Erie St. Clair **LHIN**

A New Beginning

Erie St. Clair Local Health Integration Network
Annual Report 2017–18
for the year ending March 31, 2018

Ontario
Local Health Integration Network

Contents

ISBN 978-1-4868-2438-0 Print
ISBN 978-1-4868-2439-7 HTML
ISBN 978-1-4868-2440-3 PDF
ISBN 978-1-4868-2441-0 French Print
ISBN 978-1-4868-2442-7 French HTML
ISBN 978-1-4868-2443-4 French PDF

Message from the Board Chair and CEO

When we look back on 2017–18, what stands out is the concept of a new beginning. On June 21, 2017, the former Community Care Access Centre and the Erie St. Clair Local Health Integration Network became one organization, with the goal of health care improvement and improved coordination for patients. While we are still in the infancy of coming together, we commend our staff on this outstanding achievement.

The notion of change isn't new to health care. In fact, it is because of change that health care keeps improving. People are living longer, innovation has improved our quality of life, and new treatment options are available every year — all because of change. When you read about the initiatives in this year's annual report, you will see the many, many examples of where we have worked through change to try to make a difference in patients' lives. Whether that was new investments in mental health and addictions care, or whether it was better supporting our most ill patients at home, change is there.

Improving health care is a journey that never ends, and each day is a new beginning; a new day to think about how we can make changes that will benefit our neighbours, friends, and residents who live in Erie St. Clair. Each year the list of improvements grows, thanks in large part to the collaboration and willingness of our health care providers to think differently and work at a perpetual and uncomfortable pace of change.

As we look to 2018–19, we will continue to focus on making change, but we won't do it alone. We are now guided by the first-hand wisdom of our Patient and Family Advisory Council, which keeps us grounded on where we need to go. We are also guided by the wisdom of local physicians, nurses, nurse practitioners, and other allied health professionals — the people who are on the frontlines caring for us when we are ill. Within our new sub-regions we have the opportunity to better understand local health care needs at the micro-level: to determine what each community, if not each neighbourhood, needs from the health care system. This concept positively changes the way we will plan, manage, deliver, and fund health care.

The downside of change is that sometimes it can get confusing for patients. We need to get better at connecting the dots so that patients don't get lost in the system, and the act of getting better isn't more stressful than what is ailing you. We have to work better together, and that means all of us — patients, families, clinicians, hospitals, and community organizations — so that we can build a health care system that is here when we need it and that is a better place for our children and grandchildren.

We encourage you to learn more about the ESC LHIN and the initiatives we are working on to improve health care in your community.

Sincerely,

Martin Girash, Board Chair

Ralph Ganter, Chief Executive Officer

Introduction to the Erie St. Clair LHIN

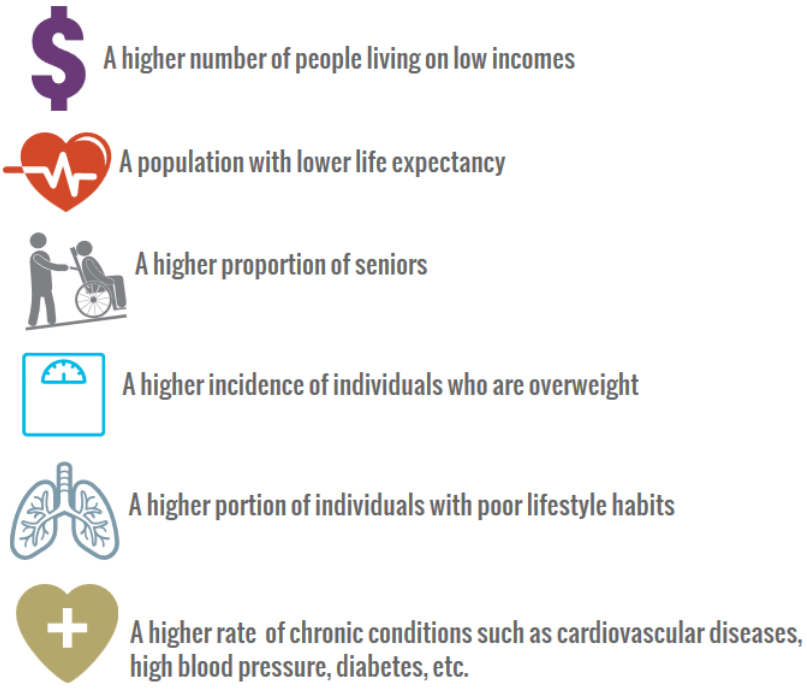
The Erie St. Clair Local Health Integration Network (ESC LHIN) is one of 14 LHINs in Ontario. The LHINs were established in 2006 to manage the planning, integration, performance, and funding of the health care system. The *Patients First Act, 2016,* stipulated that the LHINs were to provide oversight on the delivery of home and community care, which was formerly provided by Community Care Access Centres (CCACs). The ESC LHIN took over responsibility for home and community care services on June 21, 2017.

The ESC LHIN also provides funding to 82 local health service providers (HSPs), including:

- Hospitals
- Long-term care (LTC) homes
- Community support service (CSS) agencies
- Mental health and addictions agencies
- Community health centres (CHCs)

Population Health Profile

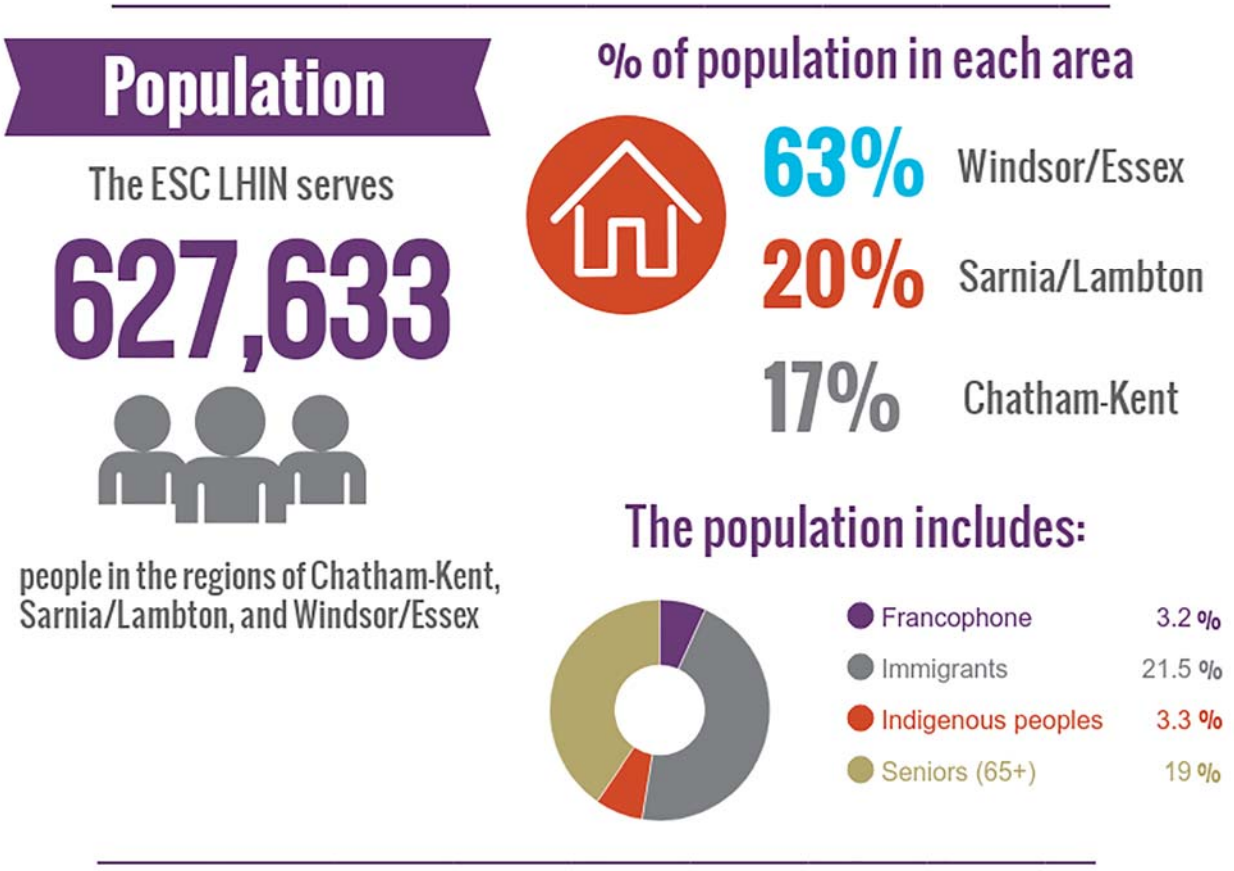
The health service needs of Erie St. Clair residents are significantly different from those of Ontario as a whole. Compared to the province, Erie St. Clair has:



For more detailed information on Erie St. Clair's population health care utilization, or demographic information, see *ESC LHIN's Integrated Health Service Plan 4 – 2016-2019* (IHSP 4) at http://www.eriestclairlhin.on.ca/Accountability/IHSP/IHSP4-2016-2019/IHSP 4 - 2016-2019.aspx.

Service Area

The ESC LHIN serves the regions of Chatham-Kent, Sarnia/Lambton, and Windsor/Essex (see Figure 1), and is home to 627,633 people, or 4.66% of the province's population. The region's population grew by 1.4% between 2011 and 2016, which is much slower than the provincial rate of 3.25%. The region's population is also somewhat older than the rest of Ontario: 19% of ESC LHIN residents are over the age of 65, while the provincial average is 16.7%. The ESC LHIN also has fewer newcomers than does Ontario as a whole. Data show that 21.5% of LHIN residents are immigrants, compared with the provincial average of 28.64%.



LHIN Sub-regions

The *Patients First Act, 2016,* provided guidance to the LHINs to help them establish smaller geographic planning sub-regions so that they could better understand and address patient needs at the local level. The ESC LHIN is made up of six sub-regions. These sub-regions do not affect where patients can receive care, but allow the LHIN to better plan, coordinate, and improve the performance of the local health care system on a much smaller scale. This allows the LHIN to better understand the unique care needs of each area and work to ensure that patients are able to access the care they need, when and where they need it. Each sub-region was established based on consultations with providers, patient referral patterns, demographic data, and where health care services exist across the region. Using this model, the LHIN will work to increase access to care for residents and build strong care communities around patients.

The ESC LHIN has identified six sub-regions (see Figure 2 and Table 1).

Figure 2: Map of the Erie St. Clair LHIN Sub-regions

Table 1: ESC LHIN Sub-regions	
Sub-region	**Characteristics**
Windsor	• Population: 217,188 • 1 acute hospital • 1 tertiary hospital • 1 community health centre • 9 LTC homes • 15 CSS agencies
Tecumseh Lakeshore Amherstburg Lasalle	• Population: 111,956 • 2 CSS agencies • 7 LTC homes
Essex South Shore	• Population: 72,148 • 1 acute hospital • 3 CSS agencies • 3 LTC homes
Chatham City Centre & Rural Kent	• Population: 101,292 • 2 acute hospitals • 1 community health centre • 9 CSS agencies • 7 LTC homes
Lambton	• Population: 125,049 • 1 acute hospital with two sites: Sarnia and Petrolia • 2 community health centres • 7 CSS agencies • 11 LTC homes

Minister's Mandate Letter

The ESC LHIN mandate letter was issued by the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, on May 1, 2017. The mandate letter focuses on key Ministry of Health and Long-Term Care (MOHLTC) initiatives and outlines the broad service and performance expectations for the ESC LHIN in 2017–18.

The mandate letter further acknowledged that 2017–18 was a transition year, as the LHINs and the CCACs engaged in extensive (and ongoing) efforts to ensure the success of the CCACs' transfer to the LHINs. The ESC LHIN remains committed to meeting the priorities outlined in the mandate letter, which provided the groundwork for a more sustainable, efficient, and accessible health care system for future generations.

Table 2 details the ESC LHIN's progress in 2017–18 on each of these priorities. It is important to note that many initiatives were, at the end of 2017–18, in various stage of progress; Table 2 includes a sampling of the work to date. Many other key initiatives are detailed within other sections of this annual report.

Table 2: ESC LHIN Progress on Minister's Mandate Letter Priorities

2017–18 Minister's Mandate Letter Priorities	ESC LHIN Progress on Initiatives
Transparency and Public Accountability	Advancements were made through the following initiatives: • The ESC CCAC successfully transitioned to the ESC LHIN on June 21, 2017, without any interruption to patient care • Open Board meetings held throughout the year were an opportunity for the public and stakeholders to learn more about local health care, relevant issues, and new initiatives, and to engage in open and transparent decision-making. Through the open mic session and presentation components of the meetings, the public and providers were able to engage directly with the Board. Board meetings are also available via webcast, and all open Board meeting material is available online in advance of the meeting • Transparency in reporting included regular updates to the Board's Quality Committee on quality improvement indicators, Ministry-LHIN Accountability Agreement (MLAA) indicators progress reports, and service provider scorecards • A funding framework was identified and publicly approved by the Board • The LHIN maintained two websites that include information about its senior team and Board members, home and community care services, and public accountability information such as dashboards, funding announcements, annual reports, annual business plans, Board material and minutes, executive expense reporting, and additional material • After transition, the LHIN revised its public complaints processes for system-level issues and home and community care-related concerns. This information was made available online and protocols for time to response were re-established
Improve the Patient Experience	Advancements were made through the following initiatives: • The ESC LHIN continued to partner with the University of Waterloo on a pilot to test the Caregiver Distress Index, which supports the identification of caregiver burnout early in a patient's journey. This pilot supported a change in how the LHIN delivers care to complex patients and their caregivers. This was accomplished by supporting appropriate respite services through home and community care when patients are not eligible for other community respite supports

	• Additional respite funds were allocated to support caregivers whose loved one had chosen to die at home • The LHIN established a Home and Community Care Patient and Family Advisory Council (PFAC), based on the PFAC within the former CCAC. Twelve members formed the new PFAC and the inaugural meeting was held in September 2018. As well, the LHIN's 31 patient advisors contributed 292 hours of volunteer service including reviewing 13 new documents that were directly connected to patient care. These volunteers are members of 12 working groups, councils, or committees
Build Healthy Communities Informed by Population Health Planning	Advancements were made through the following initiatives: • The LHIN profiled each sub-region to better understand how residents access health care and social services. In alignment with *The Patient's First Act, 2016,* the LHIN continued to build relationships with all three public health units • Population health assessment is the key enabler to sub-region success. The LHIN further diversified its stakeholder engagement in population health planning to include not-for-profit organizations, public health, and an increased number of social services

