from hospitals, select physician offices and a Family Health Team within the Erie St. Clair LHIN.*

#### Appendix F - Part 1: e-Health

- Supporting the expanded use of the Ontario Telemedicine Network (OTN) across the ESC LHIN to deliver clinical care and professional education among healthcare providers and patients.
  - The geographic expanse of the Erie St. Clair LHIN coupled with limited health human resources has impacted on the ability of patients to access some services close to home; it has also had an impact on the volume of visits in our Emergency Departments (EDs). Additional Ontario Telehealth Network (OTN) sites and enhanced usage, particularly with Family Health Teams and Long-Term Care Homes, will enable increased access to services for patients while potentially reducing some unnecessary visits to EDs. It will also provide e-learning opportunities for our healthcare practitioners and physicians.

*In year one, we will focus on linking interested organizations with OTN to expand the number of sites within the region as well as to support the infrastructure required for effective connectivity.*

- Developing a Health Information Access Layer (HIAL) architecture that links the Erie St. Clair region to the provincial and pan-Canadian standards.
  - HIAL will result in an increased ability to share information in a standard and secure way across the region and province; it will enable key systems and applications to link data and results to each other.

*In year one, we will focus on securing CHIS and the Erie St. Clair region as a HIAL custodian and begin to develop a regional architecture.*

#### Summary

By leveraging the resources and capacity of CHIS, the Erie St. Clair LHIN has positioned this region to be a leader in e-Health. CHIS, in collaboration with e-Health Ontario, the LHIN and our founding member hospitals and customers, will develop and execute a long-term plan to implement standardization across the region, to leverage the investment in technology and apply knowledge and best practice to improve health outcomes for patients.

The focus over the coming year will be to ensure that the foundations for supporting effective provision of health services will be put in place. We will work to support the initiatives that put patient quality and safety first while preserving patient confidentiality and privacy. Through the strategic alignment of provincial, LHIN and local priorities, Erie St. Clair will be ready to meet the province's goal of an EHR / EMR by 2015.

## French Language Services

**Contact Person:** Marthe Dumont

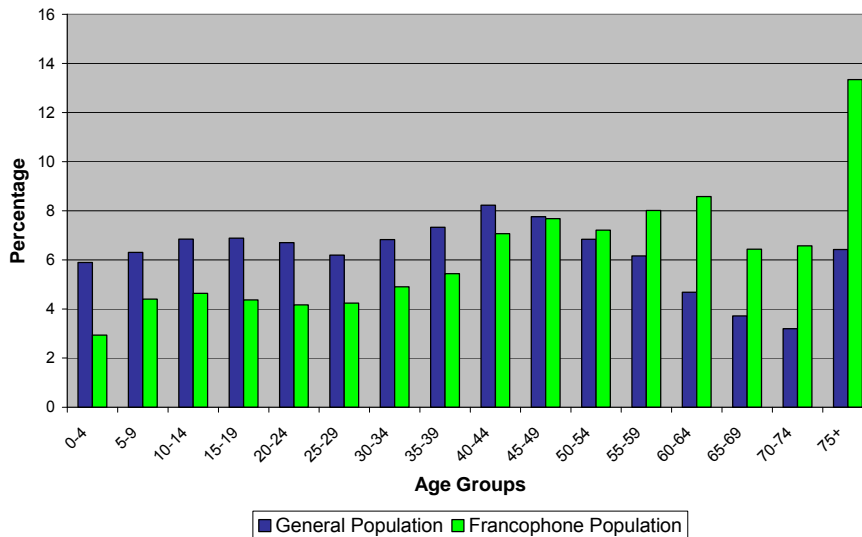
**1. Describe the ‘current state’ for your area of responsibility including:**

- Relevant support data (e.g. utilization, population, service, etc.)
- Current Health Care Issues/Needs/Risks
- Current Health Care Successes (within the past 3 months)

a) Some facts about the Francophone population in Erie St. Clair:

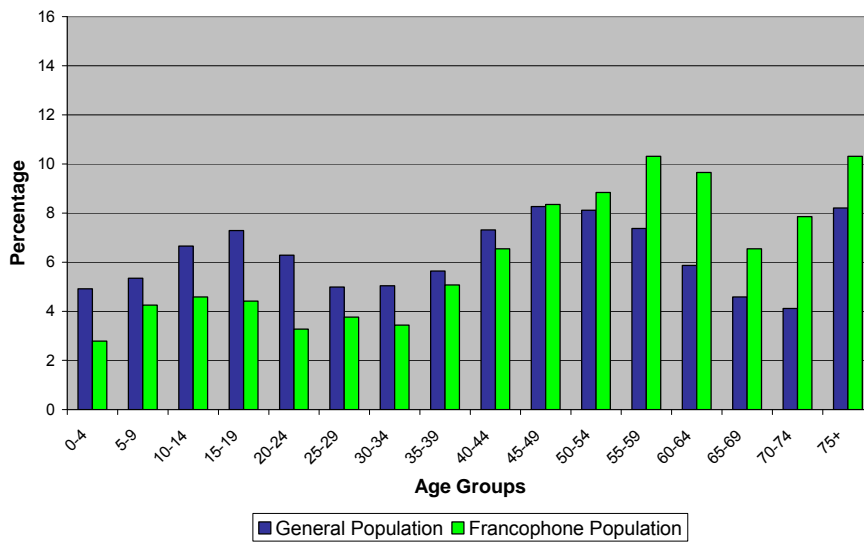
According to the 2006 Census, the Francophone population in the Erie St. Clair LHIN counts approximately 21,000 people, representing 3.4% of the total population. This figure only reflects the number of people who have French as a mother tongue. To this figure, we need to add the approximately 6,000 Francophone immigrants for who French is their usual language of communication.

**Windsor-Essex, Population by Age Groups**

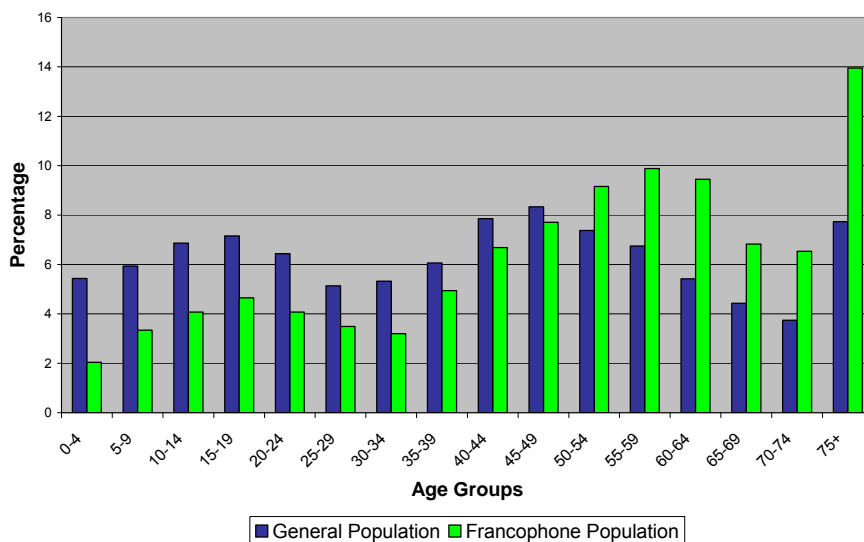


Appendix F - Part 1: French Language Services

**Sarnia-Lambton, Population by Age Groups**



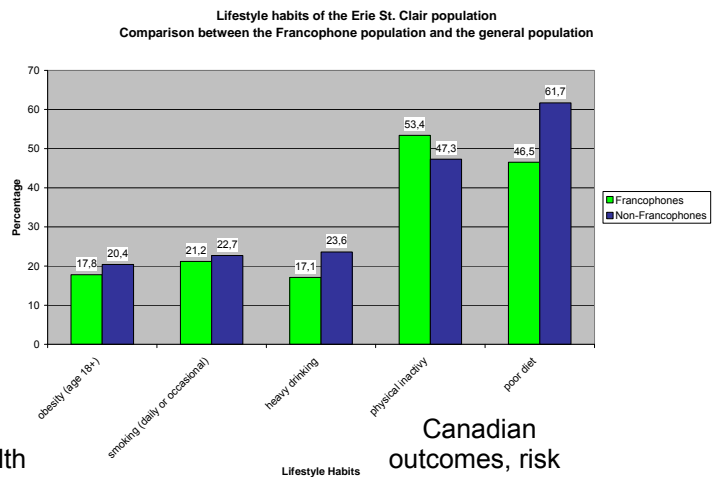
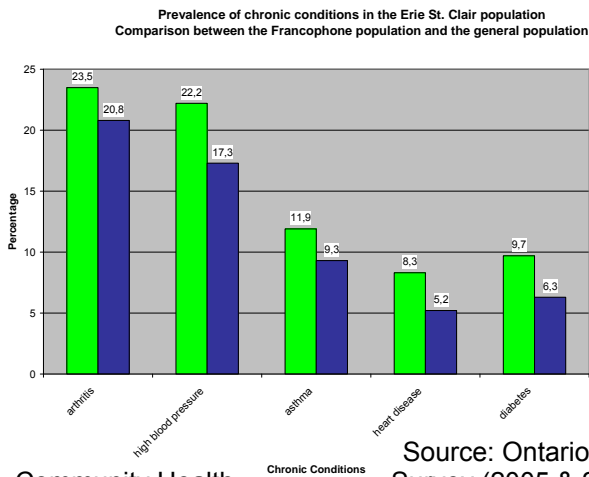
**Chatham-Kent, Population by Age Groups**



Appendix F - Part 1: French Language Services

The above graphs clearly show that the Francophone population is much older than the general population. Approximately 52% of the Francophone population is aged 50 and over as compared to approximately 33% of the general population.

