Appendix E

Health Services Blueprint Implementation Elements

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The implementation road map includes a comprehensive list of elements that are needed to operationalize the integrated health system of care.
These elements are anchored to the South West LHIN system level goals. While there are overlapping elements, we anchored each element to the goal that best fits the essence of the element. Each element is then described through the use of additional informative columns, which include:

Current initiatives that are in alignment with the implementation element - this may include ministry strategies, current LHIN-led initiatives, and/or IHSP actions related to strategic directions (the IHSP actions are bolded)

Lead: This column identifies the most appropriate stakeholder which will lead the delivery of this element, LHIN or Health Service Providers. While both parties are required to move the element along, knowledge/expertise and resources determine who will drive the initiative. Thus, this column is either noted as 'Provider-driven, LHIN-supported' (PD-LS) OR 'LHIN-driven, Provider-supported' (LD-PS)

Two groups of columns are used to describe the sequencing for each element. These columns do not reflect any specific year, but describe the natural sequencing which enables logical flow, quick wins, and current IHSP strategic directions. These include:
•**Initiated within Years 1-3**: A highlighted arrow within this section denotes the start of implementation within Years 1-3. It does not signify completion of implementation during this timeframe as some elements may continue past 3 years.
•**Initiated after Year 3+:** A highlighted arrow within this section denotes the start of implementation post Year 3.

Appendix E. Health Services Blueprint Implementation Elements - DRAFT

Sorted by Sequencing

***IHSP actions related to strategic directions are in bold**

System level goals	Implementation Elements	Current initiatives that are in alignment with element (e.g. IHSP actions, LHIN, Ministry strategies)	Lead (Provider-driven; LHIN-supported OR LHIN-Driven; Provider-Supported)	Initiated within Years 1-3 (Columns are not for specific years, but to show natural sequencing within this timeframe)	Initiated after Years 3+ (Columns are not for specific years, but to show natural sequencing within this timeframe)
Sustainability of SWLHIN System	Develop an implementation and accountability framework leveraging existing LHIN resources	*Health System Design Steering Committee	LHIN-Driven; Provider-Supported	⇨	
Sustainability of SWLHIN System	Develop a shared understanding of health services Blueprint through a targeted communications/engagement strategy	*Area Provider Tables, LHIN networks, LHIN Steering Committees	LHIN-Driven; Provider-Supported	⇨	
Sustainability of SWLHIN System	Empower key stakeholders to champion elements of health services Blueprint	*Area Provider Tables, LHIN networks, LHIN Steering Committees	LHIN-Driven; Provider-Supported	⇨	
Sustainability of SWLHIN System	Develop HHR strategies to institute alternative HHR models where shortages persist in the current ED sites	***Emergency services coverage with current resource pool; Emergency services health care personnel capacity** *Provincial priority: Improve access to emergency care	Provider-Driven; LHIN-Supported	⇨	
Sustainability of SWLHIN System	Redefine the roles and responsibilities of each ED site based on community needs leveraging relevant primary care capacity, existing HHR, and infrastructure	*Engage key stakeholders to develop and initiate a process to implement the EDHR study strategies, specific to needs at the local, multi-community, LHIN-wide levels *FastTrack program *Provincial priority: Improve access to emergency care	Provider-Driven; LHIN-Supported	⇨	
Sustainability of SWLHIN System	Develop and implement common physician governance process that involves: physician on-call; credentialing; administration of hospital privileges		Provider-Driven; LHIN-Supported	⇨	