Equity, Quality Improvement, Consistency, and Outcomes-Based Delivery	Advancements were made through the following initiatives: *Quality Improvement* • The Regional Quality Table (RQT) is made up of system partners, the ESC LHIN, and Health Quality Ontario (HQO). This regional table was developed to enhance public reporting, obtain alignment on quality improvement plans, foster the implementation of HQO quality standards, and facilitate cross-sectoral improvement on outcomes especially related to transition to care. The RQT introduced HQO's quality standards to health service providers and worked with them to establish a process and evaluation mechanism for these standards. A major focus was the implementation of standards related to opioids and to dementia care. The RQT also worked with providers to assist them in migrating their quality improvement plans (QIPs) to integrated and shared plans that assist care coordination and transitions • On October 5, 2017, the LHIN partnered with HQO to host its first annual Quality Symposium in Chatham-Kent. Approximately 200 participants from health service providers around the region attended. The symposium brought together providers and clinicians to learn about quality improvement, including practical skills. Areas of focus included effective collaboration across sectors; the creation, implementation, and evaluation of quality improvement projects; using the patient-centred model for quality improvement; and applying leading quality improvement concepts to clinicians' practices • The LHIN re-established a Board-level Quality Committee to implement responsibilities specified by the Board with respect to quality issues; the overall quality of health services delivered by the LHIN, health service providers, and service provider organizations; and quality improvement initiatives and policies *Equity* • An equity-based questionnaire was co-developed by the University of Windsor's Faculty of Nursing, the LHIN's Indigenous Health Planning Committee, and HQO. Data were collected from 805 patients in Windsor emergency departments (EDs) to uncover whether patients' social and material circumstances — such as lifestyle, income, age, or culture — have an impact on the quality of health care they receive. The findings will help health care officials and administrators make necessary changes to ensure that residents receive timely and equitable care. Report results are expected in early 2018–19

	• ESC LHIN-funded HSPs are required to report on three health equity reports under their SAAs: the Health Equity Report; the Language and Indigenous Identity Report; and the French Language Services Report. Health service providers must submit a description of their equity initiatives, as well as the number of patients who self-identify as Indigenous, request services in French and other languages, and report their mother tongue language. In 2017–18, questions focused on the language supports and equity-based questions that are asked as part of the HSPs' intake processes. The results will be analyzed as part of 2018–19 equity planning. The language and Indigenous identity reporting is a way for the LHIN to better understand different population groups and their health care needs • An Elders Council was established to determine and provide guidance on the best approaches to addressing: o The creation of a regional traditional healing strategy o Patient-assisted death cultural supports o Alternatives to self-identification o Criteria for an Indigenous patient care plan o Indigenous-specific determinants of health for the ESC region • The LHIN hired a Home and Community Care Patient Services Manager/Indigenous Lead to address service gaps and issues of home and community care services for Indigenous patients and families across the region • An assessment of both the capacity of health service providers within LHIN sub-regions and the extent to which Francophone citizens are provided with an active offer of health services in French was conducted. These data will be used to develop a plan to strengthen health services in French • The ESC LHIN and the French Language Health Planning Entity (FLHPE) actively participated in a research project led by University of Ottawa researchers to develop a tool to promote the active offer and continuity of services in French for Francophone seniors. This led to the development of a tool that was tested with five health service providers from the Erie St. Clair LHIN. A debriefing meeting was held with participants and researchers to obtain feedback and suggestions on how to improve the tool
Primary Care	Advancements were made through the following initiatives: • Sub-region Clinical Leads (physicians) were hired in January 2018 and have engaged primary care providers in their sub-regions to identify priorities around coordination, access, and transitions. Additionally, the

	LHIN's Primary Care Council members were engaged on sub-regions and Health Links initiatives • Four Health Links were re-aligned to the sub-regions across the LHIN, covering all six sub-regions. All Health Links have an established common scorecard and a common clinical approach, and their leadership teams are working closely with LHIN's Clinical Leads • A new model of clinical care coordination support was implemented with three family health teams (FHTs) and Health Links organizations in three sub-region areas. Clinical Care Coordinators carry a caseload of Heath Link high-acuity patients, and follow the patient through identification as a Heath Link patient, acute care admission (if this occurs), and complete ongoing home visits to perform both nursing and Care Coordinator assessments to implement strategies to mitigate ED and hospital re-admissions. This was done in collaboration with the patient/family, primary care provider(s), and other health system colleagues • The MOHLTC provided annualized funding to the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) for the delivery of enhanced primary care services in Windsor, Caldwell First Nation, Aamjiwnaang First Nation, and Delaware First Nation. With the availability of this funding, Indigenous people have increased access to culturally based primary care services
Hospitals and Partners	Advancements were made through the following initiatives: • Intensive Hospital to Home program: the ESC LHIN received funding to implement short-term transitional care models to assist with creating capacity and flow from hospital to community for those patients designated alternate level of care (ALC) or those at risk of being designated ALC should they remain in hospital. Intensive Hospital to Home (IHH) is based on a "home first" philosophy with robust service plans put in place to support the patient and their needs as they transition from hospital to home. The funding allowed IHH to be extended from a 30-day length of stay (LOS) to a 60-day LOS, which lets patients return home to recuperate before having to make a decision about their next level of care, including transitioning to long-term care. Through these programs over 200 patients were discharged safely from hospital to home at an average cost of $198/day. Outcomes were excellent: 50% of patients returned to regular, regulated home care service maximums and 35% were supported through home and community care until they moved into LTC.

	Plans are in development to further expand this program model • System integration/enhanced care coordination to support patient transitions: the LHIN implemented a pilot program to provide enhanced care coordination support to all medium and large ESC LHIN hospitals on weekends from October to March 31, 2018. This supported patient discharges seven days a week, thereby enabling improved access to home and community care services and better flow in the hospitals throughout the week, which also supports influenza surge times • This focused attention on ALC resulted in a 2.4% reduction in the overall ALC rate in the ESC LHIN, from 15.1% in the fourth quarter of 2016–17 to 12.7% one year later, meeting the provincial target of 12.7% and ranking fourth lowest in the province
Specialist Care .	Advancements were made through the following initiatives: *Musculoskeletal conditions* • The ESC LHIN Musculoskeletal Steering Committee, made up of the chiefs of orthopedic surgery, hospital surgical site leaders, and representatives from primary care, began meeting in July 2017 to plan the implementation of both central intake and rapid access centres (RACs) for patients with hip and knee arthritis or low back pain • The programs are intended to work in combination with triage and expedite access to orthopedic specialist care, when appropriate. Planning for the low back pain model of care will be undertaken in fiscal 2018–19 • Bundled care pilot projects for hip and knee joint replacements were approved at BWH, CKHA, and WRH in December 2017. A bundled care model provides a single payment for an episode of care across multiple settings and providers. A LHIN-wide steering committee was struck in February 2018 to support the hospitals in preparation for the project's launch in April 2018 *Mood disorders* • Mood disorders, particularly major depression, remained a key reason for mental health ED visits and hospital admissions in fiscal 2017–18 in the ESC LHIN. Electric shock therapy (ECT) is a very safe and effective clinical therapy option for people who suffer from mood disorders. A regional ECT study was commissioned by the LHIN to review the current state

	of meeting standards and using best practices, including establishing consistent clinical and administrative (bookings and education) processes LHIN-wide. The review was conducted by an independent psychiatrist and resulted in greater access for patients with mental health conditions as all acute and post-acute mental care hospital sites now provide ECT on an urgent and maintenance basis • The LHIN funded cognitive behavioural training (CBT) education for primary care social workers. CBT is a recommended therapeutic modality for major depression and anxiety, and the training focused on ensuring that providers have the core competencies required to implement and effectively address treatment needs. This training also supports the HQO guidelines on therapeutic services for patients discharged within seven days • Mood disorders can also include the risk of suicide and suicide attempts. Each of the two Canadian Mental Health Associations (CMHAs) in the ESC LHIN region worked collaboratively with community providers on education and prevention via increased awareness
Home and Community Care	Advancements were made through the following initiatives: *Wait times strategies* • A new technology was developed internally and introduced to the Home and Community Care intake team. The ESC LHIN Intake Tool (ELIT) enabled the LHIN to track when home and community care patient referrals are received and then set key performance indicators for assessment timelines, depending on the urgency of the referral. This enabled the LHIN to reduce the time from referral receipt to a patient's first visit from a high of 33 days to 23 days at the end of the fourth quarter, moving closer to the provincial target of 21 days • A pilot project aimed at enhancing care coordination support to all medium and large ESC LHIN hospitals during weekends from October 2017 to March 31, 2018, was implemented. The project supported patient discharges seven days a week, enhancing access and flow as well as ensuring that the LHIN was well positioned to support surge concerns • A total casting project for diabetic foot ulcers was implemented in the fourth quarter. This important clinical initiative provides casting for people with diabetes who suffer from foot ulcers, thereby improving the quality of life for these patients and significantly reducing the number of diabetes-related amputations. Further promotion and communication of this initiative will

	continue with physicians/nurse practitioners (NPs), pharmacies, and the public into 2018–19
Mental Health and Addictions	Advancements were made through the following initiatives: • In response to an increase in youth mental health needs, including the rising number of youth suicides in the Sarnia/Lambton area and increasing referral volumes, Home and Community care added an additional Mental Health and Addiction Nurse (MHAN) in the fourth quarter to better support this sub-region. The MHAN collaborates with hospital partners, local school boards, and community organizations to support youth requiring mental health supports at school. They also support transitions for youth from acute care back to school. The number of patients admitted to the MHAN program in 2017–18 increased by 6% in Lambton-Kent-area schools. The eight MHANs that service Chatham-Kent, Sarnia/Lambton, and Windsor/Essex saw a combined total of 920 patients through 5,330 visits • As part of Ontario's comprehensive Strategy to Prevent Opioid Addiction and Overdose, the LHIN invested $1 million in regional supports to help people affected by opioid addiction and overdose. Through a new base funding investment of $475,000, Hôtel-Dieu Grace Healthcare, Windsor Essex Community Health Centre, and the Victorian Order of Nurses (VON) were able to help support more people living with addiction by expanding access to withdrawal management and harm-reduction services in the community. This expanded capacity ensured that people are receiving withdrawal management support closer to home. By March 31, 2018, more than 140 unique individuals received addictions support from these new resources • The LHIN partnered with the City of Windsor and the Windsor-Essex County Public Health Unit to provide new funding for harm-reduction supplies, including community safe-disposal units for used needles • The LHIN supported the Westover Treatment Centre in its new efforts to provide residential treatment care to clients on suboxone (drug-replacement therapy) • A new addiction treatment program was implemented in Windsor's Downtown Mission to support vulnerable populations who are at risk of homelessness *Supportive housing* • The ESC LHIN funded a nurse practitioner (NP) to work in collaboration with a psychiatrist at two large domiciliary hostels in Windsor that house 210 individuals aged 16 to 99. A significant number of these clients

	have mental health and addiction conditions. This partnership has resulted in a significant decrease in ED visits; when visits do occur, they are generally for medical reasons that cannot be managed at the hostel. The homes are managed by the City of Windsor • The LHIN provided new base funding to the Canadian Mental Health Association Lambton-Kent and Windsor-Essex to provide staff support to transitional-aged youth who have serious mental illness and/or concurrent disorders, and who live in the region's 18 new supportive housing rent-supplemented units • The House of Sophrosyne received an additional five rent supplement units and funding for an additional support worker. The focus for these units is on pregnant women with an addiction who are at risk of homelessness in the county
Innovation, Health Technologies, and Digital Health	Advancements were made through the following initiatives: • Home and Community Care piloted an innovative service-delivery model of care with Windsor Regional Hospital to support community rehabilitation for mild and moderate stroke patients following an acute care stay. This model links a remote directing therapist to a therapy technician in the patient's home in real time via technology to support the patient's rehabilitation goals. The pilot resulted in lower length of hospital stays, from 5.5 days to 5.0 days, eliminated patients being designated as ALC (patients with mild stroke only), and lowered hospital re-admission rates by 3%. The program increased the previous service delivery volumes of 4.6 therapy units (2015–16 fiscal) per episode of care to 14.5 therapy units, with 71% of patients having their first therapy visit within one day of discharge from hospital. Planning occurred to expand the program in 2018–2019 to other local hospitals • Extensive planning also occurred to launch a similar program, eRehab, focused on orthopedic patients, which was scheduled to go live April 1, 2018 • In July 2017, the Connecting South West Ontario (cSWO) team reached its target for OntarioMD Health Report Manager (HRM), with 370 physicians connected to the interface. This innovation delivers word-based medical record reports such as discharge summaries and transcribed diagnostic imaging reports from sending hospitals directly into patients' charts, therefore increasing efficiency and eliminating the need for faxing • The ESC LHIN became the first LHIN to have 100% of its hospitals connected to the acute and community Clinical Data Repository (acCDR). Like ClinicalConnect,

	the acCDR includes hospital patient demographics and reports from transcription, diagnostic imaging, and cardiology. It also includes respiratory and scanned reports, information that is not currently accessible through the cSWO program's regional clinical viewer

Initiatives in the ESC LHIN Region

In alignment with the Ontario government's current vision for health care — including *The Patient's First Act, 2016;* the *Patients First: Action Plan for Health Care*; the IHSP 4; and the ESC LHIN's *Annual Business Plan 2016–2017* — the ESC LHIN undertook a number of strategic initiatives this year in order to move toward achieving its vision of "Better Care, Better Experiences, Better Value" for the residents of Erie St. Clair. These achievements included the following initiatives.

Alternate Level of Care

Receiving the right care in the right place is the expectation of all patients and the goal of all care providers. Sometimes, however, the transitions between care settings can take longer than patients and providers would like. When patients cannot access the care setting they need, the situation is referred to as ALC; that is, needing an alternate level of care setting that is not available at that time.

This year, there has been a renewed focus on ALC patients in Ontario because of the impact their continued hospitalization has on both capacity and flow within the acute care sector. Hospitals have embraced the Home First philosophy, which supports transition from hospital to the most appropriate level of care in the community and/or at home. This focused attention on ALC has resulted in a 2.4 percentage point reduction in the overall ALC rate in the ESC LHIN, going from 15.1% in the fourth quarter of 2016–17 to 12.7% one year later, meeting the provincial target of 12.7% and ranking fourth lowest in the province.

Alternate level of care continued to be a key priority for the ESC LHIN in fiscal 2017–18. The LHIN used a multi-faceted approach this year to improve the ALC rate, including:

- Re-establishing the Access and Flow Leadership Forum to focus exclusively on ALC and the processes required to reduce the ALC rate in ESC LHIN hospitals. Best practice strategies were shared, knowledge exchange took place, and processes for reducing ALC were disseminated across the LHIN. The Forum is currently developing an ESC LHIN discharge planning toolkit
- Using Cancer Care Ontario's 12 Leading Practices Tool and Audit Form. All hospitals have completed the audit tool as a self-assessment and the tool will be completed regularly as a way to measure progress on ALC
- Instituting complex discharge rounds, ALC reviews, and reviews of long-stay ALC patients to ensure that all discharge options have been explored and that community-based options are assessed and reassessed regularly
- Funding for some hospitals to implement MOVE, a progressive mobility program to help prevent functional decline in hospitals and stop patients from deconditioning
- The implementation of two projects, IHH (as described on page 52) and Mobile Assisted Living (MAL) Neighbourhoods of Care to enhance capacity and flow within hospitals by focusing attention on patients already designated as ALC or who are at risk of being designated ALC. Two hundred patients were transitioned safely from hospital to community either through a robust IHH service plan or by supporting the patient with mobile-assisted living supports to help them transition from hospital to home

- Mobile Assisted Living (MAL) Neighbourhoods of Care is a continuum of assisted living and mobile supports for daily living services in which geographic hubs are organized around assisted living facilities, thereby creating a “hub and spoke” model. This model enables efficient use of staffing resources to provide 24/7 care and respond to patients within the hub area. The model further supports patients to live independently in the community, patient choice, autonomy, and quality of life outside of a hospital — essentially allowing clients to age at home.

