

Detailed Plans to Implement Integrated Health Service Plan (IHSP) Priorities

Priority Action Teams (PATs) developed high level strategic directions for each of the priorities for change identified in the South West LHIN's IHSP. It is acknowledged that achievement of the desired future state presented for each of the strategic priorities will take place over the longer term and as program implementation occurs a number of objectives will be achieved. Key projects are being implemented in 2009/10 to move the South West LHIN closer to the future state identified by those PATs. A summary of the six IHSP's priorities and key 2009/10 projects that advance the priorities follow. In some cases, projects do support multiple priorities, but are only described in one section of the document.

1. Strengthening and Improving Primary Health Care

Primary health care serves a dual function in the health care system:

- A direct provision of first-contact services (by providers such as family physicians, nurse practitioners, pharmacists, and telephone advice lines); and
- A coordination function to ensure continuity and ease of movement across the system, so that care remains integrated when individuals require more specialized services (with specialists or in hospitals, for example).

Primary health care is a cornerstone of an efficient and robust health care system. As the initial entry point to the health care system for patients and families, an integrated and comprehensive primary health care system also acts as the mechanism to ensure continuity of care throughout the system. Primary health care physicians are often challenged in guiding patients to necessary and available resources. As a result, highly skilled physicians may spend time addressing types of care that might be more appropriately addressed by other skilled professionals. These issues can be addressed through integrated and comprehensive practice primary health care models that co-locate doctors, nurses, nurse practitioners, pharmacists, dietitians, social workers, health educators, mental health workers and other providers who then operate as an integrated team.

The South West LHIN 2007/08 – 2009/10 IHSP implementation plan included two action plans:

1. Support the evolution and development of a more connected system across primary health care, by focusing on primary health care renewal models and through greater awareness and connection of independent and small group family physicians to other community primary health care services; and

2. Focus on improving access to comprehensive primary health care with an emphasis on early intervention and wellness for people with mental health and addictions conditions as an integral component of primary health care services. Improvement will occur through the development and monitoring of clinical care paths and increased communication processes between local providers.

The work of the two (2) Primary Health Care PATs resulted in a comprehensive set of recommendations that have informed the selection of priority initiatives for 2009/10 to 2011/12. The full reports of the Primary Health Care and Primary Health Care – Mental Health and Addictions PATs can be found at www.southwestlin.on.ca

Future State	
<p>The proposed future directions would provide and link the individual with public health promotion, protection and prevention; work with the individual to facilitate self-management of disease; take part in education/continuing education; and support IT initiatives (such as EHR and portals providing access to information) to support administrative functions, individual’s self-management and continuing education. These directions would provide individuals who have, or are at risk for mental health and/or addiction problems, and their families, equitable access to timely, responsive, appropriate, effective and coordinated person centred care that encompasses education, prevention, identification, assessment and treatment through a primary health care system that works in partnership with other service providers.</p>	
Mental Health and Addictions Services	Primary Health Care Services
<ul style="list-style-type: none"> • Family Health Teams (FHTs) and Community Health Centres (CHCs) have dedicated, onsite primary mental health and addiction staff (employees or staff deployed from mental health and addiction services) for assessment and brief treatment. When possible provide services in other primary care settings (e.g. fee for service physicians) • Incorporate education about mental illness, addiction and related primary care competencies in core curriculum and as part of other health conditions (e.g. co-morbid conditions), in addition to ongoing education of primary health care providers • Deliver public education to broad-based coalitions of health care providers • Incorporate information about mental illness and addiction and related self care as component of public/patient education provided about other health issues (e.g.. co-morbid conditions) 	<ul style="list-style-type: none"> • Continue to support FHTs and CHCs to promote further improvement in primary health care • All communities have local access to basic primary care services (primary health care physician and/or nurse practitioner) in addition to access to designated centres (minimum of one centre per county) that would provide a broader and more extensive range of services • Form “Hubs” of services around existing gathering places and/or non-traditional access points • Services that are currently only available in one location are made more accessible to others through outreach (e.g., providers can travel to the individual) • Establish a Centre of Excellence for education, knowledge transfer and translation, evaluation and service delivery that supports the primary health care model and delivery of priority services

Future State

- Expand role of current information and referral service and market broadly as the number to call for mental health and addiction information and referral
- Expand eReferral tracking pilot to include sites within the South West LHIN
- Consider financial incentives for implementation of best practices re: screening and assessment
- Address service gaps and capacity issues within formal mental health and addiction system with special attention to services for people with mild and moderate mental health problems, seniors, youth, peer support for clients and caregivers, and respite care
- Implement standardized comprehensive assessment for at-risk populations that includes consideration of caregiver needs and risk factors
- Ensure timely referral to mental health and addiction services for those at high risk, those with complex needs and/or requiring longer term treatment
- Ensure monitoring and follow-up for patients treated for mental health problems and addictions issues
- Increase the supply of mental health and addictions providers (including psychiatrists and nurse practitioners with specialized psychiatric training) through recruitment and retention efforts
- Expand opportunities and incentives for primary care provider participation in collaborative care models and consultation resources
- Develop system navigation resources (e.g. care coordinators) and/or advocates for vulnerable populations, those with complex needs, access barriers
- Equip electronic record with prompts to ensure completion of required assessment and treatment, with reminders for monitoring and follow up
- Influence the education system to incorporate inter-professional team practice into health service provider education. Provide continuing education and coaching support to enable current providers to have success in inter-professional teams
- Primary Health Care “active” practice management
 - Access to Information for Providers Individuals via registry of services and Internet-based portals
 - Education for primary health care professionals to promote patient self-management
- Promotion of the Nurse Practitioner role in the Integrated and Comprehensive Primary Health Care Services Model
- Integrated accessibility – i.e., better integration of transportation and use of eHealth services, such as telemedicine

Current State

Primary Health Care

- There is a shortage of primary health care providers; physician shortages were of particular concern
- The region is fairly well inter-connected through establishment of health provider tables and use of www.thehealthline.ca
- Academic excellence in the region provides opportunities for education/research/teaching around inter-professional team development
- 16 FHTs in operation across the South West LHIN; 4 are located in the North, 9 in the Central area and 3 in the South
- 2 CHCs, 1 satellite CHC and one Aboriginal Health Access Centre (AHAC) in the South area of the LHIN
- 3 CHCs are in the pre-operational phase of development; 1 in the North and 2 in the South

Mental Health and Addiction System

- Many mental health and addiction programs are operating at and beyond capacity. Waiting lists exist for various services
- Existing pressures on acute care beds and specialty (tertiary) resources
- Shortage of psychiatrists
- Inequitable distribution of and access to certain services
- There are only 2 residential withdrawal management programs and one community withdrawal management program within the South West LHIN and the only residential addiction treatment programs within the region are specifically targeted to aboriginal people
- Limited resources allocated to peer support
- Various service gaps to specific populations, including women, seniors, youth, people with crystal methamphetamine problems, people with concurrent disorders and people of various cultures and ethnicity
- Mandate of most mental health programs has been narrowed to exclude those with mild to moderate mental health problems
- Stigma and discrimination are barriers to seeking and receiving help
- People that live in rural communities often experience inequitable access to services due to barriers such as poverty and lack of public transit

Ministry LHIN Accountability Agreement (MLAA) Indicator Alignment and Performance Considerations

Although all MLAA performance targets are impacted by primary health care activities, two MLAA targets could be influenced by the improvements identified in the future state section:

- Rate of Emergency Department Visits that could be managed elsewhere
- Hospitalization Rate for Ambulatory Care Sensitive Conditions

Performance activities and indicators to be incorporated over time:

- Accountability agreements between Health Service Providers and the South West LHIN identify performance and outcome measurements including metrics that are system, population and organizationally based
- Over time movement to publicly report these performance and outcome measurements pertaining to system, populations and programs
- Track # of Emergency Department visits for mental health & addiction issues (pre & post)
- Track Hospitalization Rate for Ambulatory Care Sensitive Conditions (pre & post)
- # of providers within the primary care system receiving education about mental health & addiction issues
- # of physicians recognizing and treating mental health and addiction issues initially selecting a few FHTs or targeted group and doing a pre and post test
- # of providers within the primary care system using common depression & addiction tools
- # of primary health care professionals/teams willing to participate in specific primary care collaborative projects

Challenges and Risks

Policy and legislation need to be congruent around scopes of practice, prescriptive authority, and referral practices. Overlap of roles across the professions may cause conflict and integration challenges.

