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**LOCAL HEALTH INTEGRATION NETWORK**

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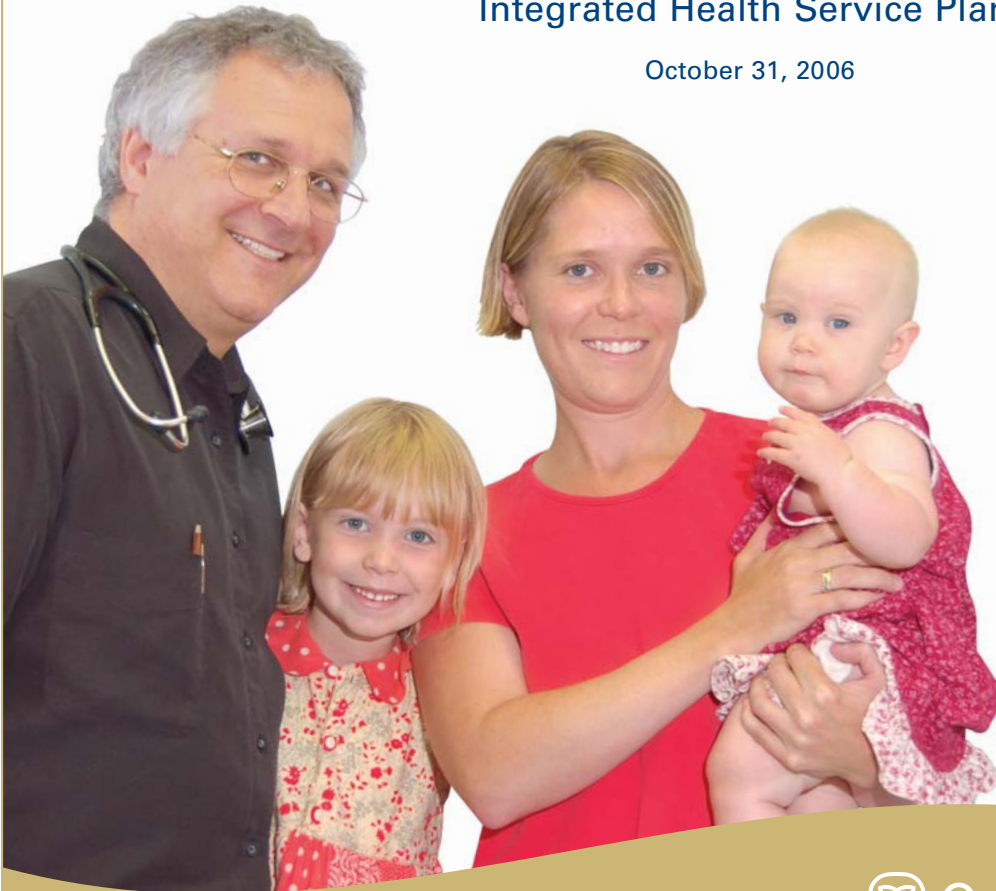
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# Working Together for Better Health

The South West LHIN  
Integrated Health Service Plan.

October 31, 2006





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## PART I: PROVINCIAL CONTEXT

The residents of Ontario benefit from excellent health services. However, consumers and families, providers and policy-makers all recognize that there are growing pressures on our health care system – rising costs, an aging and growing population, new technologies, and emerging public health threats from an increasingly connected world.

The South West Local Health Integration Network (LHIN) is one of 14 organizations that has been established across the province to meet these changing demands on the system and improve access to, and the quality of, health services in Ontario. The South West LHIN will bring decision-making about health care services closer to home and make sure that input from local citizens, consumers and providers helps to shape the priorities and directions for change. By building partnerships among providers, the South West LHIN will encourage local solutions and innovations to address community needs and make the most of available resources.

### Provincial Vision and Strategic Directions


The provincial government's vision is anchored on a clear statement for the future of health care in Ontario:

***"A health care system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren."***

LHINs are critical to this vision and will be a catalyst for implementing a number of province-wide strategies with goals to reduce wait times for services, improve coordination to make it easier for people to understand and use services, and make sure that providers and government are accountable to the people who depend on them (see Appendix A for more on provincial priorities).

The Ministry of Health and Long-Term Care (MOHLTC or 'Ministry') has set out five draft strategic directions for Ontario's health system that will be the basis for the development of a 10-year Provincial Health System Strategic Plan due to be released in the spring of 2007. The five draft Strategic Directions are:

1. Renewing community engagement and partnerships concerning health care
  - Ensuring that community awareness and engagement remain core elements / processes in local health system planning
  - Building partnerships with other participants in the local health system including Public Health and primary care groups
  - Ensuring active participation in local community planning processes
2. Improving the health status of Ontarians
  - Improving the health of all Ontarians, especially groups with the poorest health status

- 
- Enhancing uptake of provincial disease screening programs
  - 3. Ensuring equitable access to health care for all Ontarians no matter where they live
    - Reducing wait times for key services
    - Eliminating barriers to access
    - Instilling appropriate supports to enable Ontarians to age in the most appropriate place
    - Ensuring more effective health human resource planning and management
  - 4. Improving the quality of health outcomes
    - Placing the consumer at the centre of planning and coordination of health services and chronic disease prevention and management
    - Improving integration and coordination of health services and facilities related to disease prevention, health promotion, diagnosis, treatment, rehabilitation, and palliative care that is based on the populations' need
    - Building leadership and participation in continuous quality improvement of the health system
  - 5. Establishing a framework for a sustainable health system
    - Providing equitable allocation of health resources according to the health needs of the population
    - Optimizing use of available resources to deliver health care
    - Increasing efficiency of service delivery
    - Basing planning and decision-making on evidence, analysis of need and value of investment
    - Increasing use of appropriate care settings
    - Moving toward an electronic health information system
    - Ensuring financial stability

To fulfill its mandate, the South West LHIN is responsible for engaging the community to identify health needs and priorities, and developing a plan that looks across the full range of health care services. This Integrated Health Service Plan (IHSP) is a three-year local strategic plan that will lay the foundation for LHIN activities and decision-making. With a focus on integration, the IHSP defines the priorities that will guide the LHIN and its partners to enhance local health care services and develop a health care system that is accountable, coordinated, effective, efficient and sustainable. The IHSP will also play a role to inform and influence broader policy and strategic planning activities at the provincial level.

## PART II: LHIN LOCAL VISION

### Our Context

The South West LHIN encompasses an expansive geographic area, and is home to almost a million people. It includes more than 225 health service organizations and has a long-standing tradition of excellence in health care. The City of London hosts one of the country's most respected universities and a leading academic health science centre. This research and teaching centre is the backbone of health services in the South West, attracting professionals from across the country, acting as a hub for education and innovation, and providing services to those with the most complex health needs.

***“Local health care services  
for local people”***

Outside of London is a rich rural culture that characterizes the whole of the South West. It is traditionally agricultural, but has become an attractive tourist destination and home to a growing number of retirement communities. Many providers in these communities have developed innovative ways to address the unique challenges of delivering health care in rural areas, and have developed a culture of collaboration and partnership.


Integration has a strong history in the South West, as health service providers have come together to bridge differences and coordinate the delivery of quality care. The South West LHIN will work together with providers to enhance these linkages and build on the tremendous work already being done.

### The Vision for Integration in the South West LHIN

Health services integration is about connecting parts of the health care system to work better together. It is about changing the ways in which providers work – as a team and individually. It is not an end in itself, but a journey that requires commitment and determination. Achieving our desired integration outcomes will require innovation in many areas of our system, and we will need to work together to enhance the health and wellness of our communities.

The role of the South West LHIN is to create a consumer-focused health care system by building a single system of providers who are collectively focused on the health and well-being of our communities. Our mandate is to facilitate health services integration by supporting and enabling providers to work collaboratively together.





**Strategic Goals:** Integration can take many forms, and may involve a full range of health care partners as well as other organizations or individuals. Some integration initiatives may focus on coordinating services for a defined population such as children or seniors, while others may focus on how similar health services are managed and delivered to improve coordination at an operational or clinical level. To guide the development of the Integrated Health Service Plan (IHSP), the South West LHIN has identified the following goals of integration:

1. Develop “local health care services for local people” through the most appropriate service across our rural and urban settings.
2. Establish, through partnerships, a single system of providers that offers:
  - Equity in access to quality services;
  - Ease of movement through the continuum; and
  - Informed and responsible consumer choice.
3. Leverage existing strengths and create new ways of delivering health care that achieve optimal health outcomes and support health system sustainability.
4. Enhance the academic health care culture across the South West and strengthen leadership in education, rural health research and knowledge transfer to support service innovation.
5. Establish a coordinated and collaborative approach to health human resources through planning, recruitment, maximizing scope of practice, education and professional development.
6. Promote linkages with regional and provincial partnerships and networks to enhance service delivery.