Community Support Services

The importance of strengthening linkages and partnerships with primary care, home care, hospital care, and LTC continued to be a focus in 2017–18. Working toward a more connected and coordinated health care system is essential to improving access, creating patient-centred care, and improving the quality of care received.

The ESC LHIN believes that community-based health care is essential, and understands that people prefer to live in the community as long as possible and access care as close to home as they can. Additionally, community-based care is essential in promoting health and wellness, providing care when people are ill and helping people recover from illness.

Because of the important role community services have in our health care system, the ESC LHIN continued to make investments this year (see Table 6 for full details). Community investments in 2017–18 included the following:

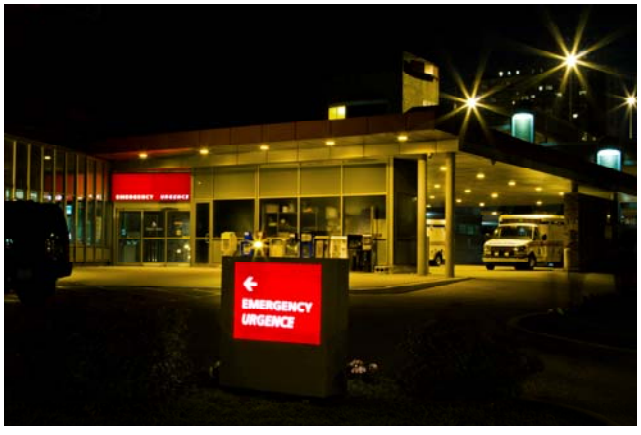
- A 1% base funding adjustment was provided to all community support service providers to support sustainability and address inflationary pressures
- Funding to advance an improved model of care for patients with hip and knee arthritis was received. Planning for implementation of central intake centres and RACs staffed by advanced practice providers is ongoing and will be fully operationalized across the LHIN in fiscal 2018–19. Planning an additional pathway for patients with low back pain commenced and will continue in 2018–19
- The LHIN funded $445,000 to Bluewater Health to open seven interim residential withdrawal management beds. Bluewater Health continues to work with the ESC LHIN to create a larger strategy for community withdrawal management

Emergency Department Care

The ED is a place that must be available when people need it most. It is also one of the busiest areas within a hospital.

In 2017–18, the ESC LHIN undertook a number of innovative initiatives to address wait times and strengthen ED care for patients, including:

- Investing in workflow renewal
- Mapping work to improve flow, decrease length of stay, and improve patient satisfaction
- Enhancing physicians’ hours of coverage
- Hiring Access and Flow Managers



- Enhancing access to diagnostic imaging services
- Investing in technology and equipment that supports the management of patients and access to care

The use of innovative technologies is key to the LHIN's continued efforts to monitor and improve both patient flow and capacity. Live Oculys reporting data enabled the LHIN to:

- Monitor the ALC rate, occupancy rates, available beds, number of patients admitted, and LOS, thereby helping reduce bottlenecks
- View the current, real-time ED situation in each hospital
- Monitor episodic and sustained surges, especially during influenza and seasonal surges

Other strategies to enhance access, capacity, and flow included:

- Process changes to improve ambulance off-load times
- Assessing patients in the ED and referring them to community-based care when appropriate
- Creating and investing in rapid assessment zones (RAZs) and supporting the creation of clinical decision units (CDUs) for patients waiting for transfer or diagnostic or investigative procedures
- Hosting an annual ED Pay For Results (P4R) Best Practice Forum to share information between hospitals
- Developing strategies to reduce the length of time patients must wait to move to an inpatient bed
- Monitoring and reducing the number of "admit no beds" and those waiting in the ED at 8:00 a.m. each day for either admission, assessment, or referral to other programs
- Connecting mental health and addictions patients to community resources
- The use of LEAN mapping process to identify areas for improvement, streamlining workflows, and reviewing all aspects of the patient experience throughout the patient journey
- A discharge planning pilot project, which provided patients and families with greater access to services and the ability to meet with a Hospital Care Coordinator on weekends, and that allows for reduced LOS and easier transitions from hospital to community services
- Drafting and implementing a seasonal surge plan to address access to health care during seasonal influenza surge times, thereby reducing demands on the ED and ensuring patient flow through the hospital to community care or home
- Establishing a working group, with representation from all hospitals, to support learning and better utilization of educational resources and share best practices on issues affecting ED care in the region

eHealth and Innovation

ConnectingOntario and the Connecting South West Ontario (cSWO) Program

ConnectingOntario is a provincial initiative funded by eHealth Ontario that is making Ontarians' health information from across the continuum of care available at any point of care, in a timely and secure fashion. In Southwestern Ontario, it is being delivered by the cSWO Program and four change-management and adoption-delivery partners.

In Erie St. Clair, this responsibility belongs to TransForm. This year, the Erie St. Clair cSWO team reached its target for OntarioMD HRM connections, with 370 physicians connected to an interface that delivers text-based medical record reports such as discharge summaries, and transcribed diagnostic imaging reports from sending facilities directly into patients' charts.

Digital Health

Erie St. Clair's inaugural Digital Health Symposium was held in December. Billed as a starting point to better patient care in the acute, sub-acute, and community settings through digital health, the event was kicked off by Greg Hein, Interim Assistant Deputy Minister of the Digital Health Secretariat, MOHLTC. The event attracted 150 participants and focused on digital health strategy, including ClinicalConnect and other digital health applications. It also promoted the use of digital health technology by practitioners and fostered important conversations around digital health within the ESC region. The need for this event and strategy development was driven by the needs and care of the patient; the use and optimization of digital tools adds to a higher standard of care and often better health outcomes. A concurrent event was also held for physicians who achieved Mainpro credits for attending. ESC LHIN has begun planning for the ESC Regional Health Information (HIS) project. The focus has been on developing the communications plan, governance structure, and change management processes.

ClinicalConnect

In 2017–18, pharmacies began to be connected to ClinicalConnect, the electronic health record. Select pharmacies began contributing to the electronic health record for some patients in our region to assist in prescription reconciliation so that patient medications are coordinated between different care settings. This work is ongoing and more pharmacies will come onboard during the next fiscal year.

Acute and Community Clinical Data Repository

The ESC LHIN became the first LHIN to have 100% of its hospitals connected to the acute and community Clinical Data Repository (acCDR). Like ClinicalConnect, the acCDR includes hospital patient demographics and reports from transcription, diagnostic imaging, and cardiology. It also includes respiratory and scanned reports, information that is not currently accessible through the cSWO program's regional clinical viewer.

Innovation

This was an exciting year for the LHIN-funded Executive Program in Health System Innovation (EPHSI). In March and June 2017, the sixth cohort of the EPHSI took place. It represented five innovation projects including the development of a coordinated access strategy for outpatient mental health services within Hotel-Dieu Grace Healthcare, and the development of a comprehensive strategic plan for the implementation and engagement of eHealth platforms in the ESC LHIN region. This cohort brings the total of program alumni to 111 individuals, which represents all five hospitals, the CCAC/LHIN, TransForm, and many other community health service providers.

A strong regional innovation alumni network is evolving and was supported through the Innovate ESC Alumni Fund, which launched in August 2017. Projects from three organizations were selected to receive the funding: Windsor Regional Hospital & Windsor-Essex EMS – 12-Lead Early ECG Transmission, Bluewater Health – Choosing Wisely Campaign, and Thamesview Family Health Team – Educate While You Wait. These projects were successfully implemented across

the region, leading to safer and timely patient care, more informed patients, and a decrease in unnecessary test ordering. All of these projects have made a significant impact within the region.

End-of-Life Care

The Erie St. Clair LHIN continues to make significant progress in enhancing the patient and family experience for those receiving end-of-life care. Quality of care is enhanced when a specially trained interdisciplinary team is in place to support patients who are facing life-threatening illness. A review of all educational resources within the ESC region is in the process of being completed to ensure that resources are in place to support residents, with a specific focus on engagement with First Nations and Francophone communities.

Home and Community Care focused on the importance of improved transitions of care as well as increased access to care for the palliative community. Through its participation in a quality improvement team through the Improving and Driving Excellence Across Sectors (IDEAS) program, the LHIN is improving access to palliative care services as it works on quality improvement measures with system partners from hospice and acute care. The LHIN is monitoring family and caregiver feedback using the Voices survey. The Voices survey is a specialized questionnaire provided to bereaved caregivers to capture perceptions of care received in the last three months of a patient's life.

A collaborative project was completed with local emergency management services (EMS) partners to improve the communication of patients' advanced care directives in the community setting. Specifically, when end-of-life care decisions have been made by a patient and they wish to remain in their home with comfort measures only, a white-dove icon with a vibrant purple background is placed in an obvious location within the home to serve as a communication tool. In the event that a caregiver calls 911, paramedics will quickly recognize the icon and respond to the call accordingly.

Through the Palliative Care Consultation Team (PCCT), the LHIN was able to support the complex-pain and symptom-management needs of patients in the community setting. The PCCTs consistently increased their visits to complex patients in the last three quarters of the year, and increased their visits by an average of 13.4% across the ESC region. Medication reconciliation was also an important component of the visits. Current performance is 94.2%, a 5.37% overall improvement from the second quarter to the third.

An Advance Care Plan (ACP) note template was developed within the CHRIS system for new-patient assessments and reassessments. The template triggers Care Coordinators to facilitate patient and family education on the definition and importance of ACP. It also triggers Care Coordinators to confirm that the patient and family understand the role and designation of a substitute decision-maker, as applicable. This practice will be measured on an ongoing basis.

Health Care Planning and Delivery

The LHIN held a symposium that focused on each sub-region's particular needs, including the transition of the CCACs to the LHIN and the Indigenous cultural integration model, and reviewed the quality agenda, among other items. This information gained from the symposium assisted in planning further sub-region developments.

The Community Paramedicine program achieved positive results, including fewer ED visits and 911 calls, and more support in patients' homes. In the Lambton sub-region this year, the program's paramedics made 1,000 house calls to patients referred by the Ed at Bluewater Health. The result was a 62% drop in 911 calls, 58% fewer ED visits, and a 55% reduction in hospital admissions. Similarly, in Windsor/Essex, the Community Paramedicine program had over 3,000 paramedic interactions with vulnerable, high-user patients, resulting in a 26% (453) reduction in 911 calls and 460 ED transports avoided. The Chatham-Kent Community Paramedicine program via Medavie EMS also showed a 48% reduction in the number of 911 calls received from enrolled patients in the 2017–18 fiscal year compared to the previous fiscal year. This year, 1,667 clients were served by the Chatham-Kent CP program.

In collaboration with the Windsor FHT and the City Centre Community Health Centre, the ESC LHIN supported a successful application to the MOHLTC for funding to implement an Integrated Care Team (ICT) in Windsor. The ICT will support primary care providers with access to a variety of allied health and service professionals, such as social work therapy and psychotherapy, dietary, pharmacy, and nursing care, to meet the needs of the most vulnerable patients. Similar successful applications were also supported for the Sarnia Rapids FHT and the Essex NP-Led Clinic.

The LHIN brought together all of its health-sector partners in September to develop a surge plan for seasonal influenza pressures, which typically occur from November to March each year. A comprehensive system-wide strategy was drafted and implemented. The activation of the plan resulted in a more coordinated approach to influenza, with increased system flow between community- and hospital-based providers during the surge season. As a result of this approach, the impact of influenza was reduced compared to other areas of the province, as demonstrated by average acute care occupancy rates through the months of November 2017 to March 2018 of 81% in the region, compared to 96% in the province as a whole. A similar planning approach will be undertaken in 2018–19.

On March 5, 2018, the LHIN, in collaboration with Windsor Essex Local Immigration Partnership, hosted a provider and community event about access to health services; 145 newcomer patients, service providers, community partners, and volunteers attended. The event was a follow-up to the Listening to You event held three years ago, and was designed to engage newcomers and immigrants in Windsor and Essex County to understand their need for local health care services. The consultation empowered patients and families to share their health journeys and be recognized as important community members and "owners" of their health care. It was also an opportunity to engage with health service providers and community partners to discuss collaborative approaches to addressing health access barriers. The Health Equity for Newcomers

and Immigrants (HENI) committee reviewed the feedback from the session and will incorporate it into strategic planning in 2018–19 to collectively respond to the identified gaps, opportunities, and recommendations.

By focusing on prevention and improved chronic disease management, people may live longer and, most importantly, experience a better quality of life. In support of this goal, the Chatham-Kent Breathe Well Pulmonary Rehabilitation program introduced a new intake process that lets clients begin the exercise program whenever they are ready, instead of being placed on a wait-list for the next session. By improving timely access to the program, more people with COPD will be better able to manage their chronic disease and ultimately improve their quality of life.

Health Links

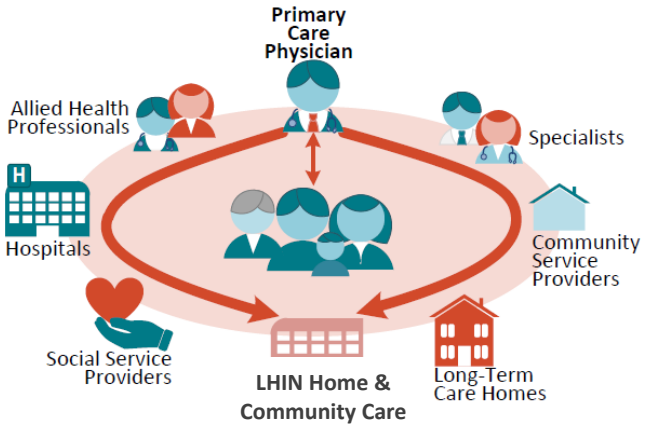
Five percent of people consume 66% of health care spending in Ontario because of the complexity of their medical conditions; this is true both in the province as a whole and in Erie St. Clair. Complex patients are those who have four or more chronic conditions.