Challenges of geography and mix of population and rurality of population with a large proportion of seniors who require services that are difficult to access create barriers to care. Barriers to access, such as language, transportation, age, and lack of providers' awareness of cultural health practices', create gaps in care.

Health Human Resources: shortage of resources, recruitment and retention is an ongoing issue, particularly with the aging of the workforce. Without adequate funding for personnel and infrastructure challenges will continue to exist.

Potential liability of teams not working under a Primary Health Care model, lack of health care leader and provider "buy-in" to the inter-professional collaborative team model, and the continued perception of physician as sole point of entry into primary health care present challenges.

Continued imbalance in priority placed on management of illness versus health promotion and prevention of chronic diseases will be a challenge to overcome so that we can move to a new model of primary health care.

Strengthening and Improving Primary Health Care: Key Projects 2009/10

Project Name	Description	MOHLTC Priority Alignment	Outcomes Alignment with Future State
<i>Community Health Centre Development</i>	Development of 3 CHCs: <ul style="list-style-type: none"> • South East Grey CHC • Woodstock and Area CHC • Central CHC (Elgin) 	Access to Primary Health Care	<ul style="list-style-type: none"> • Communities have local access to basic primary care services • Create “Hubs” of services around existing gathering places and/or non-traditional access points • CHCs have dedicated, onsite primary mental health and addictions staff (employees or staff deployed from mental health and addictions services) for assessment and brief treatment • Communities have access to primary health care and a wide range of client-centred services and programs • Services that are available in one location are made more accessible through points of access and outreach • Integration and partnership with existing community services in order to build community capacity
<i>Training for Implementation of the GAIN CD Screener in the South West LHIN</i>	Implementation of GAIN-SS screening tool to facilitate universal screening for concurrent disorders	Access to Primary Health Care	<ul style="list-style-type: none"> • Improving access to comprehensive primary health care with an emphasis on early intervention and wellness for people with mental health and addictions conditions • The mental health and addiction system must measure quality against Best Practice Standards • Providers in the mental health and addictions sectors must be trained and supported in the use of standardized screening and assessment tools

2. Chronic Disease Prevention and Management

The work of the Chronic Disease Prevention & Management (CDPM) PAT stems from the integration priority “Preventing and Managing Chronic Illness”, as identified in the South West LHIN’s IHSP:

- Develop and implement a comprehensive chronic disease prevention and management program across the South West LHIN.

To achieve the vision outlined in the CDPM framework, it will be necessary for significant health system redesign to take place. To support that transition, improvements in population health, eHealth, client self-management and access to primary health care are considered essential first steps. Practice settings such as FHTs, CHCs, and Nurse Practitioner-led clinics are examples of models that may better support integration of health promotion, disease prevention and optimal chronic disease management.

The objective of the CDPM PAT was to develop a system-wide approach to chronic disease that will broadly address the many commonalities shared by various diseases; such as identifying and addressing modifiable risk factors, screening and early detection, care pathways, self-care strategies, community supports, and the need for healthy public policy development. The committee worked towards the development of a comprehensive and integrated approach towards chronic disease prevention and management.

The work of the Diabetes PAT dovetailed with the efforts of the CDPM PAT to ensure that a coordinated approach to CDPM is developed that is appropriate to a range of chronic diseases. The PATs developed recommendations that included advancing team based care, increasing the use of care guidelines and algorithms, the development of tool kits to support person-centred care and self-management strategies, as well as the need to use technology to support care.

The CDPM framework adopted by the MOHLTC will guide the South West LHIN strategy for CDPM in the region. The framework identifies the evidence-based attributes of a high functioning health system. Capacity for change amongst health service providers and consumers must be further advanced to ensure there is system readiness for the transformation required.

The full report of the CDPM and Diabetes PATs can be found at www.southwestlhin.on.ca

Future State

The MOHLTC has adopted a CDPM Framework. The framework fosters the creation of informed, activated patients and prepared, proactive practice teams. Within the framework, health care organizations are collaborative and integrated, working as a system. Prepared, proactive practice teams have the necessary information, tools and personnel throughout their relationship with the individual. This includes, appropriate, accessible, user-friendly and effective decision support tools to provide both preventative and clinical care in addition to self-management support. Collaborative care entails understanding the individual’s confidence level in self-managing the chronic condition, collaborative goal setting and problem-solving with active, sustained follow-up.

Future State

Key directions to move the South West LHIN closer to achieving the vision of the CDPM Framework includes:

- Effective CDPM integrated care teams of inter-professional health care providers and client/family memberships that incorporate the key components of case management, care coordination, system facilitator role and peer support through adherence to clinical best practice standards, education and team development
- Multi-point access to care and information that includes a website and phone number to call for personal assistance that supports self referral and mechanisms for referral for “orphan” patients when physician referrals are required
- Education, tools and resources to enable and support individuals and health care professionals to support health promotion, prevention and management of chronic diseases including life style coaching tools, community CDPM implementation tool kits, self management tool kits
- An integrated electronic information system across health care settings, providing prompts for screening and early detection, standardized care, patient portals to support day to day health monitoring by the individual, provider portal and patient registry, and interactive website with supportive tools for implementing, monitoring and evaluating quality of care
- A CDPM “Centre of Excellence” to identify and work toward a consistent use of best practices and clinical guidelines for health promotion, CDPM and diabetes management across the South West
- Health promotion and CDPM education integrated into academic curricula for physicians, nurses and allied health professionals
- A mandatory, formal accreditation system related to chronic disease prevention and management outcome and process indicators for all health care organizations, including organizational health and wellness programs/policies that help create healthy workplaces and healthy communities
- Redistributing funding to align resources and incentives to the CDPM Framework, so programs and services are provided by the most appropriate provider(s) to meet community and individual needs.
- Enhanced funding support for:
 - Outreach services for key populations at risk (marginalized, culturally distinct, individuals without access to a primary care physician, people with mental health issues)
 - Self management programs, client empowerment activities, wellness clinics, behaviour change programs
 - Prevention programs and their associated costs born by the individual
 - Access to healthy food, nutritional supplements and/or medications for vulnerable populations
 - Health literacy
 - Research to evaluate care in primary care settings
- Incorporate upstream approaches when developing CDPM strategies and interventions to ensure that the social determinants of health are defined and addressed

Current State

Within the South West LHIN, diabetes became the first disease focus for chronic disease prevention and management because:

- Diabetes care is suboptimal and
- Diabetes is often a precursor to other chronic diseases and conditions.

Diabetes was selected as the model of effective disease management with the understanding that, if the model is successful for diabetes, it may show effectiveness for other chronic diseases.

Diabetes also presents a unique lens to understanding chronic disease prevention and management strategies.