**Values and Principles:** The South West LHIN must manage and balance multiple interests including the province’s priorities and strategy, local characteristics and preferences, provider characteristics and interests and best available evidence. In an effort to ensure ‘fair and transparent’ decision-making, the South West LHIN has developed decision-making principles that support its direction for integration. These principles were used in the selection of integration priorities and guided the development of the first IHSP.

**Consumer-focused** – users of the system and their families are able to access quality services when needed and they experience respectful and caring interactions with the system

**Population-based** – opportunities to improve population health through an emphasis on health promotion and disease prevention are optimized

**Data driven** – support is provided through both qualitative and quantitative data. Sources of data include relevant research, the use of clinical pathways/maps, standards of care or other best practice research, expert opinion and consensus-based input

**Outcome-oriented and measurable** – short and long-term goals as well as process and outcome indicators are identified to measure impacts in the short, medium and long term



**System sustainability** – strategies are developed to ensure the future sustainability of our health system

**Builds system capacity** – through creativity and innovation and the leveraging of current capability, greater system capacity is built

**Leverages partnership activities or initiatives** – the establishment or strengthening of cross-sectoral networks and partnerships is fostered in a way that enables the success of the initiative

**Achievable** – strategies are implemented to ensure achievement of the intended goals

## Community Engagement Framework

To achieve our goals, the South West LHIN will need to engage those who are most knowledgeable about their needs, experience and satisfaction with health care services. We will need to work in close partnership with the public, health providers and our other partners so that the collective wisdom of our communities is available to help guide and influence change within our health system. To this end we will endeavour to keep all partners informed and engaged, foster positive relationships across the local health system, and encourage involvement in all aspects of our activities.

The South West LHIN Community Engagement Framework is founded on principles of transparency, accountability and mutual respect. Within our communities, various groups will be affected by, or have the ability to affect, the activities of the LHIN. These groups were the focus of our community engagement to develop the Integrated Health Service Plan, and will be our partners as we do more detailed planning and implementation of our priorities. Our collective success will depend on a shared commitment to the community engagement process, and continuing involvement from all of our community partners. The Community Engagement Framework and Plan have been provided in Appendix B, and Appendix C provides a summary of our community engagement findings.

## Performance Management Framework

Performance measurement, reporting, and quality improvement are fundamental to greater accountability, one of the guiding principles for system change. Measurable, outcome-based results will provide the evidence that is needed to monitor and report on the success of these transformation and integration initiatives. Strategic management tools such as scorecards will enable the measurement of health system quality, value, and sustainability.

In support of the Provincial transformation agenda, the South West LHIN has established a performance management framework (see Appendix D). The framework leverages existing tools and supports cascaded performance reporting at multiple levels (e.g., LHIN-level, sector-level, provider-level) to ensure consistency in performance improvement throughout the local health system. The following three strategic elements comprise the South West LHIN Performance Management Framework: Provincial Strategies; LHIN Integration Strategies; and Organizational Strategies.

## PART III: ENVIRONMENTAL SCAN

To better understand the current and future issues facing the South West LHIN residents and health service providers, we have undertaken an extensive environmental scan. This includes a community and health system profile (*what our data has told us*) as well as extensive public and provider engagement (*what we heard*). This high level profile and analysis provides a basis for discussion with our partners and a view of the South West in comparison to other communities in Ontario.

Three *geographic areas* within the South West LHIN have been identified to enable a broad-based approach to engaging with local health providers and planning for integration priorities. These areas are closely aligned to county boundaries and in many cases providers are already joined in networks or alliances. Below are the geographic areas and the municipal entities that they include.

Geographic Area	Municipal Entities within each Geographic Area	Population	Square Kilometres
North	Bruce County, Grey County (excluding parts of Southgate Township, West Grey, and The Town of the Blue Mountains)	148,250	8,663
Central	Huron and Perth Counties	125,490	5,626
South	City of London, Middlesex, Oxford and Elgin Counties, Norfolk County (the south west portions only)	637,954	7,576

### 3.1 COMMUNITY AND HEALTH SYSTEM PROFILE

The information contained here has been compiled from both historical and current information. Additional data is still being generated by the Health Systems Intelligence Project (HSIP) to help LHINs describe and assess the health needs of their communities, and some LHIN-level data is not yet available. Where appropriate, historical data was included from reports produced by other sources (e.g., District Health Councils; Public Health Units; Municipal Planning Departments) and noted in the report. A more detailed environmental scan, which includes source data, can be found in Appendix E. Section IV of this document also provides further interpretation of this data and how it relates to specific Integration Priorities identified in the South West LHIN.

#### Population Profile and Need

- **Population:** The population of the South West LHIN in 2006 is approximately 935,000, representing 7.5% of Ontario. It contains a significant urban population in the City of London, with many rural communities in the outlying areas. The population is projected to increase by almost 70,000 by 2016, primarily in the 55+ age group. The child and youth population (0 to 19 years) is projected to decrease by 14,399 or approximately 6.3% over the next decade.
- **Seniors Population:** The proportion of seniors (age 65 and over) in the South West LHIN is 14.7%, which is greater than the provincial average of 12.9%. Of the three geographic areas, the North has the highest proportion of seniors at almost 18%. The South area contains the highest

total number of seniors in the LHIN with 87,710. The population of seniors in the LHIN is expected to grow by almost 43,000 by 2016.

- **Diversity:** Overall ethno-cultural diversity is considerably less than the provincial average. However, London/Middlesex is the most diverse with the immigrant population accounting for just over 17% of the population. The most common countries of origin for newcomers are the UK, Netherlands and Mexico. The Central and South areas of the LHIN contain populations of Low-German Mennonites originating from Mexico. While the population of Francophones is comparatively small, the South West LHIN has the largest proportion of older Francophones in Ontario (more than half are 45 years or over).

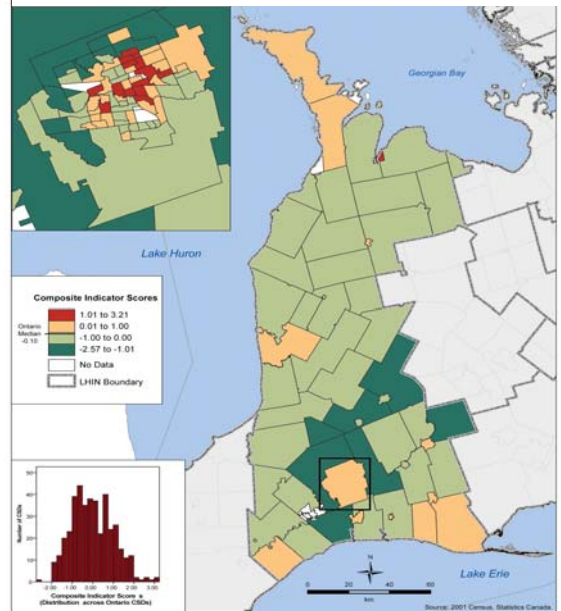
**Table 1: LHIN-Level Characteristics Compared to Ontario**

SOUTH WEST LHIN	North	Central	South	South West LHIN	Ontario
% population age 65 and over	18.1%	15.9%	13.5%	14.4%	12.9%
% lone parent families	19.8%	18.1%	23.7%	23.0%	23.4%
% female lone parent families	15.7%	14.6%	19.7%	19.0%	19.3%
% non-owned private dwellings	22.1%	24.4%	33.6%	31.4%	32.2%
% population English mother tongue	93.5%	90.7%	83.5%	85.4%	71.9%
% population French mother tongue	1.0%	0.7%	1.4%	1.3%	4.7%
% population with no knowledge of English or French	0.1%	0.3%	0.9%	0.8%	2.1%
% immigrant population	8.4%	8.6%	17.2%	15.6%	26.8%
% recent immigrant population	0.5%	0.9%	2.1%	1.8%	4.8%
% visible minority population	1.2%	1.8%	6.9%	5.8%	19.1%
% Aboriginal identity population	1.7%	0.5%	1.2%	1.3%	1.7%
Participation rate (age 15+)	63.9%	70.6%	67.7%	67.0%	67.3%
Unemployment rate (age 15+)	4.9%	3.9%	4.3%	4.1%	6.1%
Youth unemployment rate (age 15-24)	11.4%	9.0%	13.7%	13.3%	12.9%
% population with less than grade 9 education	9.7%	10.9%	8.2%	8.5%	8.7%
% population without completed high school education	31.0%	33.5%	26.7%	27.6%	25.7%
% population with completed post-secondary education	43.8%	40.5%	46.7%	46.1%	48.7%
% population in low income	10.2%	8.1%	13.3%	12.7%	14.4%
% households spending 30% or more of income on housing	20.1%	19.1%	24.4%	23.6%	25.3%