The ESC LHIN has higher-than-provincial acute hospital discharges per capita for cardiovascular disease, cerebrovascular disease, COPD, ischemic heart disease, respiratory disease, and stroke. Additionally, compared to the rest of the province, the Erie St. Clair population has higher rates of:

- Arthritis
- Asthma
- Cancer
- Diabetes
- Hypertension
- Mood disorders
- COPD
- Congestive heart failure (CHF)
- Heart disease
- Effects of stroke

Statistics like these provide clear evidence that we can do a better job delivering more coordinated care. To achieve this goal, in 2016–17 the ESC LHIN focused on improvement through better care coordination and the establishment and enhancement of its four Health Links.

A Health Link is a formal partnership of health care providers that creates a circle of care around a patient in order to improve care for those who have the most complex medical needs. These health care providers are accountable to one another, to the system, and to the patient. A Health Link provides comprehensive and coordinated care to those who experience significant health challenges, in order to improve or maintain their quality of life. Objectives of a Health Link include:



- Regular and timely access to a primary care practitioner

- Evidence-based, measurable improvement of the patient experience
- Provision of coordinated care to patients that also supports increased system value and improved efficiencies in care
- Consistent quality care across the health care continuum and social services sectors

In 2017–18, the ESC LHIN reformed its local Health Link strategy — there is now a Health Link aligned with each sub-region. The foundation of this strategy is the development of LHIN and local health leaders around LHIN-wide system thinking, supported by professional development and relationship building. The result has been an increase in coordinated care plans, a core measure used to understand health system collaboration.

The LHIN also continued implementing the Chatham-Kent Health Link and the Lambton County Lake Huron Health Link, which focus on identifying and connecting patients with coordinated care plans and enhanced access to primary care, and expanding the number of referring agencies. Work also focused on integrating Health Links' care coordination into primary care organizations, including FHTs, CHCs, and family health organizations.

The Essex County South Shore Health Link became fully operational this year, and began seeing patients in the second quarter. Planning conversations in the Windsor sub-region began in the third quarter, a lead organization was identified, and implementation planning for the Windsor Health Link began in the latter part of 2017–18. Windsor is the last Health Link to come online, and will become fully operational in 2018–19.

Also in 2017–18, the ESC LHIN's Home and Community Care Coordinators were educated on the Health Links approach so that they could begin coordinating care planning with appropriate patients in their caseload. As a result of the concentrated efforts on Health Links during fiscal 2017–18, there was a substantial increase in coordinated care plans for patients (see Figure 3).

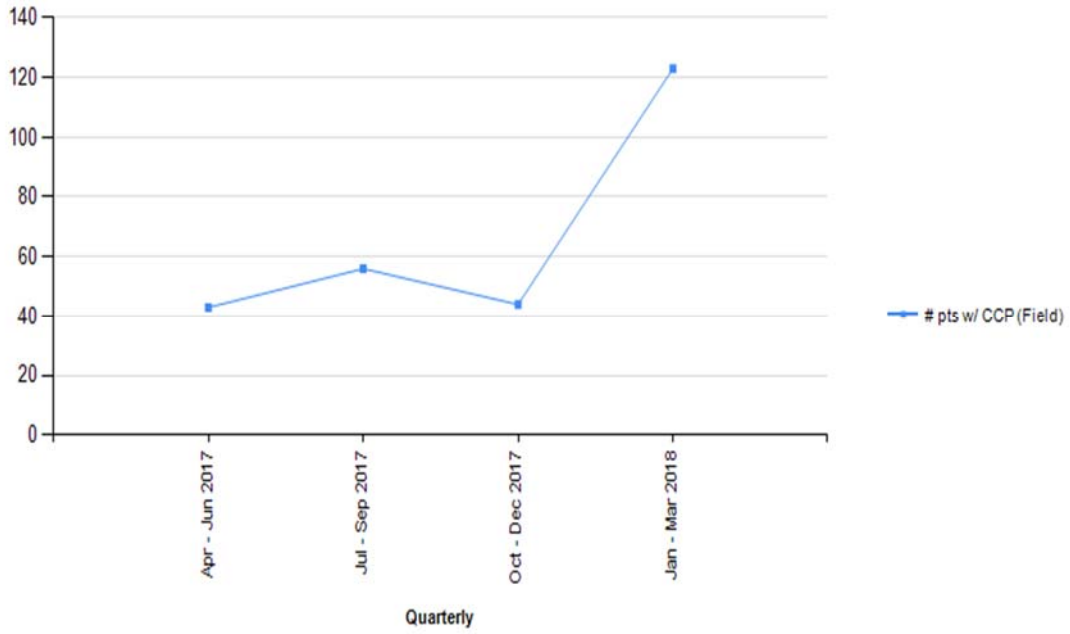
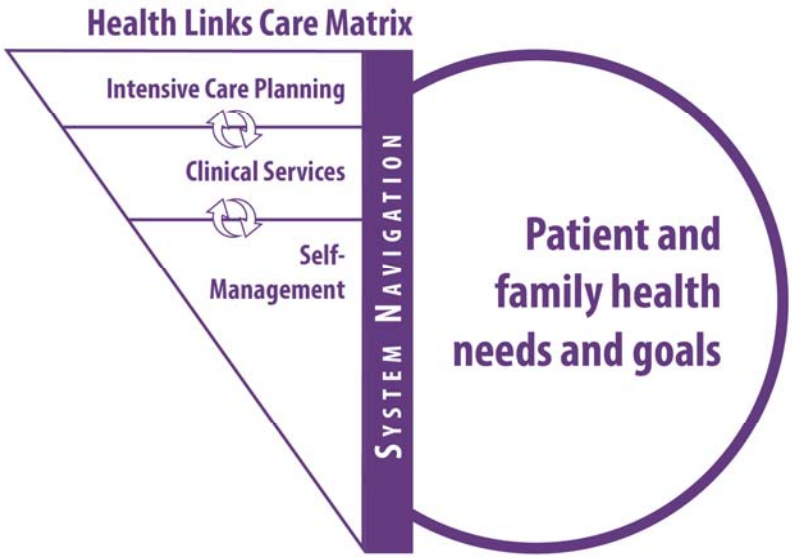


Figure 3: Coordinated care plans created in 2017–18

To further support the Health Links model of care, project planning and live testing of the ESC LHIN's technology solution, SHIIP, also began in 2017–18. SHIIP is a secure web-based portal that enables health care providers to share patient data in real time, or near real time, including hospital emergency room and acute care visits. The portal incorporates and connects information from existing technology assets, facilitating in the identification of complex/high-needs patients, helping to inform clinical decision and care planning to enhance patient experience. SHIIP increases productivity with improved access to coordinated care and ease of transitions between providers for patients, eliminating duplicated tasks and the number of forms required for clinicians to complete.



Home and Community Care

As part of *Ontario's Patients First: Action Plan for Health Care*, all home care services and staff from the Erie St. Clair Community Care Access Centre (CCAC) transferred to the ESC LHIN on June 21, 2017. This change will greatly enhance access to care, reduce wait times, and improve the patient experience. In fiscal 2017–18, ESC LHIN home and community care served 40,317 patients, an increase from fiscal 2016–17, in which 39,474 patients were served.

Key initiatives were undertaken in a number of different areas of home and community care during the year.

Primary Care Engagement/Integration

A new model of clinical care coordination support was implemented with three Health Links organizations in three of the sub-region areas. Clinical Care Coordinators carry a caseload of Heath Links and high-acuity patients, and follow the patient through identification as a Heath Links patient to acute care admission and ongoing home visits, where they perform both nursing and Care Coordinator assessment to implement strategies to mitigate ED and hospital re-admissions. This is done in collaboration with the patient/family, primary care provider(s), and other health system providers.

Innovation, Health Technologies, and Digital Health (eRehab)

An innovative service delivery model was piloted with Windsor Regional Hospital to support patients who have experienced a mild stroke. The eRehab model links a remote directing therapist to a therapy technician in the home in real time to support patients' rehabilitation goals. This pilot resulted in a reduction in LOS from 5.5 days to 5.0 days, eliminated patients with mild stroke being designated as ALC, and reduced hospital re-admission rates by 3%.

Patient Experience

The ESC LHIN continued to partner with the University of Waterloo in a pilot to test the Caregiver Distress Index to help identify caregiver burnout early in a patient's journey. The pilot supported a change in how the LHIN delivers care to patients and their caregivers — namely, to support appropriate respite services through home and community care when patients are not eligible for other community respite supports.

Additional respite funds were allocated to eShift to support caregivers whose loved ones had chosen to die at home, enabling 137 more patients to die in their home this year, an increase of 46%.

System Integration/Enhanced Care Coordination Supports to Support Patient Transitions

A pilot project aimed at enhancing care coordination support to all medium and large ESC LHIN hospitals during weekends from October 2017 to March 31, 2018, was implemented. The project supported patient discharges seven days a week, enhancing access and flow as well as ensuring that the LHIN was well positioned to support surge concerns.

Wait Time Strategies

The Erie St. Clair Local Intake Tool (ELIT), a new technology that enables the ESC LHIN to track when patient referrals are received and set key performance indicators, was developed internally and introduced to the Home and Community Care intake team. The tool enabled the LHIN to reduce the time of referral receipt to a patient's first visit from a high of 33 days to 23 days at the end of the fourth quarter, closer to the provincial target of 21 days.

Engagement with Indigenous Communities

An Indigenous Patient Services Manager was hired to help support enhanced collaboration between Indigenous patients and home and community care supports.

Mental Health and Addictions

An additional MHAN was hired to support the Sarnia/Lambton area this year. The nurse collaborated with Bluewater Health, local school boards, and community organizations to support 237 youth requiring mental health supports at school, as well as transitions from acute care back to school. The number of patients admitted to the program increased by 6% in Lambton-Kent. This is in addition to the eight mental health and addiction nurses that service schools in Windsor/Essex and Chatham-Kent. In total, 920 students were supported during 2017–18 through 5,330 visits.

Intensive Hospital to Home

Implementation of the IHH program allowed more patients with greater levels of complexity and acuity to be safely cared for at home. The program is based on a Home First philosophy that supports the patient during the transition from hospital to community by putting a robust service plan in place. Patients with medical complexities and high needs are supported through services such as nursing, personal support services, and other allied health care professionals in their home. As well, family caregivers may be assisted with respite care in order to avoid burnout and provide a well-needed break from caregiving. In order for the program to be successful, it requires developing and initiating highly coordinated service plans among multiple service provider organizations. Enhanced funding for IHH through short-term transitional care models enabled over 200 patients to be discharged safely from hospital to home at an average cost of $198 per day, with 50% of patients returning to regular regulated service maximums and 35% of patients supported until they accessed LTC.

Long-Term Care

Long-term care homes are places where older adults can live and receive assistance with daily activities and have access to 24-hour nursing and personal care. The ESC LHIN funds local LTC homes and provides care coordination to support information and eligibility determination for people who are considering moving to an LTC home. Achievements included the following:

- ESC LHIN home and community care provided patient assistance to 1,717 LTC placements, 179 short-stay convalescent care placements, and 308 short-stay respite placements
- The Chatham-Kent Nurse-Led Outreach Team (NLOT) provided outreach services to 11 LTC homes in Chatham-Kent and Sarnia/Lambton. During the year, the NLOT made 2,574 visits to residents and helped 271 residents avoid going to the ED

- Richmond Terrance and Royal Oak LTC homes launched an Attending Nurse Practitioner programs and hired an NP for each of these homes. The programs are intended to support increasing the level of primary care to LTC homes across the province through the addition of NPs where the need is demonstrated. A selection process was undertaken by the ESC LHIN to identify prospective homes based on number of criteria, including the overall complexity of residents (based on the Case Mix Index score), ED and acute care admissions, and available supports to the home. The LHIN supported the MOHLTC's Aging with Confidence initiative, which will add 5,000 new LTC beds across Ontario. A local strategy was launched to assist in receiving applications from proponents and define a process for evaluating and making recommendations to the MOHLTC on prioritization for implementation. This strategy included broad engagement with interested proponents to educate them on the process and assist with the completion of their applications. Erie St. Clair was awarded eight new beds at Trillium Villa Nursing Home and is well positioned to support the second wave of bed allocations. Additionally, in combination with the addition of the new beds, Trillium Villa will redevelop its existing 160 LTC beds.

Mental Health and Addictions

Mental health and addictions care remained a key priority for the ESC LHIN in 2017–18. Continued collaborative efforts were made in alignment with the five strategic pillars of the November 2014 update to MOHLTC's 10-year mental health and addictions plan, *Open Minds, Healthy Minds*.

The ESC LHIN continued to work with its health service providers to implement the recommendations contained in its *Addiction Strategic Plan*. The ESC LHIN has also developed strategies for community housing.

A number of key initiatives were implemented in 2017–18:

- Specialized human resources support, specifically for older adults with responsive behaviours, was expanded within the region's 36 LTC homes
- More treatment options were made available for people with opioid addictions, including expanding supports for those with chronic pain. Seventy new clients were served in 2017–18. Addiction support workers provided 124 encounters for 39 clients in the Windsor and Leamington area using a harm-reduction approach. Additionally, the VON chronic pain and addictions service provided care to 70 new clients in 2017–18

- Access to residential withdrawal management services for Sarnia/Lambton was improved as 187 individuals gained access through Bluewater Health's program. Previously, residents had to travel to London or Windsor for care. Efforts continued to plan for a new residential treatment facility in the Sarnia/Lambton region
- Access to primary care for individuals with mental health and addiction conditions via a specialized NP supporting two domiciliary hostels in Windsor, which houses 230 individuals, was implemented
- The ESC LHIN provided $84,000 in new base funding to CMHA Lambton-Kent to provide staff support to transitional-aged youth who have serious mental illness and/or concurrent disorders and who live in the region's 18 new supportive housing rent-supplemented units. This amount will be annualized up to $168,000 in 2018–19. The LHIN also provided $42,000 in new base funding to the CMHA, Windsor Essex County Branch, to help deliver supports for transitional-aged youth who have serious mental illness and/or concurrent disorders, and who live in nine new supportive housing rent-supplemented units. This amount will be annualized up to $84,000 in 2018–19

Wait Times for Surgical and Diagnostic Imaging Procedures

Although several initiatives continued from previous fiscal years, wait time and DI improvements in the area of musculoskeletal (MSK) conditions were a key priority in fiscal 2017–18 and were addressed through several initiatives, including:

- An ESC LHIN MSK Steering Committee began meeting in July 2017 to plan the implementation of both central intake centres and RACs for patients with hip and knee arthritis or low back pain. The programs are intended to work in combination with triage and expedite access to orthopedic specialist care when appropriate. Planning for the low back pain model of care will be undertaken in fiscal 2018–19. The LHIN is also working with the e-health centre of excellence in the Waterloo Wellington LHIN to implement the OCEAN e-referral platform to support MSK central intake centres and RACs for patients with hip and knee arthritis and low back pain. The web-based Ocean eReferral Network was designed to streamline the referral process for health care providers. Clinicians will be able to find a specialist, send a referral, keep a record in the electronic medical record, and even track the status of a referral at any time from the Ocean Portal
- Bundled Care pilot projects for hip and knee joint replacements were approved at BWH, CKHA, WRH hospitals in December 2017. A LHIN-wide steering committee was struck in February 2018 to support the hospitals in preparation for the project's launch in April 2018
- The ESC LHIN continued to support the work of the Bluewater Health's Choosing Wisely Campaign, which focuses on engaging clinicians and patients in conversations about unnecessary tests, treatments, and procedures. This work is particularly relevant to the diagnostic imaging (DI) clinical paths for MSK conditions. Bluewater Heath used Innovate ESC Alumni Funds to support its ongoing work in this area

Community Engagement

Community engagement is both a legislated responsibility and a core function of the LHINs. Local decision-making is the model upon which the LHINs are built, and patient and family engagement is essential to the care we provide. The LHINs value the input of community members, patients, families, health care professionals, and stakeholders to inform their planning and decision-making processes.