Unlike many diseases, there are generally accepted clinical guidelines for the management of diabetes, and evidence exists to demonstrate that good clinical management makes a big difference in positive outcomes for diabetics.

The Partnerships for Health and Diabetes Registry projects are key initiatives that are moving the South West LHIN closer to achieving the CDPM vision.

MLAA Indicator Alignment and Performance Considerations

Although all MLAA performance targets are impacted by chronic disease prevention and management improvement processes, two MLAA targets could be influenced by the improvements identified in the future state section:

- Rate of Emergency Department Visits that could be managed elsewhere
- Hospitalization Rate for Ambulatory Care Sensitive Conditions

Performance activities and indicators to be incorporated over time:

- Accountability agreements between Health Service Providers and the South West LHIN identify CDPM performance and outcome measurements including metrics that are system, population and organizationally based
- Over time, movement to publicly report these performance and outcome measurements pertaining to system, populations and programs
- Evidence of funding realignment
- # of service providers implementing CDPM strategies as identified by accountability agreements
- Centre for Excellence is established
- Phase in of electronic record is started
- Risk factor profile for the South West LHIN is improved
- Declining acute admissions to hospital for management of chronic diseases, co-morbidities and related complications
- Declining primary care visits for acute episodes related to chronic conditions

MLAA Indicator Alignment and Performance Considerations

- Reduced emergency department visits for conditions that can be effectively managed in other settings
- Client and health service provider satisfaction with improvement initiatives
- # of clients participating in self management programs
- Health and Wellness programs and policies implemented in health service provider organizations

Challenges and Risks

- There is a need for evidence-based care at the point of care as clinical pathways for standardized care are not always available or easily accessible;
- Inequities in health service availability for tertiary, secondary, primary and home/community services present challenges, such as; services not available (e.g., out patient rehabilitation) or accessible (wait lists, transportation) across the LHIN geography.
- There exists limited system capacity for self-management
- Limited availability of supporting technology to enable adoption of the framework of care.

Preventing and Managing Chronic Illness: Key Projects 2009/10

Project Name	Description	MOHLTC Priority Alignment	Outcomes Alignment with Future State
<i>Enhancing Access to Family Health Care (Diabetes Strategy)</i>	The LHIN will be working closely with the MOHLTC to implement the provincial Diabetes Strategy beginning with the goal of enhancing access to family health care through the establishment of “Hubs” of service and the development of a model for a chronic disease “Centre of Excellence” in the South West	Access to Primary Health Care	<ul style="list-style-type: none"> • Effective CDPM integrated care teams of inter-professional health care providers and client/family memberships that incorporate the key components of case management, care coordination, system facilitator role and peer support through adherence to clinical best practice standards, education and team development • Education, tools and resources to enable and support individuals and health care professionals to support prevention and management of chronic diseases including life style coaching tools, community CDPM implementation tool kits, self management tool kits • Reallocation funding to align resources and incentives to the CDPM Framework, so programs and services are provided by the most appropriate provider(s) to meet community and individual needs.

Preventing and Managing Chronic Illness: Key Projects 2009/10

			<ul style="list-style-type: none"> • Enhanced funding support for: <ul style="list-style-type: none"> ○ Outreach services for key populations at risk (marginalized, culturally distinct, individuals without access to a primary care physician, people with mental health issues) ○ Self management programs, client empowerment activities, wellness clinics, behaviour change programs • A CDPM “Centre of Excellence” to identify and work toward a consistent use of best practices and clinical guidelines for health promotion, chronic disease and diabetes management across the South West
<p><i>Partnerships for Health</i></p>	<p>Partnerships for Health, funded by the Ministry of Finance’s (MOF) Strengthening Our Partnerships program in partnership with the Ministry of Health and Long-Term Care, is a demonstration project that puts the Ontario Chronic Disease Prevention and Management (CDPM) framework into practice through our work with adults with diabetes. The project focuses on four key areas: developing partnerships; empowering patients; improving clinical outcomes; and, improving communication and information sharing through information technology. The project is central to both the eHealth and Diabetes Strategy implementations for our LHIN.</p>	<p>Access to Primary Health Care</p>	<ul style="list-style-type: none"> • Effective CDPM integrated care teams of inter-professional health care providers and client/family memberships that incorporate the key components of case management, care coordination, system facilitator role and peer support through adherence to clinical best practice standards, education and team development • Education, tools and resources to enable and support individuals and health care professionals to support prevention and management of chronic diseases including life style coaching tools, community CDPM implementation tool kits, self management tool kits • Reallocation funding to align resources and incentives to the CDPM Framework, so programs and services are provided by the most appropriate provider(s) to meet community and individual needs. • Enhanced funding support for: <ul style="list-style-type: none"> ○ Outreach services for key populations at risk (marginalized, culturally distinct, individuals without access to a primary care physician, people with mental health issues)

Preventing and Managing Chronic Illness: Key Projects 2009/10			
			<ul style="list-style-type: none"> ○ Self management programs, client empowerment activities, wellness clinics, behaviour change ● A CDPM “Centre of Excellence” to identify and work toward a consistent use of best practices and clinical guidelines for health promotion, chronic disease and diabetes management across the South West

3. Building Linkages Across the Continuum: Seniors and Adults with Complex Needs

To realize an integrated continuum of care for seniors and adults with complex needs, the South West LHIN and its partners are working to better understand and target the range of services available to proactively meet the needs of an increasing proportion of people 55 years and over who live with increased chronicity and complexity of conditions. This continuum reflects a person centred, holistic approach to care that recognizes the functional, medical, social and situational needs of people throughout their life’s journey. Partnerships and programs will need to be enhanced and services better coordinated among service providers within and across multiple systems (e.g., the health care system, social services system, etc.) and also across government ministries and municipalities.

The South West LHIN 2007/08 – 2009/10 IHSP implementation plan included three action plans:

1. Develop and implement an integrated continuum of care for all seniors and adults with complex needs which will build a foundation for continuum design for other populations.
2. Focus on rehabilitation across the continuum.
3. Develop a strategy and plan of action to ensure access to long term care services to meet the needs of the South West LHIN.

The work of the three (3) Seniors and Adults with Complex Needs PATs resulted in a comprehensive set of recommendations that have informed the selection of priority initiatives for 2009/10 to 2011/12. The full report of the Seniors and Adults with Complex Needs PATs can be found at www.southwestlhin.on.ca.

Future State

The framework that has been developed begins to scope out the current and future geographic distribution, volume, and integration structure of services at a system level for the South West LHIN. Point of access/entry, approach to assessment, care coordination, information requirements and flow, and linkages to and fit within the continuum are also included in the framework.