Sustainability of SWLHIN System	Define roles and responsibilities for non-regulated and regulated health care professionals and implement accountability agreements		Provider-Driven; LHIN-Supported	⇨	
Sustainability of SWLHIN System	Continue to support performance management and reporting processes for health service providers across LHIN		LHIN-Driven; Provider-Supported	⇨	
Sustainability of SWLHIN System	Develop human resource strategies to better leverage current resources and improve recruitment and retention across LHIN	*HealthForce Ontario	LHIN-Driven; Provider-Supported		⇨
Sustainability of SWLHIN System	Engage relevant stakeholders to develop coordinated approach to address physician reimbursement models to incentivize physician to adopt changes in service delivery		LHIN-Driven; Provider-Supported		⇨
Sustainability of SWLHIN System	Engage key ministries to work towards standardizing interpretation and application of privacy laws to enable information sharing across sectors involved in the provision of health services	*LHIN collaborative	LHIN-Driven; Provider-Supported		⇨
Sustainability of SWLHIN System	Engage key stakeholders to discuss and address the fragmented approach to funding health services	*LHIN collaborative	LHIN-Driven; Provider-Supported		⇨
Sustainability of SWLHIN System	Design and initiate development of a LHIN-wide health research strategy tailored to the unique characteristics of the population	*MOHLTC *Other ministries *LHIN Collaborative	LHIN-Driven; Provider-Supported		⇨
Sustainability of SWLHIN System	Engage ministries to discuss changes in practices beyond the scope of the LHIN	*LHIN collaborative	LHIN-Driven; Provider-Supported		⇨
Quality of care and service	Equip primary care and mental health and addictions HHR to better identify and serve specialized populations	***Implement screening tool to facilitate universal screening for concurrent disorders** *SW Addiction and Mental Health Coalition *Adoption of the Global Appraisal of Individual Needs - Short screener (GAIN-SS) to facilitate universal screening for concurrent disorders *Adoption of "Joint Policy Guideline" framework to manage dual diagnosis *Provincial 10-year strategy for MH&A needs	Provider-Driven; LHIN-Supported	⇨	
Quality of care and service	Expand the role that HHR plays in managing chronic illnesses (prevention, promotion, screening --> follow-up)	***Implement CDPM strategies with an initial focus on the provincial Diabetes Strategy, and spread to other chronic illnesses where relevant** ***Continue with implementation of provincial Peritoneal Dialysis Initiative**	Provider-Driven; LHIN-Supported	⇨	
Quality of care and service	Define the roles of inter-professional teams customized to the health needs of the community	*Applications for Family Health Teams ***Leverage success of Partnerships for Health project, and spread to other chronic illnesses where relevant**	Provider-Driven; LHIN-Supported	⇨	
Quality of care and service	Design, develop and initiate implementation of evidence-based clinical pathways to support referrals and individual movement between local, multi-community, and LHIN services		Provider-Driven; LHIN-Supported	⇨	
Quality of care and service	Multi-level system of navigation: Design, develop, and operationalize clinical case management services		Provider-Driven; LHIN-Supported	⇨	
Quality of care and service	Multi-level system of navigation: Design, develop, and operationalize service coordination capacity across the LHIN		Provider-Driven; LHIN-Supported	⇨	
Quality of care and service	Multi-level system of navigation: Design, develop, and operationalize self-navigation tools across the LHIN		Provider-Driven; LHIN-Supported	⇨	
Quality of care and service	Develop a process to disseminate best practices to health service professionals across the LHIN		LHIN-Driven; Provider-Supported		⇨