ESC LHIN key population and stakeholder groups were engaged to further develop relationships, inform planning initiatives, and provide the patient-experience perspective to the work we do. Through this engagement, the ESC LHIN was able to meaningfully meet its overall objectives and responsibilities as outlined in the *Local Health System Integration Act, 2006* (LHSIA). Key population and stakeholder groups included:

- Patients and families of the health care system
- Indigenous and Métis communities
- The Francophone community
- Health service providers
- Physicians and primary care providers
- Allied health care professionals
- Public health and social service providers

There was significant engagement during 2017–18 with the Erie St. Clair community, patients and their families, and health care providers, including:

- Program-specific engagement
- ESC LHIN sub-region development
- Public feedback process on a proposed integration decision within Chatham-Kent Health Alliance and a subsequent public report
- Patient and Family Advisory Council
- Engagement specific to the Indigenous and Francophone populations
- Emergency management preparedness
- Engagement with LHIN and CCAC staff to support a seamless integration

Engagement took many forms, including via patient advisors, PFAC consultations, meetings, surveys, interviews, social media engagement, website updates, and email. Ongoing engagement also occurred through local provider networks, committees, open board meetings, open mic and online sessions, and formal presentations. Table 3 highlights the ESC LHIN's community engagement activities during 2017–18.

Community Engagement Initiatives

The following table outlines a sample of the community engagement initiatives undertaken in 2017–18 and is not a definitive list of all engagement activities that occurred during that year.

Table 3: ESC LHIN Community Engagement Initiatives, 2017–18

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
Governance	16	Open/special Board meetings featuring "open mic"	Governance of ESC LHIN and other matters. Includes opportunity for members of the public to address the ESC LHIN Board in an open mic session at each meeting.	Open board meetings are an opportunity for the public to learn more about local health care. Open mic provides direct engagement with community members.
	7	Open Board meeting highlights	Highlights of information and decisions from open Board meetings distributed and posted online.	Increased awareness of Board activities and media coverage of important matters.
Governance Advisory Council (GAC) sessions	3 (one in each region)	Meetings	Discussions about master plan/master program, capital proposals, service changes, and ESC LHIN sub-region planning initiatives.	Reviewed several requests and agreed on action items for each matter.
CEO engagements	7	Speaking engagement at various organizations	Provided attendees with an overview of the LHIN, the LHIN/CCAC transition, and sub-regions.	Attendees were better informed about recent LHIN initiatives and ongoing planning.
	3	MPP Engagement Session	Along with LHIN Board Chair, met with local MPPs; this occurs annually.	Attendees are kept current on local health care issues.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	1	Mayoral engagement	Meeting with Mayor Bradley; this occurs annually.	Attendees are kept current on local health care issues.
	2	Strategic input sessions	Provided input at sessions around *Chatham-Kent Plan 2035* and the *United Way of Windsor-Essex Strategic Vision 2020*.	Provided the LHIN lens on local planning for the future.
	2	Patient home visits	Attended home visits with LHIN Care Coordinators.	CEO gained insight into patient care and had first-hand discussions with patients receiving LHIN services.
	7	Invited guest to special events	Attended a variety of events hosted by ESC health care partners including ribbon cuttings, alumni meetings, and fundraisers.	Represented the LHIN at important announcements and gained insight from local organizations about their programs and services.
	3	First Nations engagement	Along with other LHIN representatives, attended meetings with First Nations chiefs at Kettle & Stony Point, and Aamjiwnaang; with the Can-Am Indian Friendship Centre; and, along with other LHIN CEOs in Toronto, with Grand Chief Madahbee, who holds the health portfolio for Chiefs of Ontario. Discussions included health care initiatives for First Nations communities.	CEO is building ongoing relationships with First Nations communities and gathering input to address the health care needs of Indigenous populations.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
Hospice palliative care/end-of-life care	2	Erie St. Clair Hospice Palliative Care Advisory Council	Identify and recommend ways to improve hospice palliative care, provide advice and recommendations to the LHIN.	Continued work on priority ESC Hospice Palliative Care Network priority objectives.
Mental health and addictions (LHIN Lead)	4, with special meetings scheduled	ESC LHIN Mental Health and Addictions Network	Responsible for providing high-level strategic counsel to the ESC LHIN to advance system-wide planning, performance oversight for the Leadership Tables, and informed decision-making.	Leadership, monitoring, and oversight of mental health and addictions services, performance, and new funding.
	3	Children and Youth Leadership Table (meetings and focus groups)	Membership includes service providers from school boards, mental health/addictions agencies, Ministry of Children and Youth Services (MCYS), mental health lead agencies, Erie St. Clair CCAC, schedule one sites, early psychosis programs, etc.	Streamlined transitions in care and strengthened partnerships. Increased networking and overall partnerships.
	18	Behavioural Supports Ontario (BSO) LTC Road Show	A review of BSO-related data, including ED visits, and BSO internal and external teams.	Key themes/issues brought forward to address, as well as identifying innovative solutions to difficult cases. Roll-up report to be developed regionally and locally with actions to address concerns raised.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
	10	Addictions Implementation Group	Discussed the advancement of the *Addictions Strategic Plan* and implementing changes in the absence of new funding.	Streamlining services, including implementing the GAINs (Global Appraisal of Individual Needs) tool in Sarnia/Lambton and Windsor/Essex.
	3	Psychiatry Leadership Table	This group includes the chiefs of psychiatry from the hospitals as well as community agencies.	Focuses on current issues and spreading best/promising practices.
	2	People with Lived Experience meetings	25 individuals or family members of individuals who have received mental health or addictions services were brought together to assist in creating a more responsive mental health and addictions system.	Gained feedback and knowledge from people with lived experience. A working group was created to further discussions.
Mental health and addictions (home and community care)	11	Information booths at various awareness events	Overview of MHAN services available through the ESC LHIN.	Provided valuable information to students and staff about services provided in schools.
	16	Speaking engagements at local schools	Overview of MHAN services available through the ESC LHIN, as well as opioids and addictions education.	Provided valuable information to students and staff about services the LHIN provides in schools and how MHAN can work with those students facing an addiction.
	6	Speaking engagements at	Overview of MHAN services	Provided valuable information to staff

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
		community centres/ organizations	available through the ESC LHIN, as well as opioids and addictions education.	about services the LHIN provides in schools and how MHAN can work with those students facing an addiction.
	4	"Not My Kid" Opioid Forum	Booth and presentation providing overview of MHAN services available through the ESC LHIN.	Provided valuable information to parents, families, and the public about services the LHIN provides in schools.
	2	AM 800 interview re: Not My Kid Forum	Discussed opioid addiction and how the MHAN team works with students.	Provided public education about the work MHAN is doing in schools to address addiction.
Patient relations specialist	4	Info booth at health fairs	Provided LHIN materials and verbal information about home and community care services.	Provided public education about home and community care services, answered questions, provided contact information for patient relations.
	25	Speaking engagements for various organizations	Provided an overview of home and community care services.	Provided public education about home and community care services, answered questions, provided contact information for patient relations.
ED/ALC	1	ESC LHIN Executive Nurse/Clinical Leaders Advisory Council	An opportunity for organizations to share expert advice and leadership, and to support, enable collaboration, share models of care, and promote best practices with respect to quality and	Shared knowledge, lessons learned, and successes achieved.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			performance improvement.	
	1	Seasonal influenza surge forum	Service providers from all health care sectors participated in a collaborative full-day workshop (September 15, 2017) to initiate the process of developing a comprehensive system-wide influenza surge strategy that is aligned with provincial best practices and supports a managed and integrated response to seasonal surge.	Received feedback that enabled the development and implementation of a regional influenza surge strategy that was successful in minimizing the impact of influenza surge in Erie St. Clair.
	8	Sub-region working groups	Service providers from all health care sectors participated in a series of sub-region working groups supporting the co-design of the regional influenza surge strategy.	Finalized the regional influenza surge strategy, which was successful in minimizing the impact of influenza surge in Erie St. Clair.
Indigenous	6	Indigenous Health Planning Committee (IHPC)	Regularly scheduled meetings with Indigenous representatives from the area's First Nations, Métis, and Indigenous organizations. Discussions included updates/progress on strategic priority areas, identified initiatives, and partnerships.	Participants provided feedback and guidance on priorities for the localized health needs of the region's Indigenous communities.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			Presentations were also given.	
	3	Youth Council	Facilitated meetings with local Indigenous youth as a sub-group of the IHPC.	Enhancing Indigenous youth health education/literacy and creation of a regional Indigenous Youth Health Care Plan.
	2	Meetings with local Chiefs and ESC LHIN Board Chair/CEO	Updates exchanged and discussion of health care needs and services within the community.	Positive relationship-building between local Chiefs and ESC LHIN leadership.
	4	Elders/Traditional Knowledge Keepers Council meeting	Facilitated meetings with local Indigenous Elders/Traditional Knowledge Keepers Council as a sub-group of the IHPC.	Engagement with the Elder's/ Traditional Knowledge Keepers Council to determine: • Regional Traditional Healing Strategy • Culturally safe care standards • Performance and reporting guidelines • Patient-assisted death cultural supports • Alternatives to self-identification • Criteria for an Indigenous patient care plan • Indigenous-specific determinants of health

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
Francophone	2	ESC/SW LHINs and FLHPE Liaison Committee	A forum for collaboration and ongoing dialogue amongst the FLHPE, the South West LHIN, and the ESC LHIN in order to improve health outcomes for the Francophone population in these regions.	Partners work collaboratively to improve access to and accessibility of services in French, with a special focus on priority population groups, including people with mental health and addiction issues, people living with a chronic disease, and seniors and adults with complex needs.
	1	Ministry-LHIN FLHPE forum	Forum for ongoing dialogue and collaboration between the MOHLTC, the LHINs, and the FLHPEs in order to improve the delivery of French-language services (FLS).	Increased awareness of roles, responsibilities, and obligations vis-à-vis FLS as well as next steps.
	2	ESC LHIN FLS Identified and Designated Providers Network	Forum for improving the accessibility of culturally and linguistically appropriate health services for the Francophone population across the ESC LHIN.	Additional training provided to HSPs in completing the new FLS reporting tool.
	1	Participation in a research project with University of Ottawa for the development of an active offer and continuity of services tool	Debriefing meeting held with participating health service providers, LHIN FLS lead, FLHPE planning officer and researchers.	Opportunity for health service provider's leads to connect and build their own support network.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
Rehabilitative care	2	Sarnia/Lambton District Stroke Council	Group met to talk about planning, improved patient flow, and community care options.	Advancement of specific care paths for each population. Application sent to HQO's Adopting Research To Improve Care fund/program.
	4	Assess and Restore Working Group	Group met to discuss and plan transition from the Seniors Mobile Assess & Restore Team (SMART) model of activation to implementation of the Mobilization of Vulnerable Elders (MOVE) initiative in acute care sites, improved patient flow, and reducing ALC days.	Advancement of best practice care for frail and medically complex seniors admitted to hospital to prevent functional decline.
	2	ESC LHIN Rehabilitation Health Service Providers Definitions Implementation Group	Group met to review implementation of the Rehabilitative Care Alliance (RCA) Definitions for bedded rehabilitative care within the ESC LHIN rehabilitation system scorecard and alignment to RCA system evaluation framework.	Working toward standardized referral options tools accessible to all health service provider partners and the public, aligned with provincial directions.
	1	Fourth ESC LHIN Rehabilitative Care Forum, "Enhancing Geriatric Care Knowledge Exchange Workshop"	Held March 23, 2017, at the Chatham-Kent John D. Bradley Convention Centre. Review of education needs assessment project for geriatric assessment and management.	Advanced recommendations on a learning plan to meet educational needs identified in the survey, and build capacity in geriatric care in acute, post-acute,

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			Attended by 55 health service providers across the care continuum in all regions of the LHIN.	and community-based health service providers. Introduced a working demo of the Healthline site, categorizing services for seniors based on risk level, and care needs for health service providers to facilitate linkage of frail seniors to community supports.
Erie St. Clair sub-region engagement	1	Communities of Care Symposium	An overview to the new ESC LHIN and localized planning on sub-region development. Speaker: Deputy Minister Dr. Bob Bell.	Further development of the ESC LHIN sub-regions.
	1	ESC LHIN 2017–18 Health Equity Reporting Survey	80 reports received.	Gathering a current state of equity plans and activities from all funded providers. These data will inform a regional report aimed at integrating the principles of health equity at all levels of the health system.
Primary care	2	Primary Care Council	A network of primary care providers that advises the LHIN on ways to improve integration and coordination within ESC's primary health care system. The council also focused on ways to increase	Primary care feedback and advice to the ESC LHIN on key initiatives and priorities.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			communication between primary health care providers.	
	5	Engagement opportunities with primary care organizations	Provided information to raise awareness of community care plans for Health Links patients.	These organizations are now more aware of the benefits of a community care plan.
Quality	3	Quality Council meetings	Provided governance, leadership, and oversight for the quality of health care services, to achieve better care, better experiences, and better value for residents of the Erie St. Clair region.	Work focused on readmissions stroke care.
	4	Regional Quality Table	Focuses on regional quality challenges and initiatives. Helps connect local quality activities with LHIN regional and provincial priorities and structures. Collaboration between the ESC LHIN and HQO.	Worked toward advancing a quality agenda in the ESC LHIN.
Newcomer/ immigrant health	7	HENI Committee met with local health service providers and settlement/ community agencies	Prioritization activities focused on three main areas: access and tracking, information and education, and language and navigation. Because the patient voice is a necessary component of planning, an engagement event	After hearing from the 144 attendees, results of the patient/provider engagement were a unanimous recommendation to focus on the language barrier. Working with the HENI committee and ESC LHIN Project

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			was held March 5, 2018, with immigrant patients/families; a separate forum for providers was also held.	Management office to identify collective language project with measurable outcomes.
Chatham-Kent Community Leaders' Cabinet (CKCLC)	4	CKCLC	Community leaders work together to achieve better health outcomes and quality of life for everyone in Chatham-Kent. The ESC LHIN Director of Communications, Public Affairs, and Organizational Development is a member of the Cabinet.	The Erie St. Clair Regional Community Data Consortium was initiated; this program provides a venue for collaboration on local research/data, and benefits local service providers and community partners. The CKCLC also developed a scorecard and strategic document.
Communications	1	Chatham Active Lifestyle Centre's Seniors Fair	The ESC LHIN hosted a booth at Chatham's Active Lifestyle Centre's Seniors Fair.	Handed out information on LHIN functions including home and community care.
	3	CEEH Petrolia Hospital Steering Committee Meetings	The ESC LHIN took part in a public open house and engagement sessions led through the CEEH-Petrolia Joint Steering Committee regarding the CEEH Master Plan/Health Care Village.	The Committee hosted a stakeholder workshop, as well as a public open house, to present and gather feedback on the preliminary concept plan and design directions.
	1	Digital Health Symposium	Educational and collaborative event focusing on customizing a digital	Partners across the system engaged in digital health; now have a shared understanding.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			health strategy for the ESC region.	
	1	What's the Harm in Harm Reduction Conference	Discussed the opioid crisis and the role of harm reduction.	Attendees have a shared understanding of the opioid situation and the role of harm reduction.
	3	Smart Cities Working Group-CK	Working group established to provide feedback on smart cities grant application.	Municipality of CK submitted a grant for approval.
	1	Age-Friendly Sarnia Committee meeting	Manager of Communications presented to the committee about Healthline.	Discussed potential partnership for including an age-friendly section on Healthline; Manager of Communications to become member of Communications Sub-Committee.
	1	HENI Committee Meeting	Manager of Communications presented to the committee about Healthline and the home and community care intake process.	Members of the committee, representing several agencies in the community, are now aware of Healthline and will potentially add their agencies to the listing.
	1	Chatham-Kent Health Alliance (CKHA) Tri-Board Voluntary Integration	Reached out to all communities across Erie St. Clair for input. Digital and paper-based surveys available in both English and French. Process for feedback was communicated to staff, stakeholders, and media via news	In total, 42 responses were received. The findings were collected in December and presented to the Board at the December 21 Special Open Board Meeting.