- Configuration of the range of services to be available locally, sub-LHIN, and LHIN wide including services that support independent living; assistance & support with activities of daily living; assistance with activities of daily living with specialized resources; assistance with activities of daily living & access to 24 hour care and support; 24 hour care and treatment
- Points of entry or access would be a combination of single point of entry and every door is the right door to access information people could gain access through an interactive website that has the ability to cross reference (e.g. Google type search), is widely marketed, provides companion booklets and education information (e.g. diseases, elder abuse), provides a designated phone number to call for personal assistance, and provides maps.
- 1-800 or 211 type of phone number would provide what's available and when, where it's available and how to get it, including information outside our LHIN, particularly bordering communities who may access services in 3 LHINs. It cannot be busy, cannot put people on hold, or offer a menu of numbers to press and has the ability to transfer a caller directly to the service required
- People can choose to call the designated phone number to call or other health service providers who can look up information on the website and provide information.
- A combination of options available will allow for self directed access to services in addition to risk identification for individuals requiring additional navigational experience.
- Access points are knowledge brokers not gatekeepers
- Requires education of all health service professionals to identify risk factors associated with the range of services an individual may require at points in time
- The approach to assessment involves a common assessment tool that offers assessment components for different purposes, tracks utilization of treatments/services and client outcomes, enabled by an electronic health record that all service providers share.
- Assessments are standardized, support continuous reassessment, provide automated triggers that flag individuals for appropriate next steps based on clinical pathways, and involve the consumer and their circle of support.
- Care Coordination involves two streams:
 - Simple (Supported Self Care) - self directed, navigator or advocate may be involved, limited assistance needed to coordinate and communicate needs and services, central client outcome tracking and performance measurements. Supported self care collaboratively helps individuals and their caregivers develop knowledge, skills and confidence to care for themselves effectively
 - Complex – self directed, case management component including treatment, service coordination, plan of care, central client outcome tracking and performance measurements. Disease specific care management that provides responsive, specialist

Future State

services using multi-disciplinary teams and disease specific protocols. May also require a case manager for high intensity users of services

- Care Coordination is also enabled by Formal and Informal Advocates. Someone who helps an individual navigate “the system” seeks answers to questions, links to other services (volunteers, family, friends or staff of organizations internal or external to the health care system. ‘Share the Care’ would fit as an informal advocate model of care. Formal advocates could be trained and identified within particular organizations or communities (e.g. municipal social services, senior’s centres, supportive housing buildings, FHTs, specific disease associations.).
- Information requirements and flow include the electronic tracking of interventions and measurements with the health care system, identification of risk factors (e.g. multiple emergency department visits, hospitalization, accessing four or five community support services) that would trigger the need for enhanced case management monitoring.
- Mechanisms required to link or integrate services within and outside of the integrated service delivery model include a common approach to person centred care, access to information, referral protocols, transfer protocols, repatriation agreements

Current State

- Across the continuum of care, people are not receiving care in the most appropriate setting to meet their needs
- There is lack of system wide criteria for admission to acute care, complex continuing care, rehabilitation, long term care homes, supportive housing, and supports for daily living
- There is a lack of evidence-based clinical assessment and utilization management tools that are common across sectors
- There is a lack of post acute capacity and therefore an immediate need to compare the current range of services with the recommended PAT range of services. The Blueprint project will satisfy this need.
- Immediate need to promote a designated point of access to information, via a website and persons to respond to phone calls for the South West LHIN.
- Need to begin to develop and support advocates to better prepare the South West LHIN to meet the significant demands of a growing seniors population that will consume limited health care resources.

MLAA Indicator Alignment and Performance Considerations

Although all MLAA performance targets are impacted by seniors and adults with complex needs, four MLAA targets strongly align:

- Percentage of Alternate Level of Care Days
- Rate of Emergency Department Visits that Could be Managed Elsewhere
- Hospitalization Rate for Ambulatory Care Sensitive Conditions
- Median Wait Time to Long-Term Care Home Placement

MLAA Indicator Alignment and Performance Considerations

Performance activities and indicators to be incorporated over time:

- Accountability agreements between Health Service Providers and the South West LHIN identify performance and outcome measurements including metrics that are system, population and organizationally based.
- Over time, movement to publicly report these performance and outcome measurements pertaining to system, populations and programs
- Aging at Home performance measurement defined and reported on regularly to LHIN and Area Provider Tables
- Same performance indicators and tools used across the system including:
 - Access to services (waittimes/lists, orphan patients)
 - Client/Community Satisfaction
 - Quality of life measurements (e.g. SF12)
 - Health outcomes
 - Proportions of seniors and adults with complex needs who remain in their home
 - Functional status
 - Reduction in Alternate Level of Care days
 - Emergency Department visits
 - Unplanned hospitalization rates
 - Population health targets
 - Collective client centred goal/outcome achieved

Challenges and Risks

- Human Resources – how to attract qualified providers; how to attract volunteer sector; availability of all health care professionals in light of shifting demographics; limited pool of people, those providing services will soon be seniors, limited volunteers and they are aging; wage disparity further compromises some sectors.
- The volume of appropriate services is not meeting the demand for service e.g. backlogged in Emergency departments or admission to LTCH when required supports not available in the community
- Funding – not unlimited; equal/equitable service
- Challenges of geography and mix of population – rural – large proportion of seniors who access services who are difficult to get to – shifting demographics generally , urban, large urban
- Shifting age demographics therefore increase in demand
- Government strategic plan or priorities may not align with LHIN priorities
- Realities of financial restrictions (services may have to be delivered differently)
- Access to services is complicated by LHIN geography and lack of transportation
- Changing dynamics of service delivery partnerships - Reality that some may no longer continue providing services in future –

resistance, unemployment potential

- Are the right people providing the right service, - using expertise appropriately – connects with HR shortage, changes dynamics of service delivery

Building Linkages Across the Continuum: Seniors and Adults with Complex Needs: Key Projects 2009/10

Project Name	Description	MOHLTC Priority Alignment	Outcomes Alignment with Future State
<i>Home at Last Development</i>	A LHIN wide service that is being initiated in selected communities that offers seniors transportation and assistance to safely settle back home following a stay in hospital.	Emergency Room Access/ALC	<ul style="list-style-type: none"> • Enhanced range of services - assistance and support with activities of daily living • Common LHIN wide assessment tool that identifies people for service • Creation of formal advocates
<i>Assisted Living in the Community</i>	To provide a new model of supportive housing for people in their current home instead of needing to move to a supportive housing apartment. 24 –hour, seven day per week availability of personal support services.	Emergency Room Access/ALC	<ul style="list-style-type: none"> • Enhanced range of services – assistance with activities of daily living & access to 24 hour care and support
<i>Transportation Coordination</i>	Improved coordination will be investigated and implemented through a variety of methods such as an updated inventory of resources, best practices and innovative solutions like centralized management and dispatch of existing vehicles	Access to Primary Health Care	<ul style="list-style-type: none"> • Enhanced coordination of range of services - assistance and support with activities of daily living
<i>Community Stroke Rehabilitation</i>	To provide a team of rehabilitation specialists, across the South West LHIN, to assist individuals who have had a stroke to make further gains in their recovery after leaving the	Access to Primary Health Care	<ul style="list-style-type: none"> • Enhanced range of services – assistance with activities of daily living with specialized resources • Common assessment tool that identifies people at risk who require service

Building Linkages Across the Continuum: Seniors and Adults with Complex Needs: Key Projects 2009/10

	hospital so that they can continue to live independently.		
<i>Residential Hospice Development</i>	Development of residential hospices for terminally ill people in Grey and Bruce Counties, London, and Oxford County.	Access to Primary Health Care/ED/ALC	<ul style="list-style-type: none"> Enhanced range of services – assistance with activities of daily living & access to 24 hour care and support
<i>Share the Care</i>	Share the Care is a detailed step-by-step model that shows how to create a unique caregiver “family” from friends, relatives, neighbours, co-workers and acquaintances to pool their talents, time and resources to assist a friend or loved one facing a health or medical crisis.	Emergency Room Access/ALC	<ul style="list-style-type: none"> Enhanced coordination and delivery of range of services Enhanced informal advocates
<i>First Link™</i>	<i>First Link™</i> is a direct referral program that links the person with dementia and their family members/caregivers to coordinated learning, services and support from the point of diagnosis and throughout the continuum of the disease. The <i>First Link™</i> program targets seniors “at risk” in the community due to the debilitating and isolating nature of the disease and associated stigma.	Emergency Room Access/ALC	<ul style="list-style-type: none"> Enhanced coordination and delivery of range of services Enhanced informal and formal advocates
<i>Community Support Services Performance Indicator Project</i>	Development of a robust performance measurement framework with standardized indicators for community support services (CSS) agencies	Emergency Room Access/ALC	<ul style="list-style-type: none"> Accountability agreements between Health Service Providers and the South West LHIN identifies common performance indicators and outcome measurements including measurements that are system, population and organizationally based.

