Report of the President & CEO to the Board of Directors

Date: November 2018

Strategic Direction - Strengthen the culture of patient safety and quality care

Influenza Surge Beds

Windsor Regional Hospital has received one time funding of $1.694 million from the Erie St Clair LHIN (ESCLHIN) for fiscal years 2018/19 and 2019/20 to assist with increasing hospital capacity during the influenza period. The money is to be used to provide the hospital with twenty eight (28) additional beds to support flow and to reduce the impact of the increase in the number of patients who will require hospital admission. Typically, the increase in patients requiring hospitalization for influenza symptoms occurs from November through to the end of March. This funding was made available to the hospital last fiscal year and was instrumental in improving patient flow and reducing the costs incurred in previous years.

The surge dollars will be used, as they were last year to "open" twenty eight (28) Alternative Level of Care beds. The patients who will occupy the beds will be those awaiting a Long Term

Care placement and/or those who will be transitioned to the community with enhanced in-home services awaiting a Long Term Care bed. The majority of the patients will be cared for on 2 North at the Ouellette Campus where there is a twenty six (26) bed unit that is not currently required for acute care patients. The money allocated for surge beds is approximately $500.00 per day, which supports using a staffing model of primarily RPN's with RN oversight to provide the required care.

With the surge funding for 28 ALC's patients who were cohorted on 2 North, in conjunction with the implementation of the Medicine Patient Flow initiative, WRH was able to maintain occupancy rates of 95 -100% rather than the 110-120% that was experienced in previous years. It will be essential to monitor the utilization of the 28 beds to ensure the number of patient days does not exceed the dollars provided and that the ALC patients being cared for on the "surge" unit continue to move through the system and all involved in their care are actively pursuing the most appropriate discharge destination.

In addition, we have been informed tentatively that out of the $90M recently announced (see below) we will be receiving dollars to open five (5) surge acute mental health beds. More details to follow.

Strategic Direction – Champion accountability and transparency

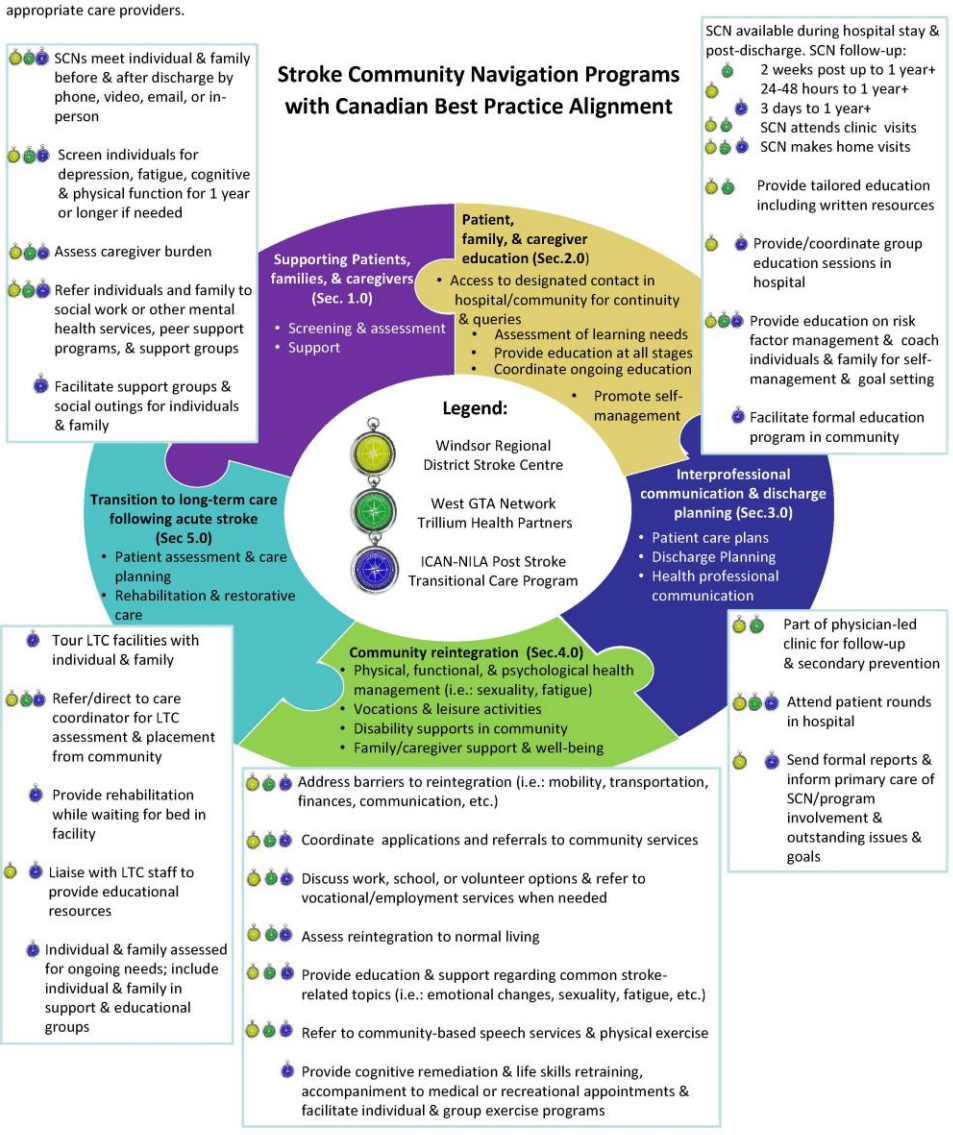
World Stroke Congress in Montreal Oct 17-20, 2018

The following posters were accepted for electronic display at the World Stroke Congress in Montreal Oct 17-20, 2018. Rachel Allchurch, Stroke Community Navigator for the Windsor Essex District Stroke Centre was one of the authors. Congrats Team!

Looking Across Ontario: How Stroke Community Navigators are Using Canadian Best Practice Guidelines to Improve Patient Outcomes

R. Allchurch[1], D. Lesko[2], S.Williams[2], R.Bowes[3]
1. Windsor Regional District Stroke Centre 2. West GTA Network, Trillium Health Partners
3. ICAN Independence Centre and Network, NILA Post Stroke Transitional Care Program

A Stroke Community Navigator (SCN) is a healthcare professional that provides support for stroke survivors and their family to positively enhance the transitions across the continuum of care. The services provided by the SCNs vary across Ontario, depending on the specific needs of those in the region. This comparison highlights the alignment of Canadian Best Practice Guidelines with the role and services provided by the SCN in three diverse regions in Ontario including West Greater Toronto Area, Windsor-Essex County and North East Ontario. Trained and professional SCNs provide holistic care and guidance which helps to improve the stroke recovery experience and improve the client's quality of life. SCNs are able to ease the adjustment to post-stroke life through education, improved access to healthcare services and connections to appropriate care providers.



Canadian Stroke Best Practice Recommendations: Managing transitions of care following stroke, Guidelines Update, 2016

Community Stroke Navigation: Different Approaches Across Ontario, Canada

D. Lesko[1], S.Williams[1], R.Bowes[2], R. Allchurch[3]
1. West GTA Network, Trillium Health Partners, 2. ICAN Independence Centre and Network, NILA Post Stroke Transitional Care Program, 3. Windsor Regional District Stroke Centre

Background:

Stroke Community Navigation has recently become an integral part of the stroke care system in Ontario, putting into action a number of Canadian Stroke Best Practice Guidelines, notably, supporting stroke clients through transitions and facilitation of community reintegration.

Navigators are trained culturally sensitive, health professionals providing holistic case management to help improve quality of life. Stroke Community Navigators help to ease the adjustment to post-stroke life for survivors and their families. Navigators increase capacity and performance of the health care system by improving access to much needed services and resources for patients and families. Navigators work to eliminate barriers, provide education, and facilitate connections to services such as transportation, in-home nursing, personal care, adaptive equipment, home modifications, community engagement, as well as physical, occupational, and/or mental health therapies at different times along the stroke care continuum.

The Navigators are part of local, regional, and national teams in order to share resources, educational events, and best practices. As members of the Canadian Navigator Network, the navigators meet quarterly via video or teleconference.

Program Overview and Comparison:

	West GTA Stroke Network Trillium Health Partners	ICAN NILA Post Stroke Transitional Care Program	Windsor Regional Hospital District Stroke Centre
WHO? **Staffing** • Designation • Work hours • # of staff members	▪ 2 part-time Navigators ▪ Monday to Friday – daytime hours ▪ RHCP preferred; health/social services background	• 1 full-time Regional Coordinator, 6 full-time Navigators, 3 full-time, & 4 part-time Rehabilitation Support Workers • Monday to Friday – daytime hours • RHCP preferred; health/social services background	▪ 1 full-time Navigator ▪ Monday to Friday – daytime hours ▪ RHCP required; health/social services background
Stroke clients • Eligibility criteria • # of clients served	✓ Adults 18 years or older ✓ Acute stroke ✓ Medically stable ~250 stroke clients per year	✓ Adults 16 years or older ✓ Acute & chronic stroke ✓ Medically stable ✓ Able to direct own care ~700 stroke clients per year	✓ Adults 16 years or older ✓ Acute stroke ✓ Medically stable ~300 stroke clients per year
WHAT? • Services Offered	✓ Care coordination ✓ Liaise with other health care providers ✓ Referral & applications for services (i.e.: medical, rehabilitative, home care) ✓ Assist with financial aid, home modification, & transportation ✓ Patient & family education & support ✓ Assessment & screening (i.e.: depression, fatigue, caregiver strain) ✓ Advocacy & coaching for self-management ✓ Support & educational Groups		
		Life skills retraining, physical & cognitive rehabilitation, assistance with adaptive aids	
WHERE? • Service area/city • Practice setting	▪ Hospital-Based office ▪ Urban area Mississauga & West Toronto ▪ Appointments in hospital & community including home visits	• Community-Based office • Urban & rural areas of Sudbury, Sault Ste. Marie, Timmins, Temiskaming Shores, North Bay, & Parry Sound • Appointments in hospital & community including home visits • Accompaniment to appointments, recreational centres, housing, etc.	▪ Hospital-Based office ▪ Urban & rural areas of Windsor-Essex County ▪ Appointments in hospital & community including home visits
WHEN? **HOW?** • When does navigator connect? • Length of service • Funding source	▪ Connect in acute care and/or rehab unit ▪ Follow up phone call at 2 weeks post discharge, 3 month face-to-face visit, call/visit at 6 months & 1 year ▪ Service length based on goals ▪ Funded by West GTA Stroke Network	• Connect in acute care and/or rehab unit • Follow up phone call/visit within 3 business days of referral, post discharge visit at 6-8 weeks, 3 months, 6 months, 1 year, & discharge from program • Service length based on goals • Funded by the North East Local Health Integrated Network (NE-LHIN)	▪ Connect once patient in rehab unit ▪ Follow up phone call 24-48 hours post discharge and in clinic at 6-8 weeks, 6 months, & 1 year ▪ Service length based on goals ▪ Funded by Windsor Regional Hospital District Stroke Centre

Key Conclusions and Recommendations:

Stroke Community Navigation is based on the individual needs and goals of the persons with stroke and their families. A key feature that lends to the success of navigation is the ability to adapt the service for the individual and their support system which not only includes their family/caregiver but also their community. The three programs featured here are similar in that they recognize the need for personalized care. They also share the same core values, are guided by best practices, provide care coordination, and involve the individual and their families/caregivers in the process of navigation. The main differences include practice setting, eligibility criteria, length of service, and the inclusion of rehabilitation services. Stroke Navigation programs do not have to be designed as a 'one fits all' program as these programs show that different approaches can be effectively implemented in a number of different stroke systems and regions.

Canadian Stroke Best Practice Recommendations: Managing transitions of care following stroke, Guidelines Update, 2016

Strategic Direction - Develop a sustainable corporate financial strategy

Ontario's Government for the People Taking Immediate Action to End Hallway Health Care - Province securing more than 1,100 beds and creating 6,000 new long-term care beds to ease hospital gridlock in communities that need it most

Premier Doug Ford and Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care, announced that Ontario is moving forward with building 6,000 new long-term care beds across Ontario.

These 6,000 new long-term care beds represent the first wave of more than 15,000 new long-term care beds that the government has committed to build over the next 5 years.

As an immediate measure, Ford and Elliott also announced that Ontario will create over 640 new beds and spaces and continue funding beds and spaces already operating in the hospital and community sectors across Ontario to help communities prepare for the surge that accompanies the upcoming flu season.

Taken together, these actions will ease pressure on hospitals, help doctors and nurses work more efficiently, and provide better, faster health care for patients and their families.

"One patient treated in a hallway is one patient too many. It's unacceptable that people are still waiting hours before seeing a doctor, or are forced to lie on stretchers in hospital hallways when they do finally get care," said Ford. "Patients are frustrated, families are frustrated, and doctors and nurses are frustrated. We told the people of Ontario we'd make our hospitals run better and more efficiently, and we'd get them the care they deserve. Today, we're keeping that promise."

"Hallway health care is a multi-faceted problem that will require real and innovative solutions," said Elliott. "Our government will continue to listen to the people who work on the front lines of our health care system as we develop a long-term, transformational strategy to address hallway health care."

Ford and Elliott made their announcement at the inaugural meeting of the Premier's Council on Improving Healthcare and Ending Hallway Medicine. Under the leadership of Dr. Rueben Devlin, the Council will recommend strategic priorities and actions to improve Ontario's health

outcomes and improve patient satisfaction, while making Ontario's health care system more efficient.

"To address the problem of overcrowded hospitals, we must have a long-term vision, planning and stable funding," said Dr. Devlin. "I look forward to working with Premier Ford, Minister Elliott and this exceptional group of leaders to bring more integration, innovation, and better use of technology to transform our health care system for the people of Ontario."

QUICK FACTS

The additional $90 million investment to address hallway medicine will create over 640 new beds and spaces and continue funding beds and spaces already operating in the hospital and community sectors, including:

- Sinai Health System - Bridgepoint
- North Bay Regional Health Centre
- Thunder Bay Regional Health Sciences Centre and Hogarth Riverview Manor
- Pine Villa
- Bayshore
- Cooksville Care Centre
- Humber River Hospital - Church Street site

Some facilities will receive additional funding immediately to address current capacity pressures and the remaining will receive funding in the fall/winter for flu season.

The following individuals will sit on the Premier's Council on Improving Healthcare and Ending Hallway Medicine:

- Dr. Rueben Devlin, Special Advisor and Chair
- Dr. Adalsteinn Brown, Professor and Dean, Dalla Lana School of Public Health at the University of Toronto
- Connie Clerici, CEO, Closing the Gap Healthcare
- Barb Collins, President and CEO, Humber River Hospital
- Michael Decter, President and CEO, LDIC Inc.
- Peter Harris, Barrister and Solicitor
- Dr. Jack Kitts, President and CEO, The Ottawa Hospital
- Kimberly Moran, CEO, Children's Mental Health Ontario
- David Murray, Executive Director, Northwest Health Alliance

- Dr. Richard Reznick, Dean, Faculty of Health Sciences at Queens University
- Shirlee Sharkey, President and CEO, Saint Elizabeth Health

Strategic Direction - Create a vibrant workplace

YOU NEED TO GET YOUR INFLUENZA VACCINE

We need to ensure our vaccine rates are high. In doing so you are not only protecting yourself BUT also our patients and your family. You do not want to be the person that spreads influenza to others.

Any staff that receive their influenza vaccination from a WRH pharmacist will receive a $2 Tim Horton's gift card.

The seasonal influenza vaccine is now available in the following areas:

We Care Pharmacy – Ouellette campus
- Monday to Friday
- 9am to 5pm

Cancer Centre Pharmacy – Met campus
- Monday to Friday
- 8:30am to 4:30pm

Health office - Met & Ouellette campus
- Monday to Friday
- from 10am to noon
- from 2pm to 3:30pm

AS A REMINDER, PLEASE REMEMBER TO BRING YOUR HEALTH CARD.

Click here to see the WRH pharmacy unit schedule for employees & professional staff.

Click here for the consent/decline form.
Click here for an influenza immunization information sheet.

Strategic Direction - Strategically engage with external partners

Working Closely with London Health Sciences Centre

Collaborative discussions with London Health Sciences Centre (LHSC) about shared patients and greater opportunity for earlier repatriations/transfer, surgical prep (diagnostics), and post-acute follow-up to be completed closer to home for patients. A site visit at WRH took place September 24th to build relationships and validate opportunities for partnership. Interest from partners and Cardiac Care Physicians to initiate a regional Cardiac Care Network (Committee) with physician, nursing and administration was represented.

Strategic Direction - Continue the pursuit of new state–of-the-art acute care facilities

Congrats to our own Dr. Larry Jacobs, new Associate Dean at the Schulich School of Medicine & Dentistry, Windsor Campus. Recently he was featured in a Windsor Star article where he says he is looking forward to providing input on the school's physical presence in the new Windsor-Essex Hospitals System.

"It's rare that you get a chance to be part of something like that," Jacobs said.

Read the full article here: New head of medical school's Windsor Campus takes pride in never rushing patients

Education and research are among the main drivers of the new Windsor-Essex Hospitals System. We look forward to working with Dr. Jacobs. #WEareReady