South West LHIN

Appendix D

Service Delivery Approaches

Ontario
Local Health Integration Network

Population-based integrated health services - service delivery approach

Roles and Responsibilities	Local Level	Multi-community Level	LHIN Community Level
Providers	• Provides regular point of contact, wellness support, screening, assessment, treatment, and monitoring of the individual's needs. • Referral relationships through the integrated health services collaborative to more specialized services. Integrated health services collaboratives will be equipped with care coordination resources to provide self-navigation, service coordination, and clinical case management support/services • Expanded referral pathways enabling non-traditional resources to refer individuals to local health services (incl. alternative providers) • 'Share the Care' - Involving information caregivers and other lay support in the health care team • Increased focus on at-risk populations (e.g. mild-moderate, transitional periods, Serious Mental Illness) • Focus on advanced care planning involving social and health determinants for elderly population segment • Delivery of health education and information in areas of congregation (e.g. employers)	• Multi-community resources to be integrated with local services to support local care delivery • Select support services, outreach services, and programs of excellence to address acute or specialized individual needs (e.g. frail elderly, youth with disabilities) • Long-term care services and specialized housing capacity are available through multi-community and local levels (LTCH, supportive housing, Alzheimer secured units)	• Highly specialized services provided to the most complex individual needs • Provision of sub-specialist support to the most complex individual needs • Advisory relationship with local and multi-community teams for standardized tools, quality guidelines, and consults through tele-medicine/health vehicles
	• Partnerships across EDs and integrated health services collaboratives to provide primary care, chronic illness and mental illness and addictions management services (e.g. virtual) • Strengthened integration and partnerships across local and multi-community levels to deliver services closer to home		

Population-based integrated health services - service delivery approach (cont'd)

	Local Level	Multi-community Level	LHIN Community Level
Access and Individual Flow	• Care coordination services through system navigation framework including service coordination, case management, and self-management elements. Individuals with complex needs will be linked with a 'most responsible provider' to aid them through life journey. • Individual can access service directly from a variety of local providers, being referred to multi-community or LHIN community providers based on complexity of care • Individuals can be connected to an integrated health services collaborative through non-health entities (employers, church, etc) • Advanced care planning to proactively address health and social needs that will be needed in the future • Multi-level community-centred transportation solution to enable access for populations in need	• As needed, the individual is referred for more specialized services, (e.g. ABI, eating disorders, dual diagnosis, psycho-geriatrics, multiple chronic illnesses, etc.) • These decisions are made in consultation with the individual, family, and the most responsible provider at the local level, which will take into account health and social considerations.	
Professional Flow and Support	• A virtual community of professionals and providers with knowledge of services across the LHIN coordinated through integrated health services collaboratives • An integrated health services collaborative, connected either in-person or virtually, delivered through clinic or mobile settings complete with health and social resources that provide holistic assessments and treatment (with referral of specialized needs (e.g. complex MH&A needs to appropriate provider) • Health human resources able to provide services for individuals and families as they transition life stages • Incentives for solo-practitioners to participate within integrated health services collaboratives (i.e. access to inter-professional resources)	• Provide resources, standardized tools and support to professionals and providers at the local level • Network of visiting specialists or physicians delivered at the multi-community or LHIN community level • Through tele-medicine and virtual communication, delivery of specialist services at a local level. • This model is supported by common credentialing/certification/training of specialized providers throughout the LHIN.	
	• Expansion of provider roles to involve responsibilities beyond clinical to include navigation and information/referral as appropriate • Clear delineation of roles and responsibilities of health care professionals across local, multi-community, and LHIN community levels		

Population-based integrated health services - service delivery approach (cont'd)

	Local Level	Multi-community Level	LHIN community Level
Information Flow	• Information follows an individual's journey through the system, with individual information accessible at the point of service • Clinical and service information is available to all professionals in the delivery team (up and downstream) and to the individual for self-management • Inventory of services across the LHIN accessible to individuals and providers • Service coordination protocols and consistent/common policies regarding information-sharing • Dissemination of leading practices to health care professionals through a coordination program		
Other considerations outside the LHIN's scope/mandate	• Ambulance Act legislation to expand scope of paramedics • Consistent application of privacy legislation to accommodate information-sharing across sectors and regulated and non-regulated health professionals • Funding coordination across ministries to manage delivery of all health services • Modification to physician fee schedules to enable change in clinical practice • Transformation of current primary care providers (solo GP/FP, FHT, FHN, CHC, etc) • Develop partnerships across ministries to develop integrated health services collaboratives • Develop partnerships across ministries to enable information-sharing across sectors (education, health, housing) • Transformation of education, training, and research to align with future needs (e.g. rural medicine training)		