Building Linkages Across the Continuum: Seniors and Adults with Complex Needs: Key Projects 2009/10

	in Southwestern Ontario in order to create stronger performance measurement tools for agency boards and staff; and help the South West LHIN to create performance indicators that can be used in the service accountability agreements for CSS agencies.		<ul style="list-style-type: none"> • Over time, movement to publicly report these performance and outcome measurements pertaining to system, populations and programs • Aging at Home performance measurement defined and reported on regularly to LHIN and Area Provider Tables
<i>Transitional Care beds in hospital, long-term care homes and retirement homes</i>	Creation of transitional care beds to assist people to move to a more appropriate level of care rather than remain in an acute care hospital bed when that level of care is no longer required.	Emergency Room Access/ALC	<ul style="list-style-type: none"> • Enhanced range of service – 24 hour care and treatment
<i>Geriatric Emergency Management (GEM)/Integrated Case Management Model</i>	The fundamental goal of the GEM initiative is to improve health care delivery to seniors presenting in Emergency Departments. GEM nurses screen and assess elderly patients at high risk and coordinate further assessment, care and follow-up, serve as consultants and in some cases, direct caregivers for elderly patients as well as their advocates.	Emergency Room Access/ALC	<ul style="list-style-type: none"> • Enhanced coordination and delivery of range of services • Common assessment tool that identifies people at risk who require service
<i>Rapid Emergency Assessment for Community Transition (REACT)</i>	To prevent inappropriate admissions to hospital, this project mobilizes a multidisciplinary team of: advanced skills RN coordinator (team lead), social worker, pharmacist, physiotherapist,	Emergency Room Access/ALC	<ul style="list-style-type: none"> • Enhanced coordination and delivery of range of services • Common assessment tool that identifies people at risk who require service

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	occupational therapist, respiratory therapist and CCAC case manager.		
<i>Nurse Led Long-Term Care Outreach Program</i>	This project builds on the South West CCAC / London Health Sciences Centre Advanced Home Care Team (AHCT). Nurse Practitioners (NPs) linked closely with area family physicians, provide service to clients with increased acuity to divert these clients from Emergency rooms and hospitals. This project allows the AHCT to expand to individuals who live in LTC homes.	Access to Primary Health Care/ Emergency Room Access/ALC	<ul style="list-style-type: none"> • Enhanced range of services – assistance with activities of daily living with specialized resources • Common assessment tool that identifies people at risk who require service
<i>Expansion of FLO Collaborative – Improvement Advisors</i>	The South West LHIN, over the past year, has supported two collaborative patient ‘Flo’ projects with Grey Bruce Health Services/CCAC and St. Thomas Elgin General Hospital/CCAC. This project focuses on expanding this collaborative and leveraging the expertise of the Improvement Advisors, as well as the experience and success of the teams to date, either at the original two sites, and/or into additional sites in the South West.	Emergency Room Access/ALC	<ul style="list-style-type: none"> • Enhanced coordination and delivery of range of services
<i>Balance of Care Analysis</i>	Collection and examination of InterRAI data for individuals who are waiting for long-term	Emergency Room Access/ALC	<ul style="list-style-type: none"> • Informed enhanced range of service availability and the distribution of those services • Following standardized assessments, provides

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	care home placement leading to an understanding of the best level of care required by people.		common platform that flags individuals for appropriate options based on clinical pathways
<i>InterRAI Suite of Assessment Tools</i>	Investigation of an evidence based common assessment tool for clinical assessment and utilization management that can be used across sectors throughout the South West LHIN	Access to Primary Health Care/ Emergency Room Access/ALC	<ul style="list-style-type: none"> • Cross sector common assessment tool that offers assessment components, tracks utilization of treatments/services and client outcomes, enabled by an electronic health record • Assessments are standardized, support continuous reassessment, provide automated triggers that flag individuals for appropriate next steps based on clinical pathways, and involve the consumer and their circle of support.
<i>Central Repository of Information</i>	Creation of an interactive website and 1-800 or 211 type of phone number that would provide health care information about what's available, when, where and how to get it, including information outside our LHIN, particularly bordering communities	Access to Primary Health Care	<ul style="list-style-type: none"> • Single point of entry/access and every door is the right door through a designated interactive website and toll free number to call to reach a person

4. Accessing the Right Services, in the Right Place, at the Right Time, by the Right Provider

Ensuring that there are appropriate services to meet the health needs of our communities is a central role of the South West LHIN and critical to the success of integration. But to deliver “the right services in the right place, at the right time, and by the right provider” we must consider a full range of issues including distances traveled, demographics and culture, as well as a variety of socio-economic considerations particularly for marginalized populations. Any analysis needs to consider people of all ages and at all stages of the lifecycle, from neonatal care to end of life. Planning for the appropriate mix of services that should be available locally also involves a range of clinical factors in order to ensure that quality care can be delivered safely and effectively.

A particularly significant factor influencing equitable access to health care is the geographic diversity of the South West and the distances often traveled from rural and remote communities. Partners within the South West LHIN will need to identify innovative solutions to support equity of access for rural and urban communities, and address some of the underlying challenges associated with this including health human resources, technology and knowledge sharing across the LHIN.

A number of factors may influence consumers’ ability to access health services, including language and culture, age, socio-economic factors such as poverty, ability to navigate the system, availability of transportation and social support services in the community. Some groups such as newcomers, immigrants, Aboriginal people, Francophone and other non-English speaking populations, seniors and those living with mental illness and/or addictions may have unique challenges for accessing health care regardless of the communities in which they live. In both larger urban centres and rural communities, barriers to accessing services exist for marginalized populations.

Health services planning needs to consider both local characteristics and provincial services and priorities (e.g., wait time and critical care strategies). It is important for providers to understand where to locate specific services to optimize access and ensure quality and safety in the delivery of those services. For consumers, it is important to know what services are available and how to access them.

Several provincial initiatives are under way to improve coordination of service providers and reduce wait times for access to services. The South West LHIN is actively participating in these programs and will continue to work with local providers to ensure that lessons learned from these initiatives inform a broader range of services in the future.

To improve access to the right services, in the right place, at the right time, and by the right provider, the South West LHIN developed three inter-related action plans in its IHSP:

- 1) Improve the understanding of the availability of and access to health services for children and youth (pre-natal to 19 years old) to identify opportunities to enhance support provided to families through better information and coordination across care providers and partners. Support this action through improved collaborative education and training opportunities for child health providers across sectors.
- 2) Define and strengthen the delivery of equitable, timely and appropriate services and improve service coordination with a focus on implementing innovative approaches to support rural community providers with links to specialized resources.
- 3) Develop and promote local solutions for provincial priorities and incorporate lessons learned from these initiatives to inform other South West LHIN access and integration activities:
 - a) Promote and build on the work of the Hips & Knees Quality, Utilization & Access Steering Committee to ensure an integrated approach to hip and knee total joint replacements across the LHIN.
 - b) Build on the work of the provincial Critical Care Strategy Group to build critical care capacity and improve accessibility, quality and efficiency of services.