According to the Canadian Community Health Survey (2005 and 2007), Francophones are slightly more likely to suffer from various chronic conditions, such as arthritis, high blood pressure, asthma, heart disease and diabetes. However, they would appear to have better lifestyle habits, and are less likely to be obese, drink heavily or have a poor diet.



Source: Ontario & LHIN Survey (2005 & 2007): Health

Community Health factors and preventative care for Francophones and Non-Francophones.

Canadian outcomes, risk

Some facts about services available in French in the Erie St. Clair LHIN:

There are 31 ‘identified’ health service providers for the provision of French language services and 2 partially designated health service providers in the Windsor-Essex and Chatham-Kent planning areas<sup>1</sup>. There are no “identified” or designated<sup>2</sup> health services providers in the Sarnia-Lambton at this time.

<sup>1</sup> AIDS Committee of Windsor; Alzheimer Society of Chatham-Kent; Alzheimer Society of Windsor and Essex County; Amherstburg Community Services; Association for Persons with Physical Disabilities of Windsor and Essex County; Banwell Gardens; Brain Injury Association of Chatham-Kent; Brentwood Recovery Home; Bulimia Anorexia Nervosa Association; Canadian Hearing Society; Canadian Mental Health Association, Chatham-Kent Branch; Canadian Mental Health Association, Windsor-Essex County Branch; Canadian National Institute for the Blind; Erie St. Clair Community Care Access Centre; Chatham-Kent Health Alliance; Chatham-Kent Public Health Services; Tilbury Manor Long-Term Care Home; Essex Community Services; Family Services Kent; The Hospice of Windsor and Essex County Inc.; Hôtel-Dieu Grace Hospital; House of Sophrosyne; Lakeshore Community Services; Leamington District Memorial Hospital; Mental Health Connections; Ontario March of Dimes; Sandwich Community Health Centre (and Diabetes Wellness Centre); Sexual Assault Crisis Centre; Teen Health Centre; Country Village Health Care Centre; Westover Treatment Centre; Windsor Regional Hospital; Windsor-Essex County Health Unit.

<sup>2</sup> Identified health service provider means a health service provider that has been mandated by the Ministry of Health and Long-Term Care, either through the former district health council, the Health Restructuring Commission or the LHIN, to provide some or all of its services in French. Designated health service provider means a health service provider who has received an official designation under the French Language Services Act by regulation. The designation recognizes the capacity of the provider to deliver its services in French.

## Appendix F - Part 1: French Language Services

Here is a breakdown by sector and by planning area:

	Windsor-Essex	Chatham-Kent	Sarnia-Lambton
Community Care Access Centre		1	
Community Health Centres	2	0	0
Community Support Services	11	4	0
Hospitals	3	1	0
Long-Term Care Homes	2	1	0
Mental Health and Addictions Services	4	2	0
Public Health Units	1	1	0

Some Facts about French-Speaking Health Human Resources in the Erie St. Clair LHIN:

A Health Human Resources mapping exercise completed in the Erie St. Clair LHIN in 2007 by French Language Health Services among all health service providers, except hospitals, showed that 3.8% of all health care professionals are French-speaking. Most French-speaking professionals identified were nurses (registered nurses/registered practical nurses), social workers or personal support workers.

According to the College of Physicians and Surgeons of Ontario's website, there are 36 general physicians indicating that they can provide services in French. A third of these physicians are aged 65 years or older.

Note: These figures need to be interpreted with caution because they were collected through self-identification. The actual language skills of these professionals were not formally assessed.

b) Current Health Care Issues, Needs and Risks facing the Francophone population:

Issues:

- General lack of health services in French. Even with the identification of a number of health service providers, the delivery of health services in French is fragmented in the Windsor-Essex and Chatham-Kent planning areas, and it is definitely not coordinated. In the Sarnia-Lambton planning area, there are no 'identified' health service provider, except the Erie St. Clair Community Care Access Centre. Services in French happen mostly by chance.
- Lack of awareness and/or sensitivity. The majority of health service providers and their staff do not recognize the right of the Francophone population to receive services in French. As well, they do not acknowledge as best practice the provision of services in French in a proactive, respectful and culturally sensitive manner.