- **Aboriginal Population:** The percentage of the Aboriginal population in the South West LHIN is slightly lower than in the province overall (1.2% versus 1.7%). There are five First Nations' Reserves in this LHIN: Saugeen; Chippewas of Nawash; Chippewas of the Thames; Munsee-Delaware Nation and Oneida Nation of the Thames. Census and population health data are limited for Aboriginal and First Nations populations, although available data indicates that Aboriginal populations demonstrate higher burdens of illness and injury. There is also a significant off-reserve Aboriginal population, but more data is needed to accurately profile this population.
- **Socio-Economic Characteristics:** There is a growing body of evidence about what makes people healthy and how these factors influence health. This includes socio-economic indicators that compare overall health status and health behaviour characteristics across populations. Table 1 above reflects selected socio-economic characteristics for the South West LHIN, demonstrating a lower rate of single-parent families, and a higher average household income and participation in the workforce. However, education levels across the LHIN are lower than the provincial average. Education may increase opportunities for employment and equip people with skills necessary to access and understand resources required to maintain their health.

- Looking at socio-economic indicators in aggregate, we can analyze the degree to which specific communities may be socio-economically “disadvantaged”. The “Composite Socio-economic Status (SES) Indicator”, shown in Figure 1, consolidates data into a single weighted summary measure that can be used to examine geographic variation in socio-economic status (Note: an indicator greater than 1 reflects disadvantage). A composite indicator such as this often shows a more complete picture of socio-economic status across an area. High-risk areas (in red) can be seen in some areas in the North and in some neighbourhoods in the City of London.

**Figure 1. Socio-economically Disadvantaged Areas in South West LHIN**



### Health Status and Health Practices

Presented below are some areas where the South West LHIN differs significantly from others in the province:

- Chronic Conditions:** Table 2 shows that compared to the provincial average, the South West LHIN has a greater proportion of people with chronic conditions, except asthma (7.3% vs. 8.0%). The South West LHIN ranks highest among all LHINs (a higher rank indicates a greater proportion of people with a chronic condition) for chronic bronchitis (3.3%).

**Table 2: Prevalence of Selected Chronic Conditions**

Health Indicator	CCHS Reporting Year	South West LHIN	Ontario	South West LHIN Ranking
<b>Prevalence of Chronic Conditions, 2003, 2005</b>				
% of Population (age 12+) with Arthritis/rheumatism	2005	18.7%	17.1%	7
% of Population (age 12+) with High Blood Pressure	2005	17.2%	15.2%	5
% of Population (age 12+) with Asthma	2005	7.3%	8.0%	11
% of Population (age 12+) with Diabetes	2005	5.2%	4.8%	7
% of Population (age 30+) with Heart Disease	2003	8.2%	7.2%	6
% of Population (age 12+) with Chronic Bronchitis	2003	3.3%	2.7%	1

- Obesity:** The South West LHIN has a higher proportion of people who are obese (18.1%) when compared to the provincial average (15.1%).
- Smoking:** The percentage of daily smokers in the South West LHIN is equal to the provincial average (20.7%) and ranks 9th among all LHINs.
- Mortality:** The overall mortality rate per 100,000 people (adjusted for age) is 6.0% higher than the provincial rate (638.7 vs. 602.6) across most disease categories.
- Hospitalizations:** The number of hospitalizations per 100,000 people (adjusted for age) is 10.4% higher than the provincial rate (8,554.38 vs. 7,746.67), and is highest in the North.



## Health Services Utilization

The South West LHIN includes 227 Health Service Providers across the entire health care continuum (See Appendix E for a complete list). The summary below outlines the types of services provided and how they are used.

**Primary Care:** The number of family physicians per 100,000 people who provided care to South West LHIN residents in 2004 was 78, which is below the provincial average of 84. 91.4% of residents visited a primary care physician whose office is within the LHIN.

**Community-Based Services:** The South West LHIN has approximately 100 community services agencies (including Community Health Centres, Community Mental Health agencies, Community Support Services, and Addictions Services). The South West LHIN ranks 10<sup>th</sup> in per capita funding of Community Support Services and 11<sup>th</sup> for Mental Health and Addictions. Wait lists exist primarily for friendly visiting, home making and transportation services.


**Home Care:** Six Community Care Access Centres (CCACs) have served residents in the South West LHIN. Together they have provided over 400,000 nursing visits and 1.1 million personal support and homemaking hours to clients in the LHIN. The Grey Bruce CCAC reported relatively more nutrition services for their clients.

**Long-Term Care:** The South West LHIN currently has 6,739 beds for its residents in 74 Long-Term Care homes. The occupancy rate for Long-Term Care homes is 100% or close to 100%, indicating that the homes are all operating at or near capacity. The South West LHIN ranks 7<sup>th</sup> and exceeds the provincial average for the median time to placement for clients seeking placement from the community or from an acute care setting.

**Complex Continuing Care (CCC):** South West LHIN hospitals treat complex continuing care patients in 286 CCC beds within their institutions. There is significant variability in the complexity of cases treated by South West LHIN hospitals, suggesting there are opportunities for collaboration to improve overall performance.

**Rehabilitation:** Hospitals in the South West LHIN treated 1,117 patients in the 123 general rehabilitation beds in their facilities in 2004/05. Relative to the provincial average, patients did better in terms of improvements to functional status while in hospitals in the South West LHIN.

**Acute Care:** The South West LHIN contains 19 hospital corporations (some with multiple sites): three in the North, eight in the Central area, and eight in the South. London Health Sciences Centre represented the highest volumes and proportion of complex care, making it the centre for the most complex acute care in the South West LHIN. Hospitals in the North and Central areas predominately provide less complex, “secondary or primary” levels of care. Almost 94% of residents of the South West receive their care within the LHIN, indicating that few residents are seeking hospital services in other LHINs. Areas of moderate “inflow” from residents in other jurisdictions include neurosurgery, cardio/thoracic, and ophthalmology services. Alternate Level of Care (ALC) days and separations



were comparable to that for the province, although a higher proportion was reported in the North. The largest proportions of ALC days for South West hospitals were associated with psychiatry and general medicine.

**Emergency Services:** In comparison to the other LHINs, hospitals in the South West LHIN rank 3<sup>rd</sup> on the proportion of “non-urgent” emergency room visits. There were 527,433 visits to the emergency room in 2004/05, with 65% being classified as “less-urgent” or “non-urgent”. While the large majority (88.1%) of visitors were discharged home, data suggests that some visitors may not be served in a timely manner.

**Inpatient Mental Health:** South West LHIN hospitals currently operate 727 psychiatry beds. The majority of beds are located at Regional Mental Health Care, London (395 beds) and Regional Mental Health Care, St. Thomas (169 beds). There were 5,488 South West LHIN mental health-related cases in 2004/05; the South West LHIN accounted for 9.5% of all mental health cases in Ontario. The mental health separation rate per 1,000 population (adjusted for age) for South West residents was significantly higher than the rate for Ontario residents (5.6 vs. 4.5).

**Problem Gambling and Substance Abuse:** Of the 8,258 residents requiring problem gambling and substance abuse support services, 13.7% of South West LHIN residents received their care from organizations outside the LHIN.



## 3.2 ASSESSMENT OF PROVINCIAL PRIORITIES IN THE LOCAL CONTEXT

The South West LHIN monitors the progress of provincial initiatives at the local level and will play an active role in stewarding their implementation. In particular, ongoing support and investment to implement the provincial e-Health Strategy and provincial leadership for a health human resources strategy will be critical to the success of the South West LHIN's Integrated Health Service Plan

A brief summary of three provincial initiatives is outlined below, and a more detailed analysis is provided in Appendix F.