PATs were established for Children and Youth and Hips and Knees. Complete reports for the Hips and Knees PAT and Children and Youth PAT can be found at: www.southwestlhin.on.ca. Given the provincial nature of the critical care strategy, a PAT was not created. A Health System Design project will be implemented in 2009/10 essentially fulfilling the directions of the second action plan regarding strengthening the delivery of equitable, timely and appropriate services throughout the LHIN.

The following summarizes the work of the Hips and Knees PAT:

Future State
<p>Hips and Knees</p> <p><u>Mission:</u> The hip and knee replacement delivery model strives to ensure that individuals have timely, appropriate and equitable access to hip and knee replacement services based on best practices and evidence-based care. Through the use of a common multidisciplinary pathway spanning primary and secondary prevention through post-acute care, services would be standardized and delivered efficiently in a coordinated manner.</p> <p>The integrated model of care aims to improve service delivery efficiency and effectiveness, resulting in decreased wait times and enhanced quality of care. A fundamental goal is to ensure consistency in the delivery of hip and knee care throughout the South West</p>

LHIN, by incorporating best practices and lessons learned from a review of comparable existing models and associated research. In addition, this new model could be used as a framework for future cross-LHIN surgical processes.

The proposed integrated model of care incorporates the following:

- Standardized Referral, Central Registry and Assessment and Education Centres to improve the overall flow of patients and ensure common information is obtained at referral and assessment;
- Enhancements to the role of Secondary Prevention and Post-Acute Care, addressing gaps in provision and access;
- Common clinical guidelines, indicators, education tools and care pathways that span the continuum of care;
- Processes and systems that enhance the flow of communication, including health information, between health care providers at each step along the continuum allowing for more integrated care and a more responsive system of care; and
- A performance management component that collects and evaluates data and outcomes in order to be more responsive to the needs of our patients.

Current State

A current state assessment of total hip and knee replacement services in the South West LHIN identified several key findings.

- Extensive human resource shortages;
- System-wide bed shortages including:
 - Lack of beds in hospitals performing surgeries is limiting the number of surgeries that can be performed; and
 - Lack of beds in Long-Term Care and Alternate Level of Care facilities means that patients stay longer in hospitals.
- Desire for a standardized provincial care path that is well established and clearly describes the roles of each player along the path.
- Need for better segmentation of patients into those who need surgery and those who do not yet require surgery; and treatment of patients according to their individual needs.
- Timing of patient discharge causes strain on post-acute care facilities and organizations.
- Interest in centralized patient waitlist to ensure patients are referred to the most appropriate surgeon and providers have access to wait list to enable better planning.
- Need to increase knowledge and information sharing across various providers along the patient care path. This will require changes to processes and enhanced information technology capabilities. Privacy and security will be the major issues to overcome.
- Funding needs to better reflect the actual costs of delivering care and needs to align better with long-term capacity planning.

MLAA Indicator Alignment and Performance Considerations

The MLAA performance targets most impacted by the implementation of the South West LHINs hip and knee replacement model is:

- 90th percentile wait times for Hip Replacement Surgery
- 90th percentile wait times for Knee Replacement Surgery

Performance activities and indicators to be incorporated over time include:

- Average wait time from referral to appointment with surgeon
- Average wait time from decision to operate to surgery
- Acute and Post – Acute care length of stay
- % completion of planned surgical volumes
- Patient satisfaction with overall care
- Post-operative infection rate (within 3 months, with 1 year)
- % patients referred through Central Registry
- % patients attending Assessment and Education Centre
- % patients receiving Secondary Prevention prior to surgery
- % patients receiving Post-Acute rehabilitation

Challenges and Risks

- Unable to obtain timely commitment to secure required resources / funding.
- Getting input and buy-in from stakeholders.
- Difficult to obtain desired level of involvement from key stakeholders and membership of Hips and Knees governance structure.
- Key stakeholders are not aware of certain tools or processes or willing to adopt certain tools or processes

The South West LHIN IHSP identified improving and understanding the availability of and access to health services for children and youth as an integration priority for *Accessing the Right Services in the Right Place at the Right Time by the Right Provider*. The breadth of health care service issues for children and youth along with the various Ministries involved add complexity to addressing areas of access and service delivery for children and youth. After extensive discussion, three areas for system level improvement were identified by the Children and Youth PAT -- acute care, mental health services and rehabilitation services. The PAT selected to focus on rehabilitation services given the other two areas have lead organizations or agencies with members participating in the Children and Youth PAT, with activities currently in progress and supported by the PAT.

The following summarizes the work of the Children and Youth PAT:

Future State

Future State is identified for each area addressed by the Children and Youth PAT.

Acute Care - The South West LHIN will continue to engage the Maternal Newborn Child and Youth Network in order to address coordination of resources to improve acute care services for the perinatal and paediatric populations.

Mental Health - The South West LHIN will work the MCYS South West Region to identify opportunities for partnership to address mental health system issues for children and youth.

Rehabilitation Services- Two areas identified as levers for future change:

- Use of a single philosophy and model; and
- Use of a lead agency (locally and/or regionally) to coordinate and foster integration.

A paradigm shift is needed to move away from focusing on a child's functional deficits to enhancing capacity, community participation and quality of life for children and youth with disabilities and their families. Ongoing support, education and coaching are needed to implement a new model of service delivery. The Life Needs Model is proposed as a model for delivery of paediatric rehabilitation services. The model is a future-focused, transitional approach that reflects the dynamic nature of growth and development and acknowledges the importance of building capacity and resiliency in children, youth and families. The model is based in research and is implemented internationally, and was developed by and currently implemented at Thames Valley Children's Centre (TVCC), the South West regional treatment centre for rehabilitation services. The following strategies were identified by the PAT to move towards a new model and philosophy for an integrated system of rehabilitation services for children and youth in the South West.

- The South West LHIN, as an interested partner and not a provider of service, acts as facilitator, animator, collaborator and as a lead champion of an integrated system of paediatric rehabilitation services based on the organizational philosophy of the LNM.
- A lead agency or agencies to be identified either regionally or locally to champion and facilitate the adoption of the philosophy and expertise of an integrated system based on the LNM and promoting it throughout the region.
- All providers of service within the diversity of their own organizations reflect the integrated system and operational philosophy with respect to paediatric rehabilitation services.

Other components of an integrated system include:

- Access to an accessible, coordinated and family-focused range of services;
- A funding model to facilitate and support a local network of services within a regionally integrated system;
- Support for paediatric rehabilitation expertise with ongoing training and education; and
- Provision of human resources necessary to deliver appropriate services.

Current State

Acute Care

Acute care services for the perinatal and paediatric populations are currently the focus of the South West Ontario Perinatal Partnership

and Regional Paediatric Network (SWOPP/RPN). Engaging SWOPP and RPN to provide leadership for issues of education and training providers was identified as a component of the action plan in the IHSP. With the LHIN's support, SWOPP/RPN is undergoing strategic planning to define governance, outcomes and sustainable funding and evolving into the Maternal Newborn Child and Youth Network (the Network). The purpose of the Network is to enable the consistent delivery of safe, quality maternal, newborn, child and youth care in South Western Ontario through/by:

- Providing leadership to develop strategies in the delivery of care;
- Enabling the work of the Provincial Council on Children's Health;
- Ensuring access by enhancing capacity to care;
- Coordinating services and resources in the provision of care;
- Improving outcomes of care;
- Ongoing evaluation of the quality of care; and,
- Providing education to care providers.

Expected outcomes of strategic planning include a clearly defined value proposition for the Network inclusive of a sustainability model for the Perinatal Outreach Program, a 3-year work plan outlining specific deliverables, and definition around the working relationship between the Network and the two LHINs (South West and Erie St. Clair).