### Appendix F - Part 1: French Language Services

- Lack of French-speaking health human resources. As indicated above, 3.8% of the healthcare workforce is French-speaking. This is far from sufficient to provide quality services around the clock. This lack of French-speaking human resources is exacerbated by the current human resources shortage facing the health care system in general. Forced to replace flocks of retiring staff, most health service providers do not indicate the knowledge of both official languages as a hiring requirement, and choose the first available suitable candidate without taking their language skills into account. Furthermore, French-speaking young adults leave the area for post-secondary education and do not come back to practice after their studies.
- Lack of accountability for the delivery of health services in French. Even if they are identified<sup>3</sup> to provide services in French, there are no mechanisms in place to ensure performance or improvement.

#### Needs:

For the most part, the Francophone population has the same needs as the general population. What distinguishes it from the general population are:

1. its higher age – the average of the Francophone population is 48, in comparison to 39 for the general population;
2. the settlement (particularly in the Windsor-Essex area) of a continually increasing number of Francophone immigrants coming from African countries; and
3. its desire and right to receive health services in French.

Considering these, it is important to ensure the delivery of services in French in the following sectors:

- services to support seniors
  - community support services
  - community care access centre services, including home care
  - respite services
  - day programs
  - geriatric services
  - long-term care services
- mental health services
  - counseling for victims of war trauma, abuse, etc.
- primary health care services
  - primary care
  - chronic disease management and prevention
  - health promotion

#### Risks:

Language is a health determinant. *“Language barriers have been demonstrated to have adverse effects on access to health care, quality of care, rights of patients, patient and provider satisfaction, and most importantly, on patient health outcomes. (...) There is also evidence that language barriers contribute to inefficiencies within the health system.”* (Language Barriers in Access to Health Care, Health Canada, 2001)

See also “issues” above.

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<sup>3</sup> Ibid.

#### Appendix F - Part 1: ESC French Language Services

##### c) Current Health Care Successes (within the past 3 months)

The Francophone community in the Erie St. Clair created the Francophone Health Action Committee with the broad objectives of making recommendations to the Erie St. Clair LHIN and health services providers, mobilizing the Francophone community and initiating and/or leading projects that will improve access to health services in French.

#### **1. Describe the ‘future state’ (in 3 years) and indicate the improvements/ goals that will have the greatest impact on addressing current needs & issues:**

In three years, “identified” and designated health service providers will be more responsive to the needs of the Francophone population. Other providers will also be encouraged to provide their services in French. The French Language Health Services Regional Consultant will have established formal relationships with existing networks, such as the Diabetes Providers Network, to facilitate the implementation and delivery of health services in French. Mechanisms will be implemented to improve the overall access to quality health services in French.

Specifically, six goals will be pursued over the next three years.

1. Strengthening the structure. At present, there are no mechanisms in place at the LHIN level or at the provider level to ensure the delivery of quality health services in French and to ensure accountability for the delivery of such services to address this issue, it is proposed:

##### LHIN level

- To review the LHIN’s own protocols and policies, and to make recommendations regarding amendments or development of new protocols and policies;
- To review the LHIN’s human resources, and make recommendations regarding the designation of positions;
- To develop accountability mechanisms regarding the delivery of health services in French;
- To develop an internal LHIN French language services plan
- To develop a comprehensive French language services plan for the Erie St. Clair LHIN – see goal #3 below.

##### Provider level

- To review protocols and policies, and to make recommendations regarding amendments or development of new protocols and policies;
- To review human resources, and make recommendations regarding the designation of positions;
- To develop or update the provider’s French language services plan.

#### Appendix F - Part 1: French Language Services

2. Improving the data collection on the Francophone population. Currently, available data on the Francophone population are scarce and too often, unreliable due to a lack of consistency in the collection, the small size of the sample, or the complete lack of collected data. To solve this issue, it is proposed:
  - To conduct an epidemiological/utilization study to determine the health profile of the Francophone population and their health services utilization habits;
  - To develop and implement clear data collection protocols for health service providers and the Erie St. Clair LHIN.
3. Developing a comprehensive French language services plan for the Erie St. Clair LHIN. This plan will identify health services providers to provide health services in French. It will set clear guidelines for providers. The plan will focus on improving: 1) knowledge and awareness of health service providers; 2) their capacity to deliver health services in French; 3) their engagement of the Francophone community; and 4) the integration of French language health services in their everyday business.
4. Improving patient experience. Due to the culture prevailing in most health services provider organizations, Francophones are made to feel like second class citizen and that they should not identify themselves as Francophones when accessing health services and not ask for services in French. To correct the situation, it is proposed:
  - To develop and deliver education sessions and materials to increase knowledge and awareness about French language health services;
  - To implement the principles of *active offer* of services in French, such as asking the preferred language of communication in a respectful manner and making resources in French readily available.
5. Investigating use of emergency departments by the Francophone population. Available data show that Francophones are responsible for numerous visits to the Emergency Department (see below). To address this issue, it is proposed:
  - To target one by one specific sub-population groups, starting with people living with diabetes, then with heart disease, then with arthritis, and so on.
  - To conduct a survey among Emergency Department patients to learn the cause(s) behind their visit;
  - To increase resources available in French on chronic disease self-management. Different mechanisms could be used to achieve this, such as
    - making an inventory of available written and on-line resources in French;
    - creating a mobile French-speaking chronic disease and prevention management and health promotion team;
  - To provide opportunities to Francophones to improve their lifestyles habits through health promotion and prevention activities in French;
  - To improve the accessibility of primary care services in French.