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
			release, social media, website, email, and in-office signage.	
Emergency management	1	Nuclear	Provincial planning meetings to discuss preparedness for a nuclear event.	Local input into the provincial plan.
	3	Meetings with emergency management professionals	Meetings to discuss emergency management plans; attended by LHIN emergency management leads.	Further coordination on local emergency management planning.
Health Links	2	Meeting with sub-regions' primary care leadership	Health Links clinical model presented.	Partnerships established and primary care physician consultation and input received on clinical process model.
	7	Monthly meeting between Health Links team and sub-region governance	Health Links Lead and partner organizations met to discuss operations and strategic governance.	Increased knowledge and engagement on the maturity model and work plans to drive evolution to next level of maturity.
	2	SHIIP: Privacy and Legal Working Group	Includes members from the ESC LHIN, TransForm, and HSPs with a goal of completing tasks assigned as per the SHIIP implementation project plan.	Continuing to work on project tasks.
eRehab – orthopedic	3	Engagement sessions with orthopedic surgeons at Bluewater Health,	Overview of the eRehab patient and the benefits for hip/knee replacement	Provided surgeons with a better understanding of the program and

Initiative	Frequency (times per year)	Format	Content	Outcome(s)
		Chatham-Kent Health Alliance, and Windsor Regional Hospital	patients and the health care system.	the opportunity to ask questions.
Nursing flex clinic	3	Meeting with CKHA and the service provider organization	Engaging with CKHA and the service provider organization to develop the format, facilities, and other plans to facilitate the implementation of the Wallaceburg flex clinic.	Decisions on the format of the clinic, the facilities' usage, and amenity provision for the Wallaceburg flex clinic. The clinic successfully opened in April 2018.
Long-term care	2	Chatham-Kent Long-Term Care (FOG) Meetings	Local engagement with LTC home providers.	Discussion of initiatives and system-coordinated planning.
Performance, accountability, and finance	4	Pay For Results (P4R) meetings	Meetings to review P4R data and related information.	Partners involved in pay-for-results funding are informed.
	1	Demystifying Radiology event	Rationally identify and order DI tests; increase patient understanding of goals, risks, and benefits of DI.	Identify clear pathways for ordering appropriate radiology testing.

Francophone Engagement

The ESC LHIN remains committed to improving access to health care services in French and bettering the health outcomes of the Francophone population in our LHIN. Throughout 2017–18, several community engagement and planning initiatives were undertaken by the LHIN so that it could better understand and address the health care challenges faced by Francophones in the region. The ESC LHIN also continued to collaborate with the FLHPE in Erie St. Clair.

Key initiatives this year included the following:

- The French Language Liaison Committee continued its work, with representation from the ESC and South West LHINs and the Erie St. Clair/South West FLHPE. This group meets and works on the deliverables from the *Joint Action Plan 2015–2018* to support better health care services for local Francophone residents

- Local conditions continued to be included in LHIN-funded health service provider service accountability agreements regarding the implementation and delivery of FLS, as well as the collecting and reporting of the linguistic identity of health system users. Continued support was provided to health service providers to help them build their capacity to provide FLS
- Implementation of the new provincial reporting tool on FLS, OZi, began with initial reporting by all LHIN-funded HSPs
- The new *Guide to Requirements and Obligations Relating to French Language Health Services* published by the MOHLTC was shared with all LHIN-funded HSPs
- Engagement with stakeholders, health service providers, and the Francophone population continued, including attending the Comité Franco Info (Francophone Roundtable)
- Attendance at a community engagement event in Sarnia organized by the FLHPE allowed the LHIN to hear first-hand about their health care needs
- The LHIN FLS Lead attended the Francophone Seniors Fair held in Sarnia, and presented on the eriestclairhealthline.ca and the Telehomecare program
- The LHIN FLS Lead, together with the FLHPE Planning Officer, actively participated in a research project led by University of Ottawa researchers to develop a tool to promote the active offer and the continuity of services in French for Francophone seniors. This led to the development of a tool, which was then tested with five HSPs from the Erie St. Clair LHIN. A debriefing meeting was subsequently held with participants and researchers to obtain feedback and suggestions to improve the next version of the tool
- Falls prevention exercise classes are now offered to Francophone seniors in Sarnia. These are in addition to classes already offered in Pain Court and in Windsor
- Filming of a series of videos to capture the Francophone patient experience within the health care system and that of health care professionals working with Francophone patients has taken place. Results of this joint initiative with the South West LHIN and the FLHPE will be available in mid-2018
- Development of a cultural and linguistic sensitivity training as it applies to the Francophone population has also begun. Results of this joint initiative with the South West LHIN are expected in the fall of 2018

Indigenous Engagement

Through a focused approach to the *Indigenous Health Strategic Plan*, the following priority areas were identified by the IHPC for implementation in 2017–18.

1. Increase direct care through allied/holistic teams in Indigenous communities:

- The MOHLTC provided annualized funding to the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) for the delivery of enhanced primary care services in Windsor, Caldwell First Nation, Aamjiwnaang First Nation, and Delaware First Nation. This funding gives Indigenous communities increased availability and access to culturally based primary care services

2. Improve patient support in acute and community-based health services:

- The ESC LHIN provided multi-year funding for an Indigenous Patient Navigator at Bluewater Health. An Indigenous Patient Care Committee was also established at the hospital
- The ESC LHIN is actively working with Kettle and Stony Point First Nation and North Lambton Community Health Centre to create and finalize a protocol agreement

- Assistance was provided to the CKCHC to revise its protocol agreement with Walpole Island
- The LHIN hired a Patient Services Manager/Indigenous Lead to assist and address service gaps in home and community care for Indigenous patients and families across the region

3. Implementation of the Cultural Integration Model:

- The model was developed in 2016–17 to articulate a culturally based health approach to addressing local Indigenous patients', families', and communities' health needs. It was used throughout 2017–18 by local health service providers as a resource for understanding and addressing:
  - Historical agreements between Indigenous communities and settlers
  - Traditional and culturally based teachings and approaches to health care
  - Creating a vision statement for Indigenous peoples' health and health outcomes
  - The current state of social determinants of health
  - Community engagement methods and expectations
- A central feature of the cultural integration model is the importance of working from a place of co-development and health system coordination between Indigenous communities and health service providers

4. Development of service and patient referral agreements/partnerships:

- A health service inventory was completed outlining the type of health services available in local Indigenous communities
- The ESC LHIN strengthened linkages between health service providers and Indigenous communities by:
  - Coordinating meetings between WECHC, Caldwell First Nation, and SOAHAC
  - Supporting and assisting St. Clair Child and Family Services to develop its Indigenous Liaison position
  - Co-developing strategy alignments with organizational initiatives (i.e., a palliative care workplan and primary care)

5. Building Indigenous community's capacity:

- A training session on reporting requirements was conducted with Indigenous health care providers
- Two palliative training sessions were completed in Aamjiwnaang First Nation
- Ontario Telemedicine Network training sessions were completed in three Indigenous communities in the region

Additional activities occurred to advance the strategic directions, including the following:

- To date, Indigenous cultural safety (ICS) training has been completed by:
  - 62 Erie St. Clair LHIN staff and board
  - 63 stakeholder organizations, which included 413 participants
- Cultural sensitivity/awareness presentations were provided to:
  - Bluewater Health (four)
  - Public health leaders
  - Correctional facility nurses

- Roots of Tolerance training was conducted for ESC LHIN staff and Indigenous partners
- Windsor Essex Public Health and Hotel Dieu Grace were supported in the development of their cultural safety organizational plans
- The ESC LHIN provided support and guidance to Walpole Island First Nation in the development of its EMS services proposal
- A three-year regional Indigenous palliative care training plan was established
- In November, an Elders Council was established to determine and provide guidance on the best approaches to addressing:
    - The creation of a regional traditional healing strategy
    - Patient-assisted-death cultural supports
    - Alternatives to self-identification
    - Criteria for an Indigenous patient care plan
    - Indigenous-specific determinants of health for the ESC region
- A health service inventory outlining the type of health services available in local Indigenous communities was implemented. Once complete, the inventory will be posted on ESC Healthline as a resource for patients and health service providers
- Facilitating and aligning service provisions and initiatives regionally and provincially with local Indigenous communities continued, including:
    - Coordinating meetings between WECHC, Caldwall First Nation, and SOAHAC
    - Supporting St. Clair Child and Family Services to develop its Indigenous Liaison position
    - Participation by the Indigenous Liaison on the CNE committee
    - Indigenous Liaison acting as the Chair of the Provincial Indigenous Leads/LHIN Network
    - Indigenous Liaison acting as the Co-chair of the City of Sarnia United Nations Declaration of the Rights of Indigenous Peoples
    - Participating in the ESC Regional Health Links governance council
    - Co-developing strategy alignments with organization initiatives (palliative care work plan and primary care)
- LHIN funding was secured to enhance an Indigenous youth recreation/skills building program to include mental health supports and traditional knowledge
- A training session was provided to local Indigenous health care providers to review and clarify reporting requirements

Integration

If we can do a better job of "connecting the dots," patients will have an easier time navigating the health care system and ultimately have improved health outcomes. The ESC LHIN has worked to help health service providers understand that integration does not need to be a formal merger process, and that it is really about increased collaboration so that the care delivery system is more connected and integrated, regardless of formal integration. Increased collaboration amongst all providers ultimately ensures greater sustainability of the health care system and better-coordinated care for patients.

In 2017–18, the ESC LHIN continued to support integration activities through both formal integration processes and informal activities. Table 4 outlines the two formal integrations that were completed during 2017–18.

Table 4: ESC LHIN Integrations, 2017–18

Date/Event	Organization/Health Service Provider	Motion
	April 25, 2017 • **Canadian Red Cross/March of Dimes: Voluntary Integration** MOTION*:* *Moved by Michael Hoare and seconded by Rick Charlebois that the Erie St. Clair LHIN Board endorses the integration, and as per our obligation under LHSIA, provide notice to the Canadian Red Cross and March of Dimes that the ESC LHIN does not intend to give notice of a proposed decision under subsection (4) or issue a decision under subsection (6).* **Motion Passed** December 21, 2017 • **Chatham-Kent Health Alliance: Voluntary Integration** MOTION*:* *Moved by Lindsay Boyd and seconded by Wally Hogan that the Erie St. Clair Local Health Integration Network (the "LHIN") Board will not stop the voluntary integration between the Public General Hospital Society of Chatham, Sydenham and District Hospital, and St. Joseph's Health Services Association of Chatham, Incorporated (collectively the "HSPs") from proceeding and authorizes the LHIN to notify each of the HSPs through their Supervisor, Mr. Rob Devitt, appointed by the Lieutenant Governor in Council, that it does not intend to give notice of a decision or issue a notice under Section 27 of the Local Health System Integration Act, 2006.* **Motion Passed**	

Board of Directors

Name	Position	Location	Tenure
Martin Girash	Chair	Leamington	November 20, 2013–November 19, 2016 (Order in Council as Chair) November 20, 2016–November 19, 2019 (OIC as Chair) (Re-appointment)
Michael (Mike) Hoare	Vice Chair	Grand Bend	May 17, 2011–May 16, 2014 March 22, 2012–May 16, 2014 (Order in Council as Vice Chair) November 19, 2014–November 18, 2017 (Order in Council as Vice Chair) (Re-appointment)
Joseph Bisnaire	Director	Windsor	June 2, 2011–June 1, 2014 June 2, 2014–June 1, 2017 (Re-appointment)
Donald (Lindsay) Boyd	Director	Blenheim	September 8, 2014–September 7, 2017 September 8, 2017 – September 7, 2020 (Re-appointment)
Nora Bressette	Director	Kettle and Stony Point First Nation	June 30, 2016–June 29, 2019
Sheila MacKinnon	Director	Amherstburg	March 8, 2017–March 7, 2020
Richard Charlebois	Director	Sarnia	April 12, 2017–April 11, 2020
Sharon Pillon	Director	Amhertsburg	April 26, 2017–April 25, 2020
Deborah Crawford	Director	Pain Court	June 7, 2017–June 6, 2020
Susan J. Martin	Director	Chatham	August 31, 2017–August 30, 2020
Wallace Hogan	Director	Kingsville	October 18, 2017–October 17, 2020

Ministry-LHIN Accountability Agreement (MLAA)

The MLAA sets out the obligations of the MOHLTC and the ESC LHIN to fulfill the LHIN's mandate to plan, integrate, and fund local health care services. Developing and updating this accountability agreement is a collaborative process that defines the relationship between the MOHLTC and the ESC LHIN, and helps the LHIN strengthen health care in the Erie St. Clair region (see Table 5).