Mental Health Services

The Ontario Ministry of Children and Youth Services (MCYS) is the lead agency for mental health services for children and youth. Participation of MCYS South West Region staff in the PAT work provided an important linkage to mental health and the work of the PAT. Work is currently underway by MCYS to map service provision at the community and provincial levels with the goal of creating a more responsive and sustainable mental health system for children.

Rehabilitation Services

Based on an environmental scan, quantitative and qualitative data and best practice research, the following findings and recommendations from the Children and Youth PAT are reflective of the current state of rehabilitation services in the LHIN.

- Access to core rehabilitation services is not consistent throughout the LHIN.
- There are insufficient numbers of core rehabilitation service providers in the areas north of London.
- Paediatric rehabilitation expertise needs to be supported with ongoing training, education and mentoring.
- Thames Valley Children's Centre (TVCC) is the regional treatment centre for rehabilitation specialty services. TVCC funds providers who provide rehabilitation services locally in all geographic areas of the LHIN, as well as providing services regionally.
- There is not a common operating philosophy or service delivery model for rehabilitation services. The model differs depending on the provider- TVCC, private provider, school health support services, hospital.

- Integration of services is needed across all sectors in a child's life- pre-school, elementary school, secondary school and into adulthood- that embrace those relationships each child or youth has with family, peers, school, neighbourhood and community.
- A review of the school health support services model is needed based on recommendations in the Caplan Report.
- Partnerships are happening throughout the region and are integral to provide leadership, resource, support and accountability across the South West.

MLAA Indicator Alignment and Performance Considerations

Although no specific MLAA performance targets are impacted directly by the recommendations identified by the PAT, given the focus on high level system change and children with current rehabilitation needs, two MLAA targets could be influenced by the improvements identified in the future state section for all three areas- acute care, mental health and rehabilitation services:

- Rate of Emergency Department visits that could be managed elsewhere; and
- Hospitalization Rate for Ambulatory Care Sensitive Conditions.

Performance activities and indicators rehabilitation services for consideration over time:

- Number of sites using a Life Needs Model of service delivery
- Lead agencies identified for communities
- Service satisfaction (children, youth and families)
- Provider satisfaction
- Participation levels/functional ability for children and youth
- Emergency department visits
- Unplanned hospitalization rates
- Family support services available and utilization data
- Quality of life measures for children, youth and families
- Range of services available throughout the region (using LNM to map)
- Number of community programs available for children and youth with disabilities and utilization of programs
- Regional assessment of LNM integration

Challenges and Risks

- Limited rehabilitation services and providers in rural areas, particularly north of London, place children at risk for poor developmental outcomes. There is not a consistent level of access to services across the region.
- Closure of rehabilitation services by current providers with no funds or capacity transitioned to others who may be able to pick up caseload.
- Challenges of how school health support services are contracted and funded, limited number of visits and little opportunity to

interact with families.

- Community capacity to build inclusive programs may be limited.
- TVCC would like to provide more service in areas without sufficient provider coverage but are not funded to do so.
- Difficulties in bringing together three Ministries (Education, Children and Youth and Health and Long Term Care) that fund different components of children's rehabilitation services. A 1984 Tri-Ministerial Memorandum provides the policy being used today to fund and administer school health support services.
- Families are in need of respite services and wrap-around support services, especially for siblings. This is necessary to build capacity and resilience for children and their families.
- Children with a disability are 2.5 times more likely to live in poverty than children who do not have a disability. The impact of poverty as a social determinant of health is well documented. Children with disabilities and their families are disproportionately impacted by the effects of poverty.

A number of key initiatives 2009/10 and beyond will contribute to our priority of accessing the right services, in the right place, at the right time, by the right provider. Additional projects supporting this priority are described below.

Projects Under Consideration: 2009/10

Currently no specific projects have been identified given the recent completion of the PAT work, however, the following recommendations put forward by the PAT include LHIN involvement in potential projects.

1. The LHIN acts as a facilitator to bring parties* together to:
 - a. Begin discussions regarding an integrated children's rehabilitation system provided in local communities;
 - b. Identify a lead agency (locally and/or regionally) that would be responsible for ongoing support and implementation of the Life Needs Model and the integration of existing and future rehabilitation services;
 - c. Address best use of current resources and accountability to fund services equitably across the region; and,
 - d. Address lack of data for this population available to aid in decision-making.

*Parties include TVCC, CCAC, school boards, service providers, MOHLTC, MCYS, Ministry of Education and others.

2. Consider contracting funds to the regional treatment centre to provide training, support, mentoring and coaching for implementation of the LNM throughout the region.

3. In partnership with the MCYS South West Region, develop a plan to define roles and areas for mutual engagement to address children's mental health issues for the South West LHIN.
4. Working with Maternal Newborn Children and Youth Network partners, identify opportunities to coordinate resources and support best practices to improve outcomes for perinatal and paediatric populations.

Right Services, Right Place, Right Time, Right Providers: Key Projects 2009/10

Project Name	Description	MOHLTC Priority Alignment	Outcomes Alignment with Future State
<i>Tier 2 & 3 Divestment</i>	Working with the MOHLTC, LHIN and partners to facilitate Tier 2 divestment (transfer) of psychiatric beds and associated services by the Tier 1 receiving public hospital to other public hospitals, as directed by the HSRC. Tier 3, refers specifically to the transfer of non-bedded programs and services from Tier 1 and 2 receiving hospitals to community mental health agencies, where appropriate	ALC and access to Primary Health Care	<ul style="list-style-type: none"> • Provisions of programs and services that meet the needs of individuals with serious mental health illness in the most appropriate and least restrictive setting(s) • Possibility of capacity-building in community mental health sector
<i>Improving Services for Aboriginal Communities</i>	Coordinator hired to work with Aboriginal communities in both the South West and Erie St.Clair LHINs to improve health services.	Access to Primary Care	<ul style="list-style-type: none"> • Equitable Access to Services
<i>Order Sets</i>	It is proposed that implementation of order set best practice methodology and	Access	<ul style="list-style-type: none"> • Quality of Care and Services

Right Services, Right Place, Right Time, Right Providers: Key Projects 2009/10

	<p>clinically intelligent order set content with measured improvements in patient care take place within all hospitals in the South West LHIN. Order Sets have the ability to transform the ordering process dramatically improving the care patients receive</p>		
<p><i>Health System Design (Blueprint Project)</i></p>	<p>Accessing the right services, at the right time, in the right place by the right provider was a key integration priority identified in the South West LHIN IHSP. When the IHSP was created it was envisioned that the LHIN would undertake a comprehensive planning process to establish a framework, the Blueprint that would guide future decisions regarding the alignment of programs and services at a local, sub-LHIN and regional level in the South West LHIN. Many of the South West LHIN PATs highlighted the need for this work to move forward in order to support more detailed planning regarding service configuration within the LHIN.</p>	<p>Access to Primary Health Care/ Emergency Department Access/ ALC</p>	<ul style="list-style-type: none"> • Sustainability of the Health System
<p><i>Emergency/Critical Care Strategy</i></p>	<p>Timely access to emergency care is a critical component of the healthcare system. The South</p>	<p>Emergency Department Access</p>	<ul style="list-style-type: none"> • Sustainability of the Health System

Right Services, Right Place, Right Time, Right Providers: Key Projects 2009/10

	<p>West LHIN has a unique challenge of having a high number of 24/7 emergency departments but a lack of physicians available and willing to provide emergency department coverage. In order to maintain a healthy system, a concerted effort is required to find the right balance to ensure timely access to emergency care. This project studies these issues in addition to implementing a dedicated Project Lead to help support the Emergency Department and associated Critical Care Strategies at the local LHIN level.</p>		
<p><i>Supply Chain Integration</i></p>	<p>South West LHIN integrated Supply Chain Management (iSCM) Model to:</p> <ul style="list-style-type: none"> • Strengthen supply chain leading practices; • Improve efficiencies and operations to generate cost savings through economies of scale; • Standardize products, services, suppliers, processes, forms, policies and procedures; • Achieve further innovation through automation and advanced technology; 		<ul style="list-style-type: none"> • Integration of Health Care Delivery

Right Services, Right Place, Right Time, Right Providers: Key Projects 2009/10

	<ul style="list-style-type: none"> • Improve performance measurement, and • Create opportunity to leverage expertise and synergies. <p>Overall, this iSCM Model will bring the remaining health care organizations (hospital first) in the South West LHIN into the region-wide strategy.</p>		
<p><i>Hips and Knees Integrated Model of Care</i></p>	<p>The hip and knee replacement delivery model strives to ensure that individuals have timely, equitable and appropriate access to hip and knee replacement services based on best practice as an evidence-based care. Through the use of common multidisciplinary pathway spanning primary and secondary prevention through post-acute care, services are standardized and delivered efficiently in a coordinated manner.</p>	<p>Improved Access and Wait Times</p>	<ul style="list-style-type: none"> • Clearly defined continuum of care available to all patients resulting in positive clinical and functional outcomes • Equitable and timely access • Reduction in surgical wait times • The patient, family and/or support system are active participants in the patients care and self-management • Demonstrated improvement in satisfaction • High quality, best practice care delivered in the South West LHIN

5. Health Human Resources (HHR)

Consideration of Human Resource issues, challenges and opportunities is required to ensure achievement of our wider strategic and operational goals. Having the right mix of skilled and professional staff ensures we are best positioned to support our partners and key stakeholders. Increasing environmental instability, demographic shifts, changes in technology, new projects and provincial strategies, and competing priorities are changing the HR requirements in health care. HR strategies can be critical inputs in determining the strategic initiatives for the LHIN. As we continue to expand the South West LHIN scope of support, responsibility, and services, it is prudent to keep in view the human resource requirements and identify the risks associated with continued expansion and integration. The South West LHIN recognizes the provinces' lead role in HR planning but continues to work with local partners to lay a foundation for future planning efforts in support of key health system directions.

The South West LHIN is pleased to be partnering with HealthForceOntario Marketing and Recruitment Agency (HFO MRA) and is hosting the new Partnership Coordinator who will be working with South West communities to support recruitment and retention activities. The Health Human Resources Advisory Group of the South West LHIN identified recruitment and retention as a key priority for the South West recognizing workforce demographics and the need to address significant human resource capacity issues that challenge service provision into the future. With the use of priority funds, the South West LHIN has enabled the creation of a career portal to be used by health care providers in our LHIN. In addition to recruitment and retention, the advisory group also identified the following key areas of focus:

- Understanding the current state of HHR supply and associated trends;
- Investigation the possibility of achieving HR efficiencies through shared services; and
- Identifying the group's role in enabling support for interprofessional collaboration within our current health care settings and within our educational programs.

Health Human Resources: Key Projects 2009/10			
Project Name	Description	MOHLTC Priority Alignment	Outcomes Alignment with Future State
<i>Career Network</i>	Development of the South West LHIN Health Career portal through thehealthline.ca to support the establishment of a health human resources virtual network. The goal of the	HFO MRA	Sustainability of the Health Care System

	network will be to assist health service providers and local communities with their HHR recruitment efforts.		
<i>Human Resources Benefits Realignment</i>	Following a feasibility assessment, the LHIN is investigating a process to realign benefit programs across our hospital sector in phase 1 and then the broader health sectors in phase 2 with a goal of realizing significant cost savings across our LHIN by moving to a single benefits consultant and the alignment of benefit administration fees.		Sustainability of the Health Care System

6. eHealth

One of the fundamental enablers to health care integration is the ability for information to be exchanged between and among providers and consumers across the health care continuum.

The eHealth agenda in the South West LHIN continues to evolve in support of the goals and objectives of the local providers within the context of the provincial landscape. The priorities of the eHealth Steering Committee are being considered in relationship to the progress on the IHSP priorities, local health system requirements and the provincial eHealth plan. Up to this point, the priority has been to implement a few key infrastructure projects that will position providers and the LHIN to integrate with existing and new strategies announced by the province.

The eHealth Program has four major deliverables:

- Ontario Diabetes Registry;
- Portals/Integrated Clinical view;
- E-Prescribing and drug systems; and
- Electronic Medical Record (EMR)/ computers for physicians.

The South West LHIN is one of two LHINs identified as an “early adopter” for the province’s eHealth strategy. The first major milestone for the strategy will focus on the introduction of a provincial Diabetes registry in early 2009, with the longer term goal of the implementation of a comprehensive electronic health record. The implementation of the provinces Diabetes Strategy will be enabled by the eHealth strategy implementation. Adoption and clinical participation in the “registry” will be a major deliverable of the LHIN.

The South West LHIN is the only LHIN in the province that has been selected to be an eHealth early adopter as well as being slated along with two other LHINs, for the first implementation wave for the expansion of team based family health care in Ontario. This presents an opportunity to build a robust infrastructure in the South West LHIN to support eHealth applications on an on-going basis. This requires careful thinking and consideration of how to align this with current needs and developments in the South West LHIN to make maximum use of this opportunity. As an early adopter site, the South West LHIN will be developing lessons learned and testing out strategies that will be applied or adapted for use elsewhere in the province.

The South West LHIN will be collaborating and working with the Ministry eHealth program on an on-going basis, taking the lead from the Ministry and adapting to local needs and circumstances to deliver on provincial expectations and requirements. The need for on-going eHealth support and sustainability has been recognized and is being addressed but is not yet resolved.

The South West LHIN continues to move forward with other initiatives. These initiatives align with the recommendations from the SW LHIN Priority Action Teams. PAT recommendations include improving the access to health information with the future state of creating an electronic health record that is accessible to all health service providers.

eHealth: Key Projects 2009/10			
Project Name	Description	MOHLTC Priority Alignment	Outcomes Alignment with Future State
<i>ONE® Mail</i>	e-mail that will allow health care professionals to send patient information quickly, confidently and securely between registered users	Harmonized, consistent, integrated eHealth platform	<ul style="list-style-type: none"> Securely send patient information to ONE® Mail users inside and outside the organization
<i>Diabetes Registry & eHealth Early Adopter</i>	Development of an online Diabetes registry The implementation of the provinces Diabetes Strategy will be enabled by the eHealth strategy implementation	Electronic Medical Record	<ul style="list-style-type: none"> Expansion of team based care and the implementation of the diabetes registry Increase access to team-based care closer to home Enable better self-care by giving

eHealth: Key Projects 2009/10

eHealth: Key Projects 2009/10			
			<p>patients access to information and educational tools that empower them to manage their disease</p> <ul style="list-style-type: none"> • Provide health care providers the ability to easily check patient records, access diagnostic information and send patient alerts.
<i>North-South Connectivity Project</i>	<p>The North South Connectivity Project is the first phase of a larger implementation that will eventually create a platform for the development of the electronic health care record incorporating community and primary health care services. The 1st phase will connect the hospitals in the North (GBHS) and South (Thames Valley, Exeter, and Wingham/Listowel) to provide access to patient clinical data.</p>	Electronic Medical Record	<ul style="list-style-type: none"> • Increase access to patient information • Electronic Health Record development