Appendix F - Part 1: French Language Services

**Prevalence Rate, Inpatient Hospital Visits and Emergency Department Visits for the Francophone Population**

	Prevalence Rate	Inpatient Hospital Visits	Emergency Department Visits
Diabetes	9.7	4	8
Depression	5.9*	6	11
High blood pressure	22.2	1	8
Heart Disease	8.3	43	47
Stroke	1.4*	8	10
Chronic Obstructive Pulmonary Disease	5.3*	10	28
Asthma	11.9	1	14
Arthritis	23.5	16	64

Source: Prevalence rate taken from the *Ontario & LHIN Canadian Community Health Survey (2005 & 2007): Health outcomes, risk factors and preventative care for Francophones and Non-Francophones*; \* For stroke, chronic obstructive pulmonary disease and depression, data for the general population were used; Number of inpatient hospital visits and emergency department visits taken from the *Prevalence, Mortality, hospital separation, ED visit and GP/FP visit Numbers and Rates*.

6. Increasing accessibility of long-term care and community support services for Francophone seniors. As indicated earlier, Francophones are much older than the general population. Since the majority of seniors are not comfortable speaking English, they are more likely to delay seeking care because of the lack of health services in French. When they finally do seek services, they are likely to be admitted at the hospital or placed in a long-term care home. For these reasons, the Francophone community has identified seniors as a priority. By targeting this issue, this will likely have a positive impact on the number of alternate level of care days used by Francophone seniors. To address this issue, it is proposed:
  - o To create at least three long-term care pods for Francophone seniors with some respite and convalescent beds as well as day programs;
  - o To make an inventory of available community support services in French for seniors;
  - o To investigate opportunities to develop programs to address gaps, eg. home care services; day program; Home at Last team; friendly visiting services; meals-on-wheels services, etc. to assist Francophone seniors in staying in their homes as long as possible.

Appendix F - Part 1: French Language Services

**3. Describe the specific ‘targets and actions’ that will be implemented to get to the future state for the next 3 months (beginning April 1, 2010 – Integrated Health Service Plan – ISHP Implementation Date):**

**a) Annual (12 month) Plan:**

<b>Target (milestones)</b>	<b>Key Actions</b>	<b>Lead</b>
Strong and meaningful engagement with the Francophone community	<ul style="list-style-type: none"> <li>▪ Liaise on a regular basis with the Erie St. Clair Francophone Health Action Committee to obtain input and feedback</li> <li>▪ Develop workplan for the Francophone Committee</li> <li>▪ Develop a communication strategy to reach the Francophone community</li> </ul>	French Language Health Services Regional Consultant
Improved data collection regarding Francophones	<ul style="list-style-type: none"> <li>▪ Identify gaps in data collection</li> <li>▪ Review existing data collection protocol and policies</li> <li>▪ Establish a data collection protocol to be used by health service providers and the LHIN</li> <li>▪ Conduct an epidemiological study among the Francophone population to determine the health profile and their health services utilization habits                             <ul style="list-style-type: none"> <li>○ Develop and validate the survey</li> <li>○ Define sample, i.e. the Francophone population in one planning area vs. the Francophone population in all three planning areas</li> <li>○ Define the methodology</li> <li>○ Administer the survey</li> <li>○ Compile and analyze results</li> </ul> </li> </ul>	French Language Health Services Regional Consultant  Senior Consultant, Planning and Integration
Draft French Language Services Plan for the Erie St. Clair LHIN	<ul style="list-style-type: none"> <li>▪ Analyze programs and services offered by health service providers</li> <li>▪ Review existing complement of ‘identified’/designated health service providers</li> <li>▪ Identify gaps</li> <li>▪ Review available French-speaking health human resources</li> <li>▪ Review Francophone population profile (demographics, socioeconomics, health, utilization)</li> <li>▪ Review needs of Francophones</li> <li>▪ Draft the plan</li> </ul>	French Language Health Services Regional Consultant