### Electronic Health Record

The goal of Ontario's e-Health Strategy is to use information technology to modernize our health system and provide better and safer patient care. The e-Health Strategy and proposed "Electronic Health Record" (EHR) will enable the South West LHIN to establish standards that permit health information to follow people as they move between providers. Having comprehensive information on patients will help providers make better decisions and allow the South West LHIN to analyze and optimize local health service and referral patterns. The South West LHIN has established an e-Health Steering Committee to develop and implement a strategic plan, as well as a shared framework for service providers to effectively partner to achieve their goals.

### Health Human Resources

A quality health care system is dependent on an adequate supply and appropriate mix of well-trained, knowledgeable and caring health care providers. This includes not only doctors and nurses, but also medical technologists, pharmacists, therapists, and others. The Ministry of Health and Long-Term Care leads development of policy and planning for health human resources, and works together with other Ministries to ensure education and training of an adequate supply of practitioners. The South West LHIN will need to work closely with the Ministry to identify and promote health human resources initiatives, and to more accurately assess supply and demand, today and in the future.

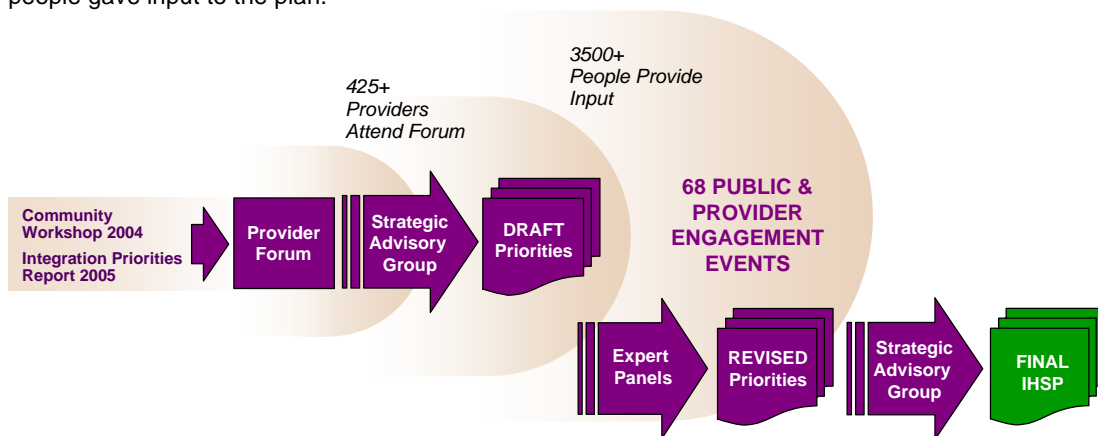
### Wait Times Strategy

The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. Wait times will be improved by expanding capacity through targeted volume increases, greater efficiencies and standardizing medical and administrative "best practices". The strategy will make hospitals accountable for managing access, and a single wait time information system will help achieve this goal. In the South West there have been decreases in wait times for cataract surgery, hip replacement, and knee replacement since the program's inception. However, there have been increases in wait times for cancer surgery, coronary bypass surgery and diagnostic imaging. The South West LHIN will need to monitor both priority and "non-priority" wait times to ensure appropriate access to a full spectrum of services.

### 3.3 SUMMARY OF COMMUNITY ENGAGEMENT TO DATE

The South West LHIN is committed to ongoing dialogue in the community. To ensure a full spectrum of perspectives contribute to the Integrated Health Service Plan, we undertook extensive engagement with health service and community leaders, providers and frontline staff, and the public. In total we held 68 community engagements between July and October 2006, and met with nearly 2800 people to listen to their stories and learn from their experiences and advice. In total nearly 4000 people gave input to the plan.


**“Conversation, not Consultation”**



The illustration above provides an overview of the South West LHIN's approach to identify key priorities for the South West and develop the LHIN's first Integrated Health Service Plan. The Strategic Advisory Group and Expert Panels, in particular, played a critical role in the process, providing advice to the LHIN and assisting with decision-making. In addition, input was received from clinical and population networks in the South West, and a telephone poll and an online survey were conducted to provide another approach to community engagement. A summary of the Community Engagement process and findings is available in Appendix C.

Community engagement **to develop the draft priorities** included a spectrum of issues and recommendations:

- Creating an integrated primary care strategy and linking family physicians to community care
- Ensuring a consistent level of service and quality in rural communities by supporting rural networks and building links between rural communities and urban centres
- Addressing transportation challenges, including effective use of non-emergency transportation
- Building links among providers, with assistance navigating the health system and improved quality of care and standardized care pathways
- Formulating a LHIN-wide strategy to coordinate and link services supporting those with chronic illnesses

- 
- Building linkages to promote wellness and encourage collaboration and coordination (including coordination of Mental Health and Addiction Services)
  - Integrating seniors services across the continuum of care, and closing the gap between long term care services and services in the home
  - Creating a common e-health strategy across the South West and creating a common data system or platform
  - Building an integrated system through:
    - *Implementing e-Health* to maximize the use of information technologies
    - *Strengthening academic health care* to foster a culture of innovation and improvement
    - *Mobilizing existing networks* and enabling integration through improved knowledge sharing
    - *Enabling access to resources*, including a LHIN-wide health human resources plan

Community engagement **to develop the final IHSP** was extensive. Below is a brief summary of input. More detail is available in Appendix C.


**Results of the Telephone Survey:** Based on a poll of more than 600 people, the study showed a relatively high level of satisfaction with and confidence in the health care system in the South West. Support for the South West LHIN's draft priorities was overwhelmingly positive, with all priorities considered important by nine out of 10 respondents. Issues of access and primary health care were the highest ranked of the priority areas.

**Results of the Online Survey:** Nearly 200 people participated in the online survey to provide their input on the draft South West LHIN integration priorities. The following reflects the ranking by participants in order of importance:

1. Strengthening and improving primary care
2. Accessing the right services, in the right place, at the right time, by the right provider
3. Preventing and managing chronic illness
4. Building linkages across the continuum - seniors and adults with complex needs

**Public and Provider Engagement Events:** Feedback on the draft priorities included a number of themes, resulting from 68 forums held with the public, provider, mental health and addictions, Deaf, Francophone, Aboriginal and First Nation communities.

- *Response to priorities:* overall, participants responded positively to the priorities, and shared numerous experiences to support the need for action in these areas. The integration priority identified as the most important varied from community to community, and many participants pointed out the inter-connectedness of the priorities. Key issues included:
  - *Availability of primary health care:* a consistent theme among providers and the public alike was a shortage of family physicians across the South West.

- 
- *Challenges of access:* a full range of accessibility issues were discussed including availability of services, wait times, cultural sensitivity, and unique challenges of those with mental health conditions. Factors influencing access included health human resources, information and education, and the current culture of the health care system itself.
  - *Success factors:* participants included better information and information management, partnerships with other ministries and levels of government, a clear understanding of geographic differences across the South West LHIN, availability of funding and accountability of the LHIN as key factors for success.
  - *Omissions:* participants voiced concern that children and youth were not included in the draft; some also suggested that mental health and addictions needed a distinct priority focus.
  - *Strengths to build on:* numerous examples of successful initiatives and programs were given by providers from across the South West LHIN. The public, too, highlighted the strengths of their communities on which to build a stronger, more effective health system. Some examples included:
    - *Local solutions and expertise* – numerous innovative programs and practices were cited that linked providers and enabled a seamless experience for patients and clients. Examples ranged from regional networks to informal local volunteer programs, and from paediatric programs to end-of-life committees.
    - *The commitment of volunteers* – volunteers in many communities currently “fill the gaps” in the health care system. These people are valuable resources and need to be supported.
    - *The role of people in the community* – people from local communities need to be actively involved and keep themselves and their communities informed about developments in the health care system. Individuals can also play a role by taking responsibility for their own health, adopting healthy lifestyles, and volunteering.
  - *Challenges moving forward:* key challenges identified were cross ministerial partnerships, equitable distribution of funds, capacity and resources, barriers to access, transportation, cultural issues and system complexity.

## The Conversation Continues

Community engagement to develop the IHSP was the first step in an ongoing conversation between the South West LHIN and its partners. The LHIN Board and leadership have been actively engaging municipal and community leaders, and will continue to maintain and enrich these relationships. Providers themselves have also been active in communicating information about the South West LHIN and the draft IHSP, creating a powerful “ripple effect” of dialogue that reaches far beyond the work of the LHIN.