Table 5: ESC LHIN Report on MLAA Performance Indicators

ESC LHIN Report on MLAA Performance Indicators
Among the 14 LHINs, the ESC LHIN is a strong performer in home and community care wait times, 30-day readmissions, ALC Rates, CT scans, and hip surgery wait times. The most significant opportunities for improvement in wait times are for knee replacements and ED visits. The LHIN also faces significant challenges for substance use 30-day repeat visits to the ED. **30-Day Readmissions** The ESC LHIN outperformed the provincial readmission rate and target. In the second quarter of 2017–18, the LHIN's rate was 13.9% and the LHIN ranked first in the province. All ESC LHIN sites performed within their expected rates. For the priority cohorts of COPD and CHF, the ESC LHIN rate was 18.4% and 16.7%, respectively — fourth in the province for CODP and second for CHF. Although the ESC LHIN is a top performer, there is still opportunity to improve on the transitions between hospital, community, and primary care. The LHIN currently ranks third and fourth best in the province for mental health readmissions and selected conditions, respectively. **ALC** The ESC LHIN had two projects funded — IHH and Mobile Assisted Living — Neighbourhoods of Care. The Chief Nursing Executive Committee provided leadership on best practices and chart audit tools. These projects created capacity and flow within hospitals by focusing attention on those patients at risk of being designated ALC. The ESC LHIN ranked fifth in the province, at 13.28% — still higher than the provincial ALC target of 12.7%. This rate showed a decline over the fourth quarter of 2017–18. Specifically, more recent data shows that in the fourth quarter, the LHIN was performing at the provincial target of 12.7%, per the most recent Stocktake results. Going forward, the LHIN will focus on ALC patients or patients trending toward an ALC designation as it relates to responsive behaviors presenting as a barrier to discharge. With new resources for home and community care specific to BSO, the LHIN anticipates targeting individuals in the community who are in a crisis, waiting for a LTC bed, and at risk of hospital admission and ALC status if not stabilized in the community and accepted by an LTC home. Existing BSO Acute Care Navigator resources and BSO LTC mobile teams will continue to transition patients from hospital to LTC and from hospital to community.

Emergency Department LOS for Complex Patients

Both the provincial and the ESC LHIN complex LOS trended upwards, but the ESC LHIN LOS is lower than the provincial rate, at 9.78 hours. Although the ESC LHIN ranks sixth in the province, the provincial target of eight hours has still not been met.

Chatham-Kent Health Alliance, Sydenham site, and Bluewater Health, Petrolia site, are within target. Erie Shores Healthcare, Bluewater Health, Sarnia site, and Windsor Regional Hospital rates are much higher than target. The biggest opportunity for improvement is at the Windsor Regional Hospital sites as they continue to see much longer-than-target 90th percentile LOS — 14.8 for the Ouellette site and 10.6 for the Metropolitan site.

The ESC LHIN has initiated and supported the following strategies to improve ED LOS across the region:

1. Facilitating an ED managers and chiefs' quarterly meeting to encourage standardization of best practices and the spread of successful process changes
2. Holding Pay for Results (P4R) forum where leading practices within the ESC LHIN are shared with all EDs' leadership, EMS, home care, and related community partners
3. The use of Oculys and real-time data to improve operational and process challenges
4. Quarterly P4R meetings with each hospital to review action plans, implementation, and progress toward meeting provincial metrics

Emergency Department Visits Best Managed Elsewhere

In addition to internal ED improvement initiatives, the ESC LHIN concentrated on ED/ALC avoidance in the community through its health service providers, home care, CSS agencies, linkages to primary care, and other health and non-allied health providers. This upstream strategy should help decrease the number of ED visits for patients who could safely receive care in a community setting. ED visits best managed elsewhere should, over time, decrease as access to community care and support increases. The ESC LHIN believes that it can help divert patients with unnecessary needs from utilizing the ED and instead receive support in the community.

The ESC LHIN improved on this indicator by reducing the rate of ED visits for conditions best managed elsewhere by almost 60%, from 8.78 in the fourth quarter of 2015–16 to 4.81 in the third quarter of 2017–18. As of the third quarter of 2017–18, the ESC LHIN is performing approximately 9% better than the Ontario rate of 4.40. Through an analysis to help inform the sub-region geographies, the LHIN found that outliers in the region are tied to areas with lower areas of primary care access, predominately the rural areas of Sarnia-Lambton and Chatham-Kent.

The ESC LHIN is committed to continually improving local health care. Health system indicators are an excellent way to track results from the system changes the LHIN makes because they are measurable improvements.

			Provincial				LHIN			
No.	**Indicator**	**Provincial target**	**2014/15 Fiscal Year Result**	**2015/16 Fiscal Year Result**	**2016/17 Fiscal Year Result**	**2017/18 Result (year to date)**	**2014/15 Fiscal year Result**	**2015/16 Fiscal year Result**	**2016/17 Result (year to date)**	**2017/18 Result (year-to-date)**
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within five days of the date that they were authorized to receive personal support services*	95.00%	85.39%	85.36%	89.86%	88.50%	92.45%	90.54%	93.46%	95.69%
2	Percentage of home care clients who received their nursing visit within five days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	96.07%	96.21%	95.04%	95.03%	95.88%	96.53%
3	90th percentile wait time (in days) from community for home care services — application from community setting to first home care service (excluding case management) *	21 days	29.00	29.00	30.00	29.00	18.00	19.00	26.00	27.00
4	90th percentile wait time from hospital	TBD	7.00	7.00	7.00	7.00	4.00	4.00	5.00	5.00

	discharge to service initiation for home and community care*									
5	90th percentile ED length of stay (in hours) for complex patients	8 hours	10.13	9.97	10.38	10.75	8.87	9.67	9.55	9.78
6	90th percentile ED length of stay (in hours) for minor/ uncomplicated patients	4 hours	4.03	4.07	4.15	4.38	4.00	3.98	4.22	4.45
7	Percentage of priority 2, 3, and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	78.47%	77.99%	83.85%	80.24%	87.90%	88.22%
8	Percentage of priority 2, 3, and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	75.02%	73.72%	75.26%	75.94%	72.62%	67.56%
9	Percentage of ALC days*	9.46%	14.35%	14.50%	15.69%	15.18%	18.07%	15.97%	14.96%	10.30%
10	ALC rate (percentage)	12.70%	13.70%	13.98%	15.19%	15.68%	19.58%	19.50%	15.24%	13.28%
11	Repeat unscheduled ED visits within 30 days for mental health conditions*	16.30%	19.62%	20.19%	20.67%	20.97%	17.05%	17.80%	19.10%	17.48%
12	Repeat unscheduled ED visits within 30 days for substance abuse conditions*	22.40%	31.34%	33.01%	32.50%	32.25%	25.04%	23.99%	30.92%	32.42%
13	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.74%	16.41%	15.51%	14.66%	15.57%	15.70%

Operational Performance

The ESC LHIN finished 2017–18 with a surplus, details of which can be found in our statement of operations. The audited financial statements include home and community care operations from the date of transition through March 31, 2018.

Table 6 summarizes our operational expenditures for 2017–18, assuming the transition occurred April 1, 2017.

Table 6: ESC LHIN Expenditures

Sector	Expenditures ($ Million)
Hospital	692.2
Long-term care	226.4
Mental Health	42.9
Community health centres	37.0
Community support services	23.7
Assisted-living supportive housing	13.1
Addictions	11.8
Acquired brain injury	1.5
Subtotal HSP transfer payments	**1,048.6**
LHIN Administration, operations, and initiatives	17.6
LHIN Home and Community Care	139.1
Subtotal LHIN Operations	**156.7**
Total for fiscal 2017-18	**$ 1,205.3**

For 2017–18, administrative salaries and benefits were 1.1% of total expenditures.

Due to the transition of the ESC CCAC's operations into the ESC LHIN during the fiscal year, staffing increased to 505 employees.

During the year, four individuals served as Professional Leads for the ESC LHIN:

- Dr. Eli Malus, Critical Care & Performance Improvement Lead
- Dr. David Ng, Emergency Department Lead
- Dr. Martin Lees, Vice President of Clinical, Primary Care & Clinical Quality Lead
- Dr. Tyceer Abouhassan, Endocrinologist Lead

During the year, four individuals served as Sub-Region Clinical Leads for the ESC LHIN:

- Dr. Sheila Horen, Sub-Region Clinical Lead, Essex
- Dr. Dennis Atoe, Sub-Region Clinical Lead, Chatham
- Dr. Vid Singh, Sub-Region Clinical Lead, Sarnia/Lambton
- Dr. Braedon Hendy, Sub-Region Clinical Lead, Windsor/Essex

Clinical Leads are responsible for local quality initiatives, working closely with primary care providers, inter-professional teams, and administrative leads in their sub-region to achieve an improved network of care that includes primary care, public health, home care and community care, mental health and addictions, long-term care, and acute care.

Initiatives that receive funding from the MOHLTC include:

- Continued support for French Language Health Planning Entity and French Language Services
- Funding for Indigenous engagement
- Continued support for Specialty Clinical Leadership
- Funding for Sub-Region Clinical Leadership
- E-referral, System Coordinated Access

Statement of Management Responsibility

The accompanying financial statements of the Erie St. Clair LHIN have been prepared by management in accordance with Canadian public-sector accounting principles, and the integrity and objectivity of these statements are management's responsibilities.

Management is also responsible for implementing and maintaining a system of internal controls to provide reasonable assurance that reliable information is produced.

The Board of Directors is responsible for ensuring that management fulfills its responsibilities for financial reporting and internal control, and exercises this responsibility through the Audit Committee of the Board. The Audit Committee meets with management and the external auditors no fewer than two times a year.

The external auditors, Deloitte LLP, conduct an independent examination, in accordance with Canadian generally accepted auditing standards, and express their opinion on the financial statements. Their examination includes a review and evaluation of the LHIN's system of internal control and appropriate tests and procedures to provide reasonable assurance that the financial statements are presented fairly in accordance with Canadian public-sector accounting standards. The external auditors have full and free access to the Performance and Audit Committee of the Board and meet with it on a regular basis.

On behalf of Erie St. Clair LHIN:

Ralph Ganter
Chief Executive Officer

Linda Vienneau
Director, Finance & Corporate Services

June 27, 2018

Financial statements of

Erie St. Clair Local Health Integration Network

March 31, 2018

Deloitte LLP
400 Applewood Crescent
Suite 500
Vaughan ON L4K 0C3
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
Erie St. Clair Local Health Integration Network

We have audited the accompanying financial statements of the Erie St. Clair Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2018, and the statements of operations, changes in net assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2018, and the results of its operations, changes in its net assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
June 27, 2018

Erie St. Clair Local Health Integration Network

Statement of financial position

As at March 31, 2018

	Notes	2018	2017
	3	$	$
Assets			
Current assets			
Cash		**15,361,767**	915,602
Due from Ministry of Health and Long-Term Care ("MOHLTC")		**994,769**	4,253,500
Due from Health Shared Services Ontario		**120,092**	—
Accounts receivable		**670,091**	62,391
Prepaid expenses and supplies		**1,152,960**	37,305
		18,299,679	5,268,798
Capital assets	7	**1,830,251**	142,369
		20,129,930	5,411,167
Liabilities			
Current liabilities			
Accounts payable and accrued liabilities		**13,514,836**	969,671
Due to Health Service Providers ("HSPs")		**434,869**	4,253,500
Due to Ministry of Health and Long-Term Care ("MOHLTC")	4	**4,260,763**	45,627
Deferred revenue		**138,616**	—
Due to Health Shared Services Ontario		**7,300**	—
		18,356,384	5,268,798
Post employment benefits and compensated absences	8	**1,574,600**	—
Deferred capital contributions	9	**1,830,251**	142,369
		21,761,235	5,411,167
Commitments	10		
Net assets		**(1,631,305)**	—
		20,129,930	5,411,167

The accompanying notes are an integral part of the financial statements.

Approved by the Board

M. Hirsch, Director

Sharon T. Pillon, Director

Erie St. Clair Local Health Integration Network

Statement of operations

Year ended March 31, 2018

	Notes	2018	2017
	3	$	$
Revenue			
MOHLTC funding - transfer payments	14	**1,080,822,329**	1,170,767,983
MOHLTC funding - operations and initiatives		**124,831,594**	6,523,561
Interest income		**188,126**	—
Amortization of deferred capital contributions		**511,316**	149,193
Other revenue		**1,261,635**	—
Less			
Funding repayable to MOHLTC		**(3,361,379)**	(8,287)
Total operations and initiatives		**123,431,292**	6,664,467
		1,204,253,621	1,177,432,450
Expenses			
HSP transfer payments	14	**1,080,822,329**	1,170,767,983
Operations and initiatives contracted out			
In-home/clinic services		**62,655,229**	—
School services		**5,976,378**	—
Hospice services		**3,418,719**	—
Salaries and benefits		**37,521,115**	4,071,917
Medical supplies		**5,298,079**	—
Medical equipment rental		**962,407**	—
Supplies and sundry		**2,727,001**	1,188,609
Equipment		**613,487**	70,071
Building and ground		**1,522,865**	317,397
Amortization		**511,316**	149,193
Professional service		**1,573,407**	726,312
Board costs		**137,554**	140,968
Total operations and initiatives		**122,917,557**	6,664,467
		1,203,739,886	1,177,432,450
Excess of revenue over expenses before the undernoted		**513,735**	—
Net liabilities assumed on transition	13	**(2,145,040)**	—
Excess of expenses over revenue		**(1,631,305)**	—

The accompanying notes are an integral part of the financial statements.

Erie St. Clair Local Health Integration Network

Statement of changes in net financial assets

Year ended March 31, 2018

	2018			2017
	Unrestricted	Employee benefits	Total	Actual
	$	$	$	$
Net assets, beginning of year	—	—	—	—
Excess of revenue over expenses before the undernoted	291,960	221,775	513,735	—
Net liabilities assumed on transition	(291,960)	(1,853,080)	(2,145,040)	—
Net assets, end of year	—	(1,631,305)	(1,631,305)	—

The accompanying notes are an integral part of the financial statements.

Erie St. Clair Local Health Integration Network

Statement of cash flows

Year ended March 31, 2018

	Notes	2018	2017
		$	$
Operating activities			
Excess of revenue over expenses		**(1,631,305)**	—
Cash received on transition		**12,548,860**	—
Net liabilities assumed on transition		**2,145,040**	—
Less amounts not affecting cash			
Amortization of capital assets		**511,316**	149,193
Amortization of deferred capital contributions		**(511,316)**	(149,193)
		13,062,595	—
Changes in non-cash working capital items	12	**1,383,570**	348,760
		14,446,165	348,760
Investing activities			
Purchase of capital assets		**(328,367)**	(3,900)
Financing activity			
Increase in deferred contributions		**328,367**	3,900
Net change in cash		**14,446,165**	348,760
Cash, beginning of year		**915,602**	566,842
Cash, end of year		**15,361,767**	915,602

The accompanying notes are an integral part of the financial statements.

1. Description of business

The Erie St. Clair Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Erie St. Clair Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandate of the LHIN is as follows:

Plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Municipalities of Essex, Lambton and Chatham-Kent. The LHIN enters into service accountability agreements with health service providers.