Appendix F - Part 1: French Language Services

**a) Annual (12 month) Plan:**

Target (milestones)	Key Actions	Lead
Improved patient experience for Francophones living with diabetes	<ul style="list-style-type: none"> <li>▪ Develop education sessions and materials for staff of health service providers in order to increase knowledge and awareness about French language health services, the Francophone population and the principles of <i>active offer</i></li> <li>▪ Make inventory of available resources to the Francophone population:                             <ul style="list-style-type: none"> <li>○ French-speaking health human resources</li> <li>○ Written resources in French</li> <li>○ On-line resources</li> </ul> </li> <li>▪ Investigate utilization of diabetes services by Francophones</li> <li>▪ Explore ways to promote existing diabetes services in French</li> <li>▪ Explore ways to investigate use of emergency departments</li> </ul>	French Language Health Services Regional Consultant
Increased accessibility of LTC and community support services for Francophone seniors	<ul style="list-style-type: none"> <li>▪ Assist these LTC providers in developing a French language services plan, beginning with recruitment and communication strategies.</li> </ul>	French Language Health Services Regional Consultant

**b) 90 Day Specific Priority Action Plan:**

Target (milestones)	Key Actions	Lead
Improved data collection regarding Francophones	<ul style="list-style-type: none"> <li>▪ Link with the Data Collection Group</li> <li>▪ Make inventory of data collected regarding Francophones</li> </ul>	French Language Health Services Regional Consultant
Improved patient experience for Francophones living with diabetes	<ul style="list-style-type: none"> <li>▪ Identify sub-population, i.e. Francophones living with diabetes</li> <li>▪ Link with the Diabetes Providers Network</li> <li>▪ Link with the Regional Diabetes Centre</li> <li>▪ Review policies of diabetes service providers regarding identification of client's preferred language of communication, hiring and recruitment, designation of positions, communication with clients and the public</li> </ul>	French Language Health Services Regional Consultant
Increased accessibility of long-term care and community support services for Francophone seniors	<ul style="list-style-type: none"> <li>▪ Maintain links with Vision 74' Inc. in Sarnia and RBJ Schlegel in Windsor for the creation of Francophone long-term care pods in their new facility</li> <li>▪ Link with an existing long-term care provider in Chatham for the creation of a Francophone pod in its facility</li> </ul>	

## Pharmacy

**Contact Person:** Christine Donaldson

**1) Describe the ‘current state’ for your area of responsibility including:**

- a) Relevant support data (e.g. utilization, population, service, etc. – put this into a Table format where possible distinguishing the 3 geographic areas of Windsor/ Essex, Chatham/Kent and Sarnia/Lambton)

In 2008, the Erie St. Clair Pharmacy Services (ESCPS) Plan was endorsed by each of the five CEO’s of LHIN #1. This document served as an agreement for the provision of an integrated pharmacy service under the leadership of myself, Christine Donaldson, appointed as Pharmacy LHIN Lead.

The role of the Pharmacy Erie St. Clair LHIN Lead was established to help guide the efforts of each independent pharmacy department so that they would share best practices and develop site-specific strategic plans in line with the Erie St. Clair LHIN Pharmacy System (ESCPS) Strategic Plan (see attached for Pharmacy LHIN Lead role description). A brief outline of the current systems for each region follows:

Area	Leadership	Staffing	Distribution System	Pharmacy Information System
<b>Windsor/Essex</b>	<ul style="list-style-type: none"> <li>- Regional Director</li> <li>- Regional Clinical Manager</li> <li>- Pharmacy Manager (s)</li> <li>- Operations Manager (s)</li> <li>- part-time Safe Medication Leader (Hôtel Dieu Grace Hospital (HDGH)</li> <li>- Leamington District Memorial Hospital (LDMH) managed by HDGH team</li> </ul>	At full staff complement for both Pharmacists and Technicians (no vacancies) <b>Unique roles:</b> - Preadmission Clinic Technician (1.0 FTE) - Clinical Pharmacist Specialists [Infectious Disease (ID), Renal, Internal Medicine, Intensive Care Unit (ICU), human immunodeficiency virus (HIV)]	>90% Central Intravenous Admixture (CIVA) >90% unit-dose (all oral dosage forms)* >90% Pyxis (automated dispensing devices) * UD launch for LDMH in fall 2009	Mediware (Worx) @ HDGH and LDMH  Mckesson (Horizons Meds Manager) @ WRH

Appendix F - Part 1: Pharmacy (cont'd)