## PART IV: LHIN PRIORITIES FOR CHANGE

This initial IHSP will be a foundational plan, setting key priorities and strategic directions for 2006-2007 and beyond. These priorities and strategies will be a direct response to the issues identified through community engagement and build on many of the strengths and successes already achieved by partners in our communities.

### 4.1 LOCAL OPPORTUNITIES AND CHALLENGES

Community input and the analysis outlined in the environmental scan have highlighted several consistent themes that have shaped the development of the IHSP. These themes have been drivers for development of the South West LHIN's priorities and will set the context for our goals and performance targets:

**Factors Affecting Access:** The geography of the South West LHIN includes a unique mix of urban and rural settings, each posing distinct opportunities and challenges for delivering health care services. In rural communities, we need to consider transportation and demographic issues in our planning, while providers in larger centres need support to balance services provided to people in their local communities as well as those traveling from outlying areas. Many other factors must be considered, including issues facing marginalized populations and those with challenges accessing services because of language or cultural barriers.

**An Aging Population:** The South West LHIN has a high proportion of seniors, particularly in the northern areas where one quarter of the population is expected to be over the age of 65 by 2018. Many of these seniors are healthy and active, and contribute to the vitality of the local system through their volunteer work and community participation. However, the health needs of our aging population will become more significant, so we must plan to provide them with effective support. We also need to consider the capacity of our current health system to meet an increase in the demand for services, and develop innovative strategies to minimize the need for acute care and support people to remain within the community setting longer.

**Primary Health Care:** One of the biggest concerns of communities today is the shortage of primary health care providers – a critical access point to the health system. These practitioners are central to prevention initiatives, management of chronic disease, and accessibility of more specialized services. We need to support attraction and retention of the next generation of primary health care providers, and consider opportunities for linkages, knowledge sharing and improved information management. Interdisciplinary teams of physicians and other service providers offer an opportunity to renew and

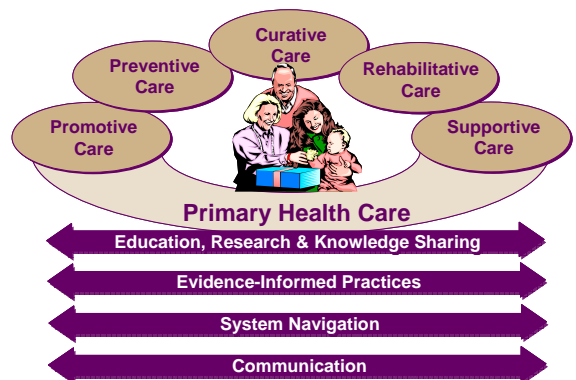
enhance primary health care, and the South West LHIN is fortunate to have 15 new Family Health Teams and three Community Health Centres under development. These new organizations have the potential to create a strong service base in many communities; however they are just getting underway and will need continued support from the LHIN and its partners.

**Supporting the People Who Make it Happen:** Health human resources encompass a range of issues including education and training of new health professionals, recruitment and retention strategies, and opportunities for ongoing professional development for those already in the system. It also includes broader workforce issues such as morale, workload, and work/life balance. The South West LHIN will need to work closely with the Ministry of Health and Long-Term Care to develop a better understanding of human resource supply and demand issues and work with providers and academic partners to ensure that communities across the South West can attract the next generation of health providers.

**Information Management/ Information Technology:** 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. There are numerous examples of successful information sharing initiatives and electronic record systems in the South West LHIN; however approaches often differ between providers, sectors and communities. We must identify ways to support integration initiatives with innovative approaches to information management, and ensure a comprehensive strategy across the South West LHIN.


## 4.2 LOCAL INTEGRATION PRIORITIES OVERVIEW

No single organization can or does provide the entire spectrum of services required by an individual. Therefore, the South West LHIN's priorities must span across traditional organizational and sector boundaries with a focus on people, not on services. The "continuum of care" diagram depicted here illustrates the range of services accessed by people throughout their lives – from cradle to grave.



### Continuum of Care

The components of the continuum of care focus on types of care provided rather than on the setting within which the care is provided. The continuum of care approach allows us to focus on a particular



population such as mothers and babies, children and youth, adults or seniors to examine the services available as well as the unique challenges of delivering and accessing quality care. The continuum will focus on ensuring that the right provider is providing the right service at the right place at the right time to achieve a sustainable system.

**Primary Health Care** serves a dual function in the health care system, providing first-contact services as well as a coordination function to ensure continuity and ease of movement across the system. Primary health care is the foundation for the continuum of care, which is comprised of five key components:


**Promotive Care:** “Health promotion is the process of enabling people to increase control over, and to improve, their health” (World Health Organization, 1996). The focus is on strengthening people’s skills and capabilities to enable them to make decisions about healthy choices and lifestyle. Access to education and information is necessary for both individuals and the community to participate in decision making. In addition, there must be a focus on modifying social, environmental and economic conditions to alleviate their impact on health.

**Preventive Care:** Disease prevention includes measures that prevent the occurrence of disease, or stop the progress and reduce the consequences once a disease is established. Primary prevention is directed towards avoiding the initial occurrence of a disease. Secondary and tertiary prevention seek to stop or slow existing disease and its effects through early detection and appropriate treatment; or to reduce the risk of a relapse or the onset of a chronic condition. Disease prevention is sometimes used as a complementary term to health promotion. Although there is frequent overlap between the two concepts, disease prevention typically refers to the action taken by health sector providers to support individuals or populations that are exhibiting risk factors.

**Curative Care:** Curative care is episodic in nature and focuses on services aimed at relieving symptoms of an illness or injury, reducing the severity, or protecting against exacerbation and complications that could threaten life or normal function.

**Rehabilitative Care:** Rehabilitative care focuses on improving functional levels for people who have had a recent illness or injury, or have a chronic condition. This may include instances when a person’s disease or impairment occurred in the past or has not been previously addressed. Rehabilitative care can be provided in the hospital, in the community or in a person’s home. It also plays an important role in both prevention and reactivation after an illness or hospital stay.

**Supportive Care:** Supportive care is an umbrella term that covers a wide range of services, provided by a wide range of individuals and organizations. These services include self-help and peer support, the provision of information and education, psychological support and therapy, pain and symptom control, social support, rehabilitation, complementary therapies, spiritual support, palliative care and bereavement care. Supportive care focuses on providing the necessary services, as defined by those living with or affected by a condition or illness, in order to meet their physical,



informational, emotional, psychological, social, spiritual, and practical needs during the pre-diagnostic, diagnostic, treatment and follow-up phases.

The focus on supporting **individuals and their families** is central to the continuum of care concept and recognizes the important role that individuals and families play as health care partners. Self-care refers to the decisions and actions taken by people to maintain and improve their health. Supporting self-care includes supporting the person (conveying acceptance, listening, etc.), sharing knowledge, facilitating learning and personal development, helping the person build support networks and providing a supportive environment. An effective continuum of care will include strategies that support self-care and enable individuals and their families to take responsibility for and participate in making decisions about their health.

The following four supporting themes are key elements of an effective continuum of care:

- Education, Research and Knowledge Sharing;
- Evidence-Informed Practices;
- System Navigation; and
- Communication.