The LHIN has also entered into an accountability agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

All funding payments to LHIN managed Health Service Providers are flowed through the LHIN's financial statements. Funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

Effective June 21, 2017 the LHIN assumed the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards for government not-for-profit organizations including the 4200 series standards, as issued by the Public Sector Accounting Board. Significant accounting policies adopted by the LHIN are as follows:

Revenue recognition

The LHIN follows the deferral method of accounting for contributions. Contributions from the MOHLTC represent externally restricted contributions which must be spent within the fiscal year provided. Unspent contributions from the MOHLTC are set up as repayable to the MOHLTC at the end of the year. Unrestricted contributions are recognized when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOHLTC. The Financial Statements reflect funding arrangements approved by the MOHLTC. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOHLTC. Due to the nature of the Accountability Agreement, the LHIN is economically dependent on the MOHLTC.

Transfer payment amounts to Health Service Providers are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOHLTC and does not flow through the LHIN bank account.

LHIN Financial Statements do not include transfer payment funds not included in the Ministry-LHIN Accountability Agreement.

Capital assets

Purchased capital assets are recorded at cost. Repairs and maintenance costs are charged to expense. Betterments, which extend the estimated life of an asset, are capitalized

Capital assets are amortized on a straight-line basis based on their estimated useful life as follows:

Furniture and equipment	5 years
Computer and communications equipment	3 years
Leasehold improvements	5 years

For assets acquired or brought into use, during the year, amortization is provided for a full year.

Deferred capital contributions

Contributions received for the purchase of capital assets are deferred and are amortized to income at the same rate as the corresponding capital asset.

Adoption of PSAS 3430 – Restructuring transactions

The LHIN has implemented Public sector Accounting Board ("PSAB") section 3430 Restructuring Transactions. Section 3430 requires that the assets and liabilities assumed in a restructuring agreement be recorded at the carrying value and that the increase in net assets or net liabilities received from the transferor be recognized as revenue or expense. Restructuring is an event that changes the economics of the recipient from the restructuring date onward. It does not change their history or accountability in the past, and therefore retroactive application with restatement of prior periods permitted only in certain circumstances. The impact of this policy on the current year is detailed in Note 13.

Financial instruments

Financial assets and liabilities are measured at amortized cost, with the exception of cash that is measured at fair value. Financial instruments measured at amortized cost are initially recognized at cost, and subsequently carried at amortized cost using the effective interest rate method, less any impairment losses on financial assets. Transaction costs related to financial instruments in the amortized cost category are added to the carrying value of the instrument.

2. Significant accounting policies (continued)

Financial instruments (continued)

Write-downs on financial assets in the amortized cost category are recognized when the amount of a loss is known with sufficient precision, and there is no realistic prospect of recovery. Financial assets are then written down to net recoverable value with the write-down being recognized in the Statement of Operations.

Post employment benefits and compensated absences

The LHIN accrues its obligations relating to the defined benefit pension plan administered by the LHIN, other post employment benefits and sick leave as the employees render services necessary to earn benefits. The LHIN has adopted the following policies:

i. The cost of benefits earned by employees is actuarially determined using the projected benefit method prorated on service and management's best estimate of expected plan investment performance, salary escalation, mortality and termination rates, and retirement ages of employees;

ii. For the purpose of calculating expected return on plan assets related to the defined benefit pension plan, these assets are valued at fair value;

iii. The excess of the net actuarial gain /loss is amortized over the average remaining service period of the employees;

iv. Differences arising from changes in assumptions and experience gains and losses are amortized on a straight line basis over the average remaining service period of the employees;

v. Past service costs arising from plan amendments are recognized immediately in the period the plan amendments occur.

A majority of the employees of the LHIN are eligible to be members of the Health Care of Ontario Pension Plan ("HOOPP"), which is a multi-employer, defined benefit, final average earnings and contributory pension plan. Defined contribution plan accounting is applied to HOOPP as LHIN has insufficient information to apply defined benefit accounting.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates include depreciation rates for capital assets and certain accruals. Actual results could differ from those estimates.

3. Change in accounting policy

As a result of the transition of responsibility for the delivery of certain services related to home care as described above, there has been a significant change in the operations of the LHIN over prior year. As a result of these changes, the LHIN has determined that the adoption of Canadian public sector accounting standards for Government not-for-profit organizations is appropriate. Previously the LHIN followed Canadian public sector accounting standards. The adoption of this policy has no impact on numbers previously reported. The impact of the change is limited to presentation only, and as a result the prior year figures presented for comparative purposes have been reclassified to conform with the current year presentation.

4. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

The amount due to the MOHLTC at March 31 is made up as follows:

	2018	2017
	$	$
Due to MOHLTC, beginning of year	**45,627**	93,318
Funding repaid to MOHLTC	**(45,627)**	(55,978)
Funding repayable to the MOHLTC related to current year activities	**3,361,379**	8,287
Funding repayable to the MOHLTC assumed on transition	**899,384**	—
Due to MOHLTC, end of year	**4,260,763**	45,627

5. Enabling Technologies for Integration Project Management Office

Effective February 1, 2012, the LHIN entered into an agreement with South West, Waterloo Wellington and Hamilton Niagara Haldimand Brant LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from South West LHIN of $510,000 ($510,000 in 2017).

6. Related party transactions

Health Shared Services Ontario (HSSO)

HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long-Term Care.

7. Capital assets

			2018	2017
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Leasehold improvements	**4,347,660**	**3,351,462**	**996,198**	66,587
Furniture and equipment	**2,562,645**	**2,160,243**	**402,402**	75,782
Computer equipment	**2,240,620**	**1,808,969**	**431,651**	—
	9,150,925	**7,320,674**	**1,830,251**	142,369

8. Post employment benefits and compensated absences

The net post employment benefits and compensated absences liability consists of:

	2018	2017
	$	$
(a) Pension plan – accrued future benefit asset	(292,700)	—
(b) Other benefits – accrued future benefit liability	1,360,900	—
(c) Accumulated sick leave liability	506,400	—
Net post employment benefits and compensated absences	1,574,600	—

(a) Pension plans

The LHIN has a defined benefit pension plan administered by the LHIN and managed by Standard Life of Canada, which provides pension benefits based on years of service prior to January 1, 1999 for some unionized employees and prior to January 1, 2002 for some non-unionized employees. Subsequent to the above mentioned dates, some of the respective employees became members of Healthcare of Ontario Pension Plan ("HOOPP"), a multi-employer final average pay contributory pension plan.

The LHIN uses actuarial reports prepared by independent actuaries for funding and accounting purposes. The most recent actuarial valuation of the pension plans for funding purposes was as of November 30, 2014. The measurement date is March 31, 2018.

The following significant actuarial assumptions were employed to determine the periodic pension expense and the accrued benefit obligations:

	2018	2017
	%	%
Assumptions		
Accrued benefit obligation as of March 31		
Discount rate	3.37	—
Rate of compensation increase	2.00	—
Benefit costs for period ended March 31		
Expected long-term rate of return on plan assets	5.00	—
Rate of compensation increase	2.00	—

Information about the LHINs defined benefit pension plan is as follows:

	2018	2017
	$	$
Accrued benefit obligation		
Accrued benefit obligation, beginning of year	—	—
Accrued benefit obligation, transferred from CCAC	967,000	—
Interest cost	23,900	—
Benefits paid	(300,900)	—
Actuarial loss	115,100	—
	805,100	—

8. Post employment benefits and compensated absences (continued)

(a) Pension plans (continued)

	2018	2017
	$	$
Plan assets		
Fair value of plan assets, beginning of year	—	—
Fair value of plan assets, transferred from CCAC	1,133,600	—
Actual return on plan assets	38,500	—
Contributions	16,800	—
Benefit payments	(300,900)	
Actuarial loss	(9,400)	—
	878,600	—

Funded status

	2018	2017
	$	$
Unamortized net actuarial loss	219,200	—
Funded status surplus	73,500	—
	292,700	—

Most employees are also members of HOOPP, which is a multi-employer plan, on behalf of approximately 505 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2018 was $2,930,989 ($314,335 in 2017) for current service costs and is included as an expense in the 2018 Statement of operations. The last actuarial valuation was completed for the plan as of December 31, 2017. At that time, the plan was fully funded.

(b) Other benefits

The LHIN provides for the continuation of medical benefits to most employees upon retirement. Information about the plan is as follows:

Accrued benefit liability is determined as follows:

	2018	2017
	$	$
Accrued benefit obligation	1,210,000	—
Unamortized actuarial gains	150,900	—
	1,360,900	—

8. Post employment benefits and compensated absences (continued)

(b) Other benefits (continued)

Continuity of benefit liability is as follows:

	2018	2017
	$	$
Balance, beginning of year	—	—
Balance, transferred from CCAC	1,341,400	—
Current service cost	64,800	—
Interest cost	28,300	—
Benefits paid	(43,300)	—
Amortization of net actuarial gains	(30,300)	—
Balance, end of year	1,360,900	—

The following significant actuarial assumptions were employed to determine the periodic benefit expense and the accrued benefit obligation:

	2018	2017
Assumptions		
Accrued benefit obligation as of March 31		
Discount rate	3.37%	—
Health care trend rate	8% trending down by 1% to 5%	—

(c) Sick leave benefits

Under the sick leave benefit plan, unused sick leave for most employees can accumulate. Information about the plan is as follows:

Compensated absence liability is determined as follows:

	2018	2017
	$	$
Accrued benefit obligation	2,496,800	—
Unamortized actuarial losses	(1,990,400)	—
	506,400	—

8. Post employment benefits and compensated absences (continued)

(c) Sick leave benefits (continued)

Continuity of benefit liability is as follows:

	2018	2017
	$	$
Balance, beginning of year	**—**	—
Balance, transferred from CCAC	**686,700**	—
Interest cost	**45,600**	—
Benefits paid	**(282,700)**	—
Amortization of net actuarial gains	**56,800**	—
Balance, end of year	**506,400**	—

The following significant actuarial assumptions were employed to determine the periodic benefit expense and the accrued benefit obligation:

	2018	2017
Assumptions		
Accrued benefit obligation as of March 31		
Discount rate	**3.37%**	—
Rate of compensation increase	**2.00%**	—

9. Deferred capital contributions

Deferred capital contributions represent the unamortized amount of contributions received for the purchase of capital assets. The changes in the deferred capital contributions balance are as follows:

	2018	2017
	$	$
Balance, beginning of year	**142,369**	287,662
Capital contributions received during the year	**328,367**	3,900
Capital contributions transferred from CCAC	**1,870,831**	—
Amortization for the year	**(511,316)**	(149,193)
Balance, end of year	**1,830,251**	142,369

10. Commitments

The LHIN has commitments under various operating leases as follows:

	$
2019	1,848,934
2020	1,470,121
2021	1,297,517
2022	1,021,310
2023	988,681
Thereafter	343,013

11. Contingencies

The LHIN enters into accountability agreements with Health Service Providers which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOHLTC providing the funding.

The LHIN has been named as defendants in various claims. Based on the opinion of legal counsel as to the realistic estimates of the merits of these actions and the LHINs potential liability, management believes any liability resulting from these actions would be adequately covered by existing liability insurance.

12. Changes in non-cash working capital balances

	2018	2017
	$	$
Due From Ministry of Health and Long Term Care	**3,258,731**	(2,552,645)
Due from Health Shared Services Ontario	**(120,092)**	—
Accounts receivable other	**(237,010)**	(13,456)
Prepaid expenses	**71,967**	(5,964)
Accounts payable and accrued liabilities	**(914,443)**	421,345
Due to Health Service Providers	**(3,818,631)**	2,552,645
Due to MOHLTC	**3,315,752**	(47,691)
Deferred revenue	**65,396**	—
Due to Health Shared Services Ontario	**7,300**	—
Due to LHIN Shared Services Services Ontario	**—**	(5,474)
Post employment benefits and compensated absences	**(245,400)**	—
Total change in non-cash working capital items	**1,383,570**	348,760

13. Transition of Erie St. Clair Community Care Access Centre

On April 3, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the Erie St. Clair Community Care Access Centre (CCAC), to the LHIN, including the transfer of all employees of the CCAC. This transition took place on June 21, 2017. Prior to the transition, the LHIN funded a significant portion of the CCACs operations via HSP transfer payements. Subsequent to transition date, the costs incurred for the delivery of services previously provided by the CCAC were incurred directly by the LHIN and are reported in the appropriate lines in the statement of operations.

The LHIN assumed the following assets and liabilities, which were recorded at the carrying value of the CCAC.

	$
Cash	**12,548,860**
Sundry receivables	**370,690**
Prepaid expenses and supplies	**1,187,622**
Capital assets	**1,870,831**
	15,978,003
Accounts payable and accrued liabilities	**13,459,608**
Due to Province of Ontario	**899,384**
Deferred revenue	**73,220**
Deferred capital contributions	**1,870,831**
Post employment benefits and compensated absences	**1,820,000**
	18,123,043
Net liabilities assumed	**(2,145,040)**

The Net liabilities resulting from this transaction are recorded as an expense in the statement of operations.

14. Transfer payment to HSPs

The LHIN has authorization to allocate funding of $1,080,822,329 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2018 as follows:

	2018	2017
	$	$
Operations of hospitals	**691,997,489**	676,437,991
Grants to compensate for municipal taxation – public hospitals	**156,975**	172,500
Long-Term Care Homes	**226,437,014**	220,720,033
Community Care Access Centres	**32,168,352**	148,779,255
Community support services	**23,678,658**	22,826,637
Assisted living services in supportive housing	**13,070,797**	12,322,437
Community health centres	**37,035,831**	35,250,458
Community mental health addictions program	**13,365,190**	12,213,804
Community mental health program	**42,912,023**	42,044,868
	1,080,822,329	1,170,767,983

14. Transfer payment to HSPs (continued)

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2018, an amount of $434,869 ($4,253,500 in 2017) was receivable from the MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

Pursuant to note 13, effective June 21, 2017 the LHIN assumed the assets, liabilities, rights and obligations of the Erie St. Clair CCAC. Current year amounts reported in respect of the CCAC in the table above represent funding provided to the CCAC up to the date of transfer.

15. Board costs

The following provides the details of Board expenses reported in the statement of operations and changes in net assets:

	2018	2017
	$	$
Board Chair per diem expenses	**34,325**	41,650
Other Board members' per diem expenses	**54,150**	40,100
Other governance and travel	**49,079**	59,218
Total Board costs	**137,554**	140,968

16. Financial risk

The LHIN through its exposure to financial assets and liabilities, has exposure to credit risk and liquidity risk as follows:

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and incur a financial loss. The maximum exposure to credit risk is the carrying value reported in the statement of financial position. Credit risk is mitigated through collection practices and the diverse nature of amounts with accounts receivable.

Liquidity risk is the risk that the LHIN will not be able to meet all cash flow obligations as they come due. The LHIN mitigates this risk by monitoring cash activities and expected outflows through extensive budgeting and cash flow analysis.

17. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s.28 of the Financial Administration Act.

Erie St. Clair **LHIN**

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

Ontario
Local Health Integration Network