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Sorted by Sequencing

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System level goals	Implementation Elements	Current initiatives that are in alignment with element (e.g. IHSP actions, LHIN, Ministry strategies)	**Lead** (Provider-driven; LHIN-supported OR LHIN-Driven; Provider-Supported)	**Initiated within Years 1-3** (Columns are not for specific years, but to show natural sequencing within this timeframe)	**Initiated after Years 3+** (Columns are not for specific years, but to show natural sequencing within this timeframe)
Integration of health care delivery	Redesign the role of community services and supportive housing capacity in delivering long-term care services	***Aging at Home Year 3: Develop and implement an integrated model of care for high-risk seniors; develop and implement a coordinated system of care for seniors with behavioural issues; enhance services and supports for aboriginal seniors**	Provider-Driven; LHIN-Supported	⇨	
Integration of health care delivery	Empower local communities to implement a community-centred transportation system	***Aging at Home Year 1, 2, and 3: Enhance capacity and coordination of transportation services**	Provider-Driven; LHIN-Supported	⇨	
Integration of health care delivery	Design and implement a LHIN-wide resource capacity coordination system	***Engage key stakeholders to develop an action plan that will result in the creation and implementation of a LHIN-wide resource capacity management system for medicine, surgical, and critical care services**	LHIN-Driven; Provider-Supported	⇨	
Integration of health care delivery	Enhance community services and supportive housing capacity in delivering long-term care services	*Balance of Care *Aging at Home Year 3	LHIN-Driven; Provider-Supported	⇨	
Integration of health care delivery	Leverage current platforms to develop a real-time repository of all health services in the South West LHIN (LHIN and non-LHIN funded)	ConnexOntario and thehealthline.ca	LHIN-Driven; Provider-Supported	⇨	
Integration of health care delivery	Expand coverage and adoption of telemedicine and telehealth services across the LHIN		LHIN-Driven; Provider-Supported	⇨	
Integration of health care delivery	Develop integrated health services collaboratives (e.g. virtual, mobile, co-location) customized to the health needs of the community and leveraging existing base of health service providers		Provider-Driven; LHIN-Supported	⇨	
Integration of health care delivery	Develop a resource capacity plan to better coordinate surgical bed capacity across LHIN to accommodate local, multi-community, and LHIN service delivery		Provider-Driven; LHIN-Supported		⇨
Integration of health care delivery	Develop a resource capacity plan to distribute Level 2/3 NICU beds across Local, multi-community, LHIN-wide providers		Provider-Driven; LHIN-Supported		⇨
Integration of health care delivery	Redefine roles of obstetrical programs according to obstetrical service delivery options	*SWLHIN Maternal Child Network	Provider-Driven; LHIN-Supported		⇨
Integration of health care delivery	Create a distributed service delivery model for oncology outpatient services to enable equitable access across the LHIN	*Cancer Care Ontario's Regionalized chemotherapy program	Provider-Driven; LHIN-Supported		⇨
Integration of health care delivery	Develop a resource capacity plan to better coordinate medicine bed capacity across LHIN to accommodate local, multi-community, and LHIN service delivery		Provider-Driven; LHIN-Supported		⇨
Integration of health care delivery	Develop a resource capacity plan to redistribute critical care level 2/3 bed capacity and community ventilation services the LHIN to better provide critical care services	*Critical Care Strategy	Provider-Driven; LHIN-Supported		⇨
Integration of health care delivery	Develop a resource capacity plan to better align rehabilitation bed capacity with population distribution		Provider-Driven; LHIN-Supported		⇨
Integration of health care delivery	Develop a coordinated program to deliver specialist services at a local and multi-community level		Provider-Driven; LHIN-Supported		⇨
Integration of health care delivery	Develop a coordinated process to manage referrals, consultations, and wait times for high-need procedures	*Criticall infrastructure	LHIN-Driven; Provider-Supported		⇨
Integration of health care delivery	Implement individual and provider health information portal to support communication, knowledge-sharing, and information-sharing across the LHIN		LHIN-Driven; Provider-Supported		⇨
Healthier SWLHIN Community	**Implement enabling technologies with an initial focus on the provincial diabetes registry and include other enabling technologies where appropriate. Explore the applicability of diabetes registry to management of other chronic diseases**	*Provincial Diabetes Registry	LHIN-Driven; Provider-Supported	⇨	
Healthier SWLHIN Community	Continue to operationalize self-health management capacity across the LHIN	***Continue with, and expand, implementation of self-management strategy**	LHIN-Driven; Provider-Supported	⇨	
Equitable access to services	Enable equitable access to high-need mental health and addictions community-based services across the LHIN	*SW Addiction and Mental Health Coalition *Provincial 10-year strategy on MH&A needs ***Increase supportive housing for people with problematic substance use and concurrent disorders** ***Improve access to community mental health and developmental services for persons with a dual diagnosis** ***Implement training program to support people to develop personal wellness plans**	Provider-Driven; LHIN-Supported	⇨	
Equitable access to services	Design a process to redistribute the acute mental health and addictions capacity which is in alignment with the planned tier 2 post divestment strategy and population distribution	***Work with partners to facilitate Tiers 2 and 3 divestment of psychiatry services** *Provincial 10-year strategy for MH&A needs	Provider-Driven; LHIN-Supported	⇨	

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Equitable access to services	Design and develop mental health and addictions strategy for children and adolescents	*SW Addiction and Mental Health Coalition *Provincial 10-year strategy on MH&A needs and priorities ***Increase availability of and access to children's mental health beds** **Ministry of Child Youth Services Mandate**	Provider-Driven; LHIN-Supported	⇨	
Equitable access to services	Enable more appropriate use of and equitable access to long-term care home capacity through redistribution of long stay, short stay, specialized beds in alignment with population needs *Define role of and access to CCC beds across the LHIN	***Aging at Home Year 3: Create additional convalescent care beds in LTCH**	Provider-Driven; LHIN-Supported	⇨	
Equitable access to services	Institute strategic efforts towards ALC and ALOS reduction consistent with Ministry ER/ALC strategy	***Continue to monitor performance of Aging at Home years 1 and 2** *Provincial priority: Improve access to emergency care *Provincial priority: Improve access to hospital care	Provider-Driven; LHIN-Supported	⇨	
Equitable access to services	Conduct site identification and sizing exercise for all health providers to inform overall health system design implementation		LHIN-Driven; Provider-Supported	⇨	