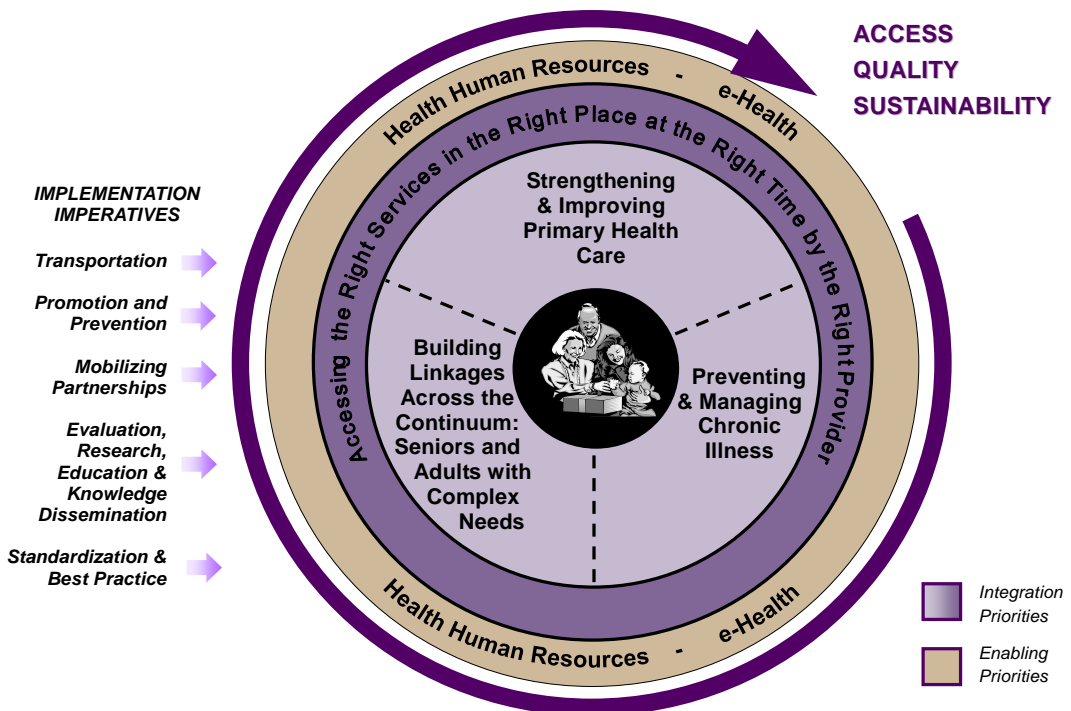
To achieve a truly integrated and seamless continuum of care that provides easy access and movement through the system, providers across the continuum will need to embrace a focus on life-long education and continuous service delivery improvement. Results from research and ongoing evaluation will translate into evidence-informed practices that require dissemination through knowledge sharing across all providers. The application of evidence-informed practice through knowledge transfer will result in behavioural change in service delivery that will have a direct impact on health outcomes. For individuals with complex health needs, the development of an enhanced care coordination role will result in better care management and system navigation. To achieve the significant benefits of this continuum of care, we must enhance communication among providers and consumers to ensure a consistent level of care across the system and a seamless experience for the consumer.

### **Overview of Priorities**

Based on our understanding of local issues and opportunities within the South West, four (4) integration and two (2) enabling priorities have been identified to guide the activities of the South West LHIN for the next three years (see illustration, next page). Given the complexity of our health care system and the challenges associated with the implementation of integration strategies, it is not surprising that the six priorities do not reflect independent areas of focus. Rather, there are major interdependencies among the priorities that will require a great deal of coordination and collaboration as the detailed planning and system design work proceeds.

For example, among our **Integration Priorities**, our efforts to **Strengthen and Improve Primary Health Care** will focus on developing Family Health Teams and Community Health Centres, while strengthening linkages among all primary care providers to ensure access to the **Right Services, in the Right Place, at the Right Time, by the Right Provider** for all residents of the South West LHIN. **Enabling Priorities** reflect areas that are critical to success. The development and implementation of a comprehensive e-health strategy as well as a coordinated health human resources approach will be necessary to enable each of the integration priorities, ensure sustainability of our system, and help us achieve the outcomes that are desired for our population and our health system.

Several **Implementation Imperatives** have also been identified for the South West. These “imperatives” represent key issues to be considered or addressed through the detailed planning and implementation related to all integration priorities. These imperatives reflect strengths that we can build on within our LHIN (e.g., academic health sciences) or challenges that will need to be overcome as we continue our integration journey (e.g., transportation). These imperatives are highlighted in the illustration below.



## 4.2.1 Strengthening and Improving Primary Health Care

### DESCRIPTION

Evidence suggests that having a strong primary health care infrastructure in place locally can improve population-level health status. Strengthening and improving access to primary health care services through better integration and coordination is therefore a fundamental component of an integrated health system in the South West.

A successful primary health care system would endeavour to provide equitable care as close to home as possible and would employ a variety of strategies including:

- Strengthening innovative and flexible primary health care service delivery models;
- Integrating and coordinating services across sectors to assist physicians to effectively support their patients;
- Making use of clinical care pathways that maximize existing evidence-informed practices and establish standardized processes;
- Developing transition strategies to address the needs of aging or retiring physicians; and
- Exploiting tools for knowledge sharing such as telemedicine, e-health, community health information networks, and video-conferencing.

Several Family Health Teams (FHTs) and Community Health Centres (CHCs) have been launched in the South West, offering a new model for interdisciplinary cooperation and a hub for innovations in service delivery locally. However, to achieve its goals for an integrated local health system, the South West LHIN and its partners will need to support primary health care professionals across the spectrum, including family doctors in traditional practices as well as nurses, nurse practitioners, pharmacists, dietitians, social workers and others working in the community. The South West LHIN will also need to consider transition strategies to address the needs of aging or retiring physicians and their communities.

### WHAT OUR DATA TELLS US

- Physician supply in all parts of the South West except Grey and Middlesex Counties is lower than the provincial average. The Ontario Under-served Area Program supports the need for additional family physicians in each geographic area (based on 2004 data).
- Provincial measures to determine access to primary health care include emergency room visits for non-urgent care and the number of practitioners per 1000 residents:
  - Hospitals in the South West ranked 3<sup>rd</sup> highest in the proportion of emergency room visits classified as less-urgent or non-urgent (65%);
  - As of 2004 there were 743 family physicians, slightly below the provincial average; and
  - People suffering from mental illness and addictions have been identified as “at risk” and their level of acute care utilization is high compared to the provincial average.

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## WHAT WE HEARD THROUGH COMMUNITY ENGAGEMENT

### *Obstacles to Overcome*

- Involving and engaging physicians, as they are not directly accountable to the LHIN
- Funding and compensation structures do not currently provide incentives to collaborate or focus on health promotion
- Need for cultural change among all health service providers
- The capacity of the current system and the need to appropriately educate and recruit the next generation
- Shortages of primary care providers in many areas means workload and recruitment challenges
- Lack of a strong technology infrastructure, or in its absence, common communications practices

### *Strengths to Build On*

- Development of Family Health Teams and Community Health Centres
- Strong and active volunteer networks (although the numbers are declining)
- Use of nurse practitioners, such as the “no physician clinic” in Goderich
- Team-based practices in communities such as Strathroy
- End-of-Life programs within the South West LHIN
- Grey Bruce’s mental health model for intake and prioritizing the needs of individuals with mild to serious mental illness

## 4.2.2 Preventing and Managing Chronic Illness

### DESCRIPTION

While Canadians enjoy relatively good health with one of the highest life expectancies in the world, we have a comparatively high burden of chronic diseases. In Ontario, the economic burden of chronic disease is estimated at 55% of total direct and indirect health costs.

Chronic Disease Prevention and Management is a proactive approach that seeks to treat patients sooner, closer to home and earlier in the course of the disease. Effective chronic disease management requires a shift in thinking toward health promotion, and will need the commitment of the South West LHIN and all of its health partners, particularly primary health care and community health partners. Key components of disease management include an emphasis on health promotion and illness prevention, and use of evidence-based clinical guidelines.

Mental illness has been associated with chronic disease, and evidence indicates that the more serious the medical condition, the more likely it is that a patient will experience a mental illness. Furthermore, mental illness left untreated results in decreased functional abilities, increased morbidity and mortality and increased health care costs.

**Chronic Disease Framework:** The South West LHIN will adopt Ontario’s framework for chronic disease, which puts an emphasis on productive relationships across providers and seamless coordinated care. Central to the framework are two concepts:

- **Integration:** as the model depicts, integration of all the traditional health care silos and broader

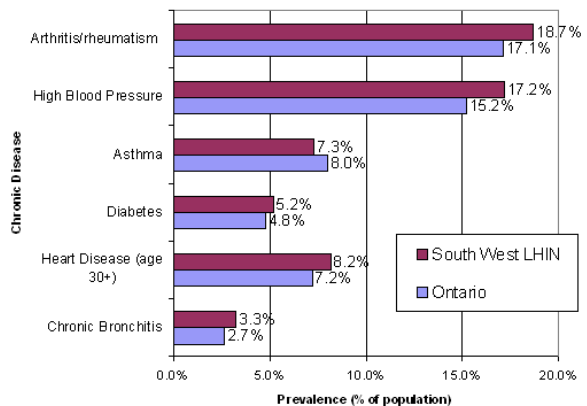
community results in shared responsibility and accountability for patient outcomes; and

- **Case management:** collaborative, client-driven strategies enable the provision of quality health and support services. The spectrum of case management spans from self-care support, to assisted care, to intensive case management.

Implementation of the framework in the South West will leverage those who have already initiated a chronic disease prevention and management program aimed at improving health outcomes, enabling long-term support of consumers and fostering adoption of best practice approaches by health care practitioners.

### WHAT OUR DATA TELLS US

- The South West has one of the highest incidences of chronic illness in the province.
- Mental health conditions often accompany physical chronic conditions. People with diabetes are two times as likely to have depression as the general population.
- Compared to the province, the South West has more people who are obese and smoke daily.



### WHAT WE HEARD THROUGH COMMUNITY ENGAGEMENT

#### *Obstacles to Overcome*

- Challenge to “get the message out” through extensive communications planning
- The need for behavioral and cultural change by both consumers and providers
- Challenges of monitoring and measuring success
- Complexity, in terms of dual diagnosis or concurrent disorders, as well as partnership and collaboration
- Barriers to access for “hard to reach” or marginalized people who often need the services most
- Lack of inter-sectoral collaboration, and collaboration across ministries or levels of government
- Human resource issues in many communities, including staff shortages and workload issues

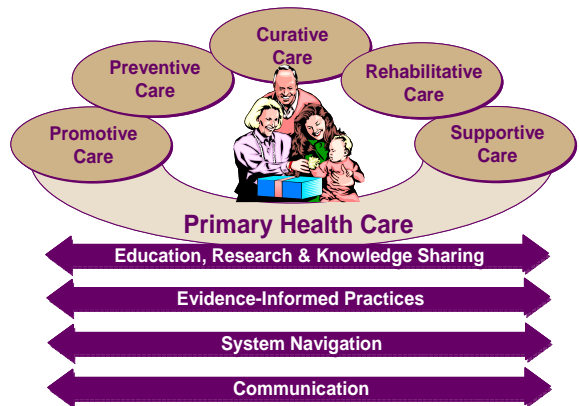
#### *Strengths to Build On*

- Established provincial model, and many examples from other jurisdictions (e.g. the Calgary model, initiatives in Northern Ontario)
- Several initiatives already underway in the South West including the Grey Bruce CDPM model, school programs, “PRIISME” program for diabetes education (private sector funded), SmartRisk.com, Cardiac Rehabilitation Programs
- Opportunities for partnership with Public Health Units, schools, business leaders to support prevention and health promotion, and workplace health and safety

### 4.2.3 Building Linkages across the Continuum – All Seniors, and Adults with Complex Needs

#### DESCRIPTION

Seniors and adults with complex needs represent a growing population in the South West. To ensure that consumers can move through the system easily, service providers across the continuum must work collaboratively to achieve the optimal health outcomes for that population. There must be a sense of shared responsibility for population outcomes. If certain targets are not achieved, then providers must collectively determine appropriate responses to obtain improvement. This requires a fundamentally different way of working together. To build effective linkages across the continuum, we must recognize past achievements and apply them broadly. An example is the work of the South Western Ontario Geriatric Assessment Network.



**The Continuum of Care:** The “continuum of care” approach allows us to focus on the health of a population - seniors and adults with complex needs - rather than on individual providers of service. Working in concert, community, primary health care, secondary and tertiary services can support consumers to make informed and responsible choices around decisions involving their health, with an emphasis on health promotion.

**Integrated Service Delivery Model:** To establish an integrated continuum of care, we will need to address the building blocks of an integrated service delivery model for the target population – seniors and adults with complex needs. This will include vision and approach, points of access and entry, scope of services, and information flows across the continuum.

#### WHAT OUR DATA TELLS US

- The proportion of seniors in the South West is higher than the provincial average, ranging from 13.7% in the South to as high as 17.9% in the North. It is estimated that the population of people over the age of 65 will increase by approximately 43% by 2018.
- Evidence from across the province suggests that this population utilizes significantly more services, over 50%, even though it represents only 14.4% of the total population.
- The South West currently has 74 Long-Term Care homes, occupancy rates are at or near 100%, the South West LHIN ranks 7<sup>th</sup> and exceeds the provincial average for the median time to placement to a long term care home for individuals residing in the community or an acute care setting;
- It has been suggested that there has been an increase in avoidable admissions to long term care homes, especially among clients under 65.

## WHAT WE HEARD THROUGH COMMUNITY ENGAGEMENT

### *Obstacles to Overcome*

- Coordination and integration of the flow of information among providers
- Confusion felt by many people trying to access community services; geographic differences
- Shortage of people providing support in the community, including volunteers and caregivers
- Shortage of appropriate care beds in many communities
- Transportation issues and barriers to access resulting from travel requirements
- Mental health issues among the seniors population
- Need for better informed providers and public on what services are available

### *Strengths to Build On*

- Transition units at long-term care homes that prevent unnecessary admissions to acute care and facilitate early discharge
- Current case managers in the system (e.g., CCACs), many of whom would welcome an expanded role as system navigators
- Hospice volunteer services and local palliative care committees
- Volunteer transportation networks
- Public Health Unit's work on falls prevention
- End-of-Life programs across the LHIN
- CCAC seniors directory of services
- Cancer care and regional stroke strategies to coordinate services

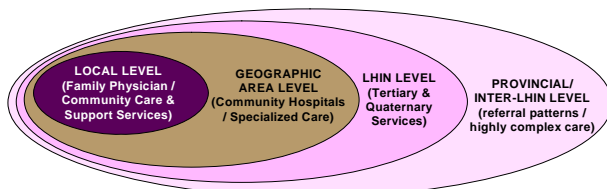
### 4.2.4 Accessing the Right Services, in the Right Place, at the Right Time, by the Right Provider

#### DESCRIPTION

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 services “in the right place, at the right time, and by the right provider” at all stages of the lifecycle, we need to 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. Planning for the appropriate mix of services available locally also involves a range of clinical factors to ensure that quality care can be delivered safely and effectively.

**Geographic Diversity:** A significant factor influencing access to health care is the geographic diversity of the South West and the distances often traveled from rural and remote communities. The LHIN and its provider partners will be challenged to identify innovative solutions to address some of the underlying problems such as health human resources, and technology and knowledge sharing across the network. Strong partnerships will be necessary to link rural and urban communities and support rural community providers with access to specialized resources.

**Marginalized Populations:** A number of factors may influence consumers' ability to navigate health services,



including language and culture, age, availability of transportation and social support services in the community. Many communities, such as newcomers, Aboriginal peoples, Francophones and other non-English speaking people have unique challenges accessing health care regardless of where they live.

**Access to Services Across the Continuum of Care:** There is often a narrower range of services available in rural areas, and community agencies and hospitals face distinct cost pressures. LHIN-level providers play a dual role, balancing the need to deliver services to their local communities as well as providing tertiary care to the entire network and beyond.

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.

#### WHAT OUR DATA TELLS US

- Health service providers tend to be concentrated in the South and Central areas, particularly in the London area.
- Several rural communities are “under-serviced” and many face an aging population of health professionals.
- Rural communities have a higher percentage of seniors, and a higher percentage of families living below the poverty line. While London as a whole, rates better on many indicators, individual neighbourhoods show disparities in socio-economic and health status.
- The proportion of people with chronic conditions is higher than the provincial average.

#### WHAT WE HEARD THROUGH COMMUNITY ENGAGEMENT

##### *Obstacles to Overcome*

- Transportation, particularly for rural communities
- Availability of services in rural communities and unique challenges facing community service providers in these areas
- Far-reaching implications of human resource challenges; need for change in education, training and recruitment approaches
- ‘Competition’ among providers
- Keeping providers and the public informed on what services are available and how to access them
- Challenges to access related to culture, language or special needs (e.g.: Deaf community)

##### *Strengths to Build On*

- Value of current networks as a source of expertise and an opportunity to share knowledge/ practices
- Huron Perth Non-emergency Transport Working Group
- Nurse practitioner programs create additional access points in the system
- Grey Bruce Care Pathways program for Hips and Knees Network
- CCAC information and referral database
- Cancer Care Ontario’s regional care strategy
- Ontario Breast Screening Program (Listowel) enables navigation, uses video-care and involves allied health professionals

## 4.2.5 Enabling Priorities: e-Health and Health Human Resources

### E-HEALTH

One of the fundamental enablers to health care integration is the ability for information to be exchanged between providers and consumers across the health care continuum. The South West LHIN has already begun with numerous initiatives ranging from laboratory information systems, to video-care, to thehealthline.ca. To further this work the South West LHIN has established an e-Health Steering Committee, with a mandate to establish a LHIN-wide strategic plan for e-Health that aligns to the provincial e-Health strategy and supports implementation of the South West LHIN's IHSP.