Area	Leadership	Staffing	Distribution System	Pharmacy Information System
<b>Chatham/Kent</b>	<ul style="list-style-type: none"> <li>- LHIN Lead acting as Director</li> <li>- Operations Coordinator (FT)</li> <li>- Practice Leader (part-time)</li> <li>- Distribution Coordinator (part-time)</li> </ul>	Full time and part time vacancies for Pharmacists	>50% CIVA >75% unit dose (limited oral liquids in UD) >75% Omnicell (automated dispensing devices)	Mckesson (Horizons Meds Manager)
<b>Sarnia/Lambton</b>	<ul style="list-style-type: none"> <li>- Director of Pharmacy</li> <li>- Lead Technician</li> </ul>	Full time and part time vacancies for Pharmacists	>50% CIVA >75% unit dose >50% Acu-dose (automated dispensing devices)	Meditech

**b) Current Health Care Issues/Needs/Risks**

**i) Pharmacist Staffing:**

Within the region, critical shortages of pharmacist are adversely affecting the provision of pharmaceutical care to patients. Opportunities to collaborate may include remote services (IT-enabled) for core functions such as pharmacist review of all new physician orders prior to administration to the patient.

**ii) Clinical program alignment:**

Due to dependency on pharmacist staffing, certain clinical programs (e.g. dosing adjustments, medication reconciliation, antibiotic stewardship) are absent or minimally performed at certain sites. Opportunities exist to align these programs and/or share clinical expertise and consultation across the LHIN pharmacy service. A LHIN-appointed Clinical Pharmacy Leader would facilitate this integration.

**iii) Site leadership within regional pharmacy service:**

There are gaps in leadership within the pharmacy group: the 3 Windsor/Essex Hospitals have a full-time dedicated Clinical Manager (the others do not); there is only one Safe Medication Practice Leader (part-time) based out of HDGH; there is no Pharmacist Manager at CKHA; and there is newly appointed Operations Manager (technician leader) at BWH. Opportunity to restructure LHIN roles to further develop the LHIN Pharmacy Service (Executive Pharmacy Lead and LHIN Clinical Pharmacy Lead).

**iv) Need for Business Manager:**

All pharmacy departments would benefit from a business manager to lend a unique perspective on the financials and other accountabilities within the business of pharmacy- including outpatient (retail) services that could provide a solid revenue stream and foster seamless care as patients transition back into the community.

## Appendix F - Part 1: Pharmacy (cont'd)

**c) Current Health Care Successes (within the past 3 months)****i) Publication of antimicrobial handbook**

This was produced with expert input from local infectious disease experts (physicians and pharmacists) to promote best practice. Goal is to continually revise with latest guidelines on intranet 'e-copy' of the tool.

**ii) Regional Formulary for Windsor/Essex**

Pharmacy and Therapeutics Committees are working towards a shared formulary of medications within Windsor/Essex (>90% complete for Windsor Hospitals) and plan to integrate LDMH within next 6 months. Ensures consistent practice between sites as patients are transferred within our area.

**iii) IV manual purchase**

The LHIN pharmacy leadership team decided on the best template for IV policies produced by another facility and procured the rights to use the Vancouver Island Health Authority manual as a shared reference. Next steps are to integrate into current nursing policy and post on a shared website.

**iv) Competency testing of Pharmacists**

All pharmacists in Windsor hospital group completed the first two phases of competency testing on key therapeutic areas and programs (antibiotics, geriatrics, renal dosing, kinetics). Plan to include other pharmacists when staffing situation stabilizes.

**2) Describe the 'future state' (in 3 years) and indicate the improvements/goals that will have the greatest impact on addressing: a) current needs & issues as well indicate how the goals will address b) LHIN priorities, specifically (if applicable): Reducing ED volumes and wait times, ALC/Hospital Flow issues, and any impact on Diabetes, and Mental Health & Addictions.****a) In the future state, our LHIN pharmacy system would have the following elements:**

- a. One pharmacy information system (PIS) linked to Computerized Physician Order Entry (CPOE);
- b. Integrated policies and procedures with site-specific differences noted where necessary. This would include: regional formulary (noting exceptions by program/patient type); shared IV manual; standard order sets; aligned clinical pharmacy programs including renal/kinetics dosing service, antibiotic stewardship, medication reconciliation, etc.)
- c. High performing practitioners working within full scope as assessed by competency testing and annual audits: clinical knowledge and interprofessional communication (for Pharmacists) and technical manipulations and safe medication practice (for regulated Technicians)
- d. Patient centred focus with decentralized pharmacists and technicians on patient care units with medication distribution managed through highly automated systems (unit dose packagers and automated dispensing devices throughout facility)
- e. Safest possible medication practice through best practice sharing within LHIN group and beyond; including full disclosure on medication incidents and resulting process improvements to prevent future system failures

## Appendix F - Part 1: Pharmacy (cont'd)

b) To address Erie St. Clair LHIN priorities, the following would benefit from pharmaceutical intervention:

**Reducing Emergency Department (ED) wait times:** An ED pharmacist situated in the triage area would enable the best possible medication history (BPMH) is ensured at the best time (intake) – this is an Accreditation standard. In addition, any ER admissions that may be diverted due to medication related problems (e.g. non-compliance) would be dealt with during the first hours of their ED visit and promote a more timely review/assessment by the expert on medications – a pharmacist.

**Alternate Level of Care (ALC)/Hospital Flow issues:** Medication issues can complicate a patient's stay in hospital leading to an extended Length of Stay (LOS); pharmacist intervention close to the point of discharge would facilitate information exchange about changes in medication therapies with the patient/caregiver thus promoting seamless discharge back into the care of their community pharmacist. Additional pharmacist resources are currently needed to meet this goal of pharmacist medication review for all discharged patients.

**Diabetes/Mental Health and Addictions:** Both of these patient groups require specialized care by residency-trained clinical specialist pharmacists (CPS) who have received additional formal education on specialized care. The CPS pharmacists would then also direct the practice of all hospital pharmacists when caring for these patients (through formalized education programs). Dedicated CPS positions would also be charged with the responsibility of extending care into the community by reaching-out to home pharmacies to collaborate on a care plan and ongoing continuing education provided through the local pharmacist associations.

Appendix F - Part 1: Pharmacy (cont'd)

**3) Describe the specific ‘targets and actions’ that will be implemented to get to the future state for the ‘next year’ and priority actions for the ‘next 90 Days’ (beginning April 1, 2010 – Integrated Health Service Plan – IHSP2 Implementation Date):**

**a) Annual (12 month) Plan:**

Target (milestones)	Key Actions	Lead
Re-structure Erie St. Clair LHIN pharmacy leadership	<ul style="list-style-type: none"> <li>- establish site managers where needed for leadership network</li> <li>- shift LHIN lead role to Executive Director of Pharmacy</li> </ul>	C. Donaldson in partnership with LHIN office (Ralph Ganter)
VIHA manual adoption	<ul style="list-style-type: none"> <li>- brand the policy database as the “Erie St Clair Pharmacy service” IV manual</li> </ul>	C. Donaldson
Shared service for clinical pharmacists across region to address staff shortages	<ul style="list-style-type: none"> <li>- establish IT support for shared PIS and web-access to pharmacy database (to promote remote support for verification as needed)</li> </ul>	CHIS/Pharmacy Managers
Publish the LHIN regional formulary	<ul style="list-style-type: none"> <li>- call together physician leads to review the final draft of the combined formulary</li> <li>- post on-line version to promote access anywhere</li> </ul>	C. Donaldson/ other P&T chairs
Antibiotic stewardship program	<ul style="list-style-type: none"> <li>- set goals for regional approach to stewardship</li> <li>- form a regional committee to assist with implementation and follow up</li> </ul>	L. Nadeau (ID Specialist)/ Karen Riley (Clinical Lead)
Establish Mental Health And Diabetes Clinical Pharmacist Specialist Positions	<ul style="list-style-type: none"> <li>- prepare business case for new positions</li> <li>- recruit into CPS positions</li> </ul>	C. Donaldson
Medication Reconciliation	<ul style="list-style-type: none"> <li>- Develop key physician metrics to identify gaps in medication review process</li> <li>- provide quarterly reports on metrics to physician groups for self-assessment</li> </ul>	Ann Petrlich (Safe Medication Leader)

Appendix F - Part 1: Pharmacy (cont'd)

**b) 90 Day Specific Priority Action Plan (where to start):**

Target (milestones)	Key Actions	Lead
Publish IV manual on shared protected intranet site	<ul style="list-style-type: none"> <li>- link with CHIS to provide this web-based portal</li> <li>- identify key nurse stakeholders for discussion of policies for IV administration</li> </ul>	P&T chairs
Class-by-class review of regional formulary	<ul style="list-style-type: none"> <li>- create regional P&amp;T committee</li> <li>- begin a formalized evidence-based review of each category and present recommendations to regional P&amp;T committee</li> </ul>	Karen Riley
Competency modules for all Pharmacists	<ul style="list-style-type: none"> <li>- RPh modules are shared with all hospitals for completion and to develop learning action plans as appropriate</li> </ul>	Karen Riley
Safe medication audit for technicians	<ul style="list-style-type: none"> <li>- consolidate technician skills audit into one tool shared with all</li> <li>- goal to complete annually by each technician</li> </ul>	Operations Managers
Monitor Metrics for High Performing Pharmacy (HPP)	<ul style="list-style-type: none"> <li>- align each site's monthly indicators to track to HPP goals (e.g. # clinical interventions by pharmacist, financial performance, follow up reports on medication incidents, etc.)</li> </ul>	C. Donaldson