Centrally coordinated resource capacity

Roles and Responsibilities	Local Level	Multi-community Level	LHIN community Level
Providers	• Manage high volume/low acuity patients • Provide primary/secondary identification, assessment, treatment, and follow-up services • Seamless referral relationships with multi-community and LHIN community level providers • Manage repatriated individuals • Implement evidence-based guidelines as needed • Leadership in best practice implementation	• Manage moderate volume/acuity patients • Deliver specialist services for multi-community population as warranted by critical mass • Manage repatriated individuals • Leadership in evidence-based guidelines for all providers	• Manage low volume/high acuity patients • Deliver highly specialized level of service for complex cases • LHIN-wide coordination of medicine, surgical, and critical care inpatient and ambulatory resources • Coordinated referrals process which allows referrals between specialists • Leadership in best practice development for all providers in collaboration with multi-community and local providers • Collaboration with local and multi-community teams to develop and execute standardized tools, quality guidelines, and consults through tele-medicine vehicles
	• Strengthened integration and partnerships across local and multi-community levels to deliver services closer to home		

Centrally coordinated resource capacity (cont'd)

	Local Level	Multi-community Level	LHIN community Level
Access and Individual Flow	• Individual can access screening, assessment and treatment services directly from local providers. Individuals may be transferred to local or multi-community hospital for recovery period • Individual will access health education, self-management tools at a local level • Care coordination services through system navigation framework including service coordination, case management, and self-management elements	• As needed, based on intensity and complexity of health need, the individual may be referred to multi-community or LHIN-level provider. These decisions are made based on clinical protocols and delivered through a LHIN-wide resource capacity management system. • Feedback mechanism process with referring physicians to track patients regarding pre- and post- operative conditions • Community-centred transportation system to connect providers across the LHIN • Individuals may be transferred to local or multi-community hospital for recovery period	
Professional Flow and Support	• To support assessment and treatment at the local level, LHIN-wide protocols and tools are available to teams (e.g. pre and postoperative guidelines, resuscitation policy, Hospital Repatriation Policy)	• Provide resources, standardized tools and support to professionals and providers at the local level • Network of visiting specialists or physicians where critical mass exists delivered at the multi-community or LHIN community level. To facilitate service delivery in multi-communities and common practices within the LHIN, there is an opportunity for professionals to practice in both multi-community and LHIN community environments. • Where critical mass does not exist, delivery of specialist services through tele-medicine and virtual communication will be provided at the local level	
	• This model is supported by common credentialing/certification/training of specialized providers throughout the LHIN. • Expansion of provider roles to involve responsibilities beyond clinical to include navigation and information/referral as appropriate • Clear delineation of roles and responsibilities of health care professionals across local, multi-community, and LHIN community levels • Development of shared physician on-call system and structure • Virtual linking of physicians across LHIN to share best practices, education, and quality monitoring		

Centrally coordinated resource capacity (cont'd)

	Local Level	Multi-community Level	LHIN community Level
Information Flow	• Information flow matches the flow of the individual, with individual information accessible at the point of service • Clinical and service information is available to all professionals in the delivery team (up and downstream) and to the individual for self-management • Inventory of services across the LHIN accessible to individuals and providers. • Collaboration and partnerships across traditional, alternative, and academic health centres for health research activities • Dissemination of leading practices to health care professionals through a coordination program		
Other considerations outside the LHIN's scope/mandate	• Consistent application of privacy legislation to accommodate information-sharing across sectors and regulated and non-regulated health professionals • Funding coordination across ministries to manage delivery of all health services • Provide resources and education support to providers at the local level. Dissemination of teaching and research activities for clinical advances • Modification to physician fee schedules to enable change in clinical practice • Transformation of education, training, and research to align with future needs (e.g. rural medicine training)		