E-HEALTH STRATEGY		
Business Strategy	Information Strategy	Technology Strategy
<ul style="list-style-type: none"> <li>Improving population health outcomes</li> <li>Improving patient health outcomes</li> <li>Improving health system performance</li> <li>Improving service provider efficiency</li> </ul>	<ul style="list-style-type: none"> <li>Information for health management</li> <li>Information for system management</li> <li>Health information quality</li> <li>Health information standards</li> </ul>	<ul style="list-style-type: none"> <li>Provincial &amp; regional e-health technology</li> <li>Inter-Provider e-health technology</li> <li>Intra-Provider e-health technology</li> <li>e-health technology standards</li> </ul>

#### **What we know:**

- A 2005 Electronic Health Record Readiness Survey found significant variation between hospitals;
- The South West LHIN ranked above the provincial average on all indicators, and highest among LHINs on interoperability between organizations.
- Most hospitals report EHR capability gaps and data on community organizations is limited
- Providers highlighted the need for better information technology as a critical success factor for integration:
  - *"1 Patient, 1 Record"*, with a focus on sharing information across the continuum of care;
  - *A comprehensive e-health strategy* across the LHIN ; and
  - *A focus on cross-sector linkages* to enable community providers to connect to existing hospital initiatives.

#### **Actions going forward:**

The Steering Committee is working toward enabling integration across the South West LHIN through supporting the development of the e-Health plan. Key activities will include:

- Performing an environmental scan to identify current e-Health initiatives at area, provincial, and national levels;
- Facilitating broad community engagement;
- Carrying out an assessment of present and future e-Health services and initiatives within the province and determining how these will likely affect Strategic Priorities;
- Documenting the principles that will be used to make decisions and measure the effective development and delivery of e-Health in the South West LHIN;
- Defining a detailed implementation plan to achieve the objectives; and
- Supporting implementation and monitoring progress against objectives.



## HEALTH HUMAN RESOURCES

The ability to provide access to high-quality, safe and effective patient-centred health services is dependent on having the right mix of health care providers with the right skills in the right place at the right time.<sup>1</sup> Achieving and maintaining the appropriate mix of health care workers and volunteers will be critical to the successful implementation of the LHIN's integration priorities, and development of an integrated health system in the South West.

The Ministry of Health and Long-Term Care plays a primary role in planning for health human resources, as coordination is needed across academic institutions for educating future graduates. However, ensuring a sufficient supply of health care workers in the South West will require innovative strategies at all levels – provincially, within the LHIN, and locally. The South West LHIN will need to take an active role in creating an environment that attracts and retains new primary health care and specialized physicians, nurses and allied health professionals. While a comprehensive health human resources strategy will require provincial coordination, the South West LHIN must be proactive to:

- Support provincial initiatives and work with the Ministry to understand local needs and supply issues;
- Foster academic involvement in detailed planning and implementation of the South West LHIN priorities;
- Enable local integration initiatives by facilitating health human resources advisory support; and
- Build better linkages among academic leaders and providers across the South West LHIN.

### **What we know:**

- Several indicators suggest that there is a shortage of family physicians, and many communities are under-served, particularly in rural areas. However, further analysis is needed to fully understand the nature of the human resources supply, both in primary health care and across specialized services.
- Provider participants identified human resources as *a top priority in the South West*, referencing challenges in *recruitment and retention* of health care professionals. They posed the question “*How do we continue to attract health care professionals to the South West, particularly rural communities?*”
- Inter-professional training will be a key ingredient to success in the future as the use of a team approach within primary health care becomes more broadly adopted.

### **Actions going forward:**

- Establish a Human Resource Advisory Group (including representatives from the Academic Health Centres and cross-sectoral leaders in Human Resources) to support implementation of all integration priorities;
- Foster academic involvement and build linkages among academic leaders and providers with the support of the South Western Ontario Academic Liaison Group; and
- Determine the unique needs of the South West LHIN with respect to professional education and training.

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<sup>1</sup> *Health Human Resources Action Plan - Status Report, Government of Canada, December 2005*



### **4.3 IMPLEMENTATION IMPERATIVES**

In addition to the priorities described above, community engagement participants pointed to a number of strategic imperatives that are critical for successful implementation. These imperatives reflect the unique strengths and challenges of the South West – the partnerships, knowledge and community support that are the foundation of the local health system. Each of these imperatives will need to be addressed as the LHIN develops and implements detailed strategies for the future.

#### **Transportation**

With a high proportion of residents living in rural and remote communities in the South West LHIN, transportation services are a significant factor in accessing services. Even in urban centres there are challenges for many populations to access affordable transportation. Informal volunteer networks play an important role in enabling access and maintaining the independence of seniors and those living with long-term disabilities. To improve access to services we will need to use our existing transportation systems more effectively, and find innovative ways to enhance them, through formal, informal, public and private arrangements.

#### **Promotion and Prevention**


It is estimated that 70% of diseases commonly seen in primary health care are preventable. Consequently, efforts to improve primary health care services while ensuring a focus on disease prevention, early detection and health promotion can have a significant impact on the health of South West LHIN residents by reducing the incidence of some types of illness and reducing the severity of related complications. A focus on disease prevention and wellness must span the full continuum of care and will require the involvement of public health and other non-health support services.

#### **Mobilizing Partnerships**

The South West LHIN has a number of successful networks (see Appendix I) and partnerships that allow for more coordinated and efficient use of health resources to meet the needs of the residents in their local communities. The partnerships in the South West LHIN will need to bridge geography, disciplines and health services (e.g., acute care; long-term care; home care), and include participation from all levels of government: local municipalities, neighbouring LHINs, the Ontario Ministry of Health and Long-Term Care, other provincial ministries, and the federal government (e.g., Health; Aboriginal Affairs). To strengthen partnerships strategies will be needed to enable participation across the LHIN including use of technologies such as video-conferencing.

#### **Evaluation, Academic Research, Education and Knowledge Dissemination**

Innovation is necessary if the South West LHIN is to deliver more integrated and coordinated health care to its communities. All levels of the system contribute to innovation – from local improvements to the care provided in local communities to medical breakthroughs and technology advancements at



the academic health sciences centres. The South West has demonstrated leadership in collaborative practices, but will need to continue to foster a culture of innovation in order to develop, test and evaluate local solutions. Equally important is the transfer of knowledge, as enhancements to health care delivery must be disseminated through effective communication vehicles as well as education and training programs.

### **Standardization and Best Practice**

Residents of the South West LHIN should be able to obtain the same quality of service regardless of where they receive care. Standard practices and consumer-focused health care pathways are two opportunities to achieve improvements in quality across the care continuum. Providers in the South West have stressed the need to maintain and enhance the quality of services and program standards locally, as well as among LHINs and at the provincial level. Leadership within the provider community is important to the development of the most effective care pathways that are supported by clinical evidence (e.g., improved outcomes); that are flexible enough to be applied in a variety of settings (e.g., urban and rural/remote); and that ensure quality is measurable and maintained at the highest possible level.



## PART V: CURRENT ACTIVITIES

### Achievements to Date

Since its inception, the South West LHIN has been working to establish a vibrant organization with strong links to its community and provider partners. Our goal has been to cultivate the strategic partnerships that will be the foundation of our strategies for change, and foster a culture of shared commitment and mutual respect. Our priority has been to:

- Promote understanding of the LHIN mandate and the responsibilities and expectations of all partners;
- Obtain input and recommendations on community needs, service gaps, and opportunities for integration; and
- Build and strengthen relationships throughout the South West LHIN to identify and develop integrated service delivery solutions.

Key initiatives of the South West LHIN included:

- **Development of the LHIN Board of Directors** including recruitment of three additional directors from within the community to ensure a full complement on the Board. The LHIN Board has been extremely active in community engagement and development of the initial Integrated Health Service Plan.
- **Extensive Community Engagement on the IHSP** including a Spring Forum attended by more than 425 service providers, 68 community engagement events, a telephone poll, and an online survey.
- **Establishment of a Strategic Advisory Group** to guide development of the IHSP, share expertise and experiences, and provide local interpretation on integration opportunities and priorities identified through community engagement.
- **Launch of the South West LHIN e-Health Steering Committee** with representative leadership from numerous clinical sectors and administrative areas across the LHIN. The mandate of the group is to establish a strategic plan for e-Health within the South West LHIN and to develop a governance model.
- **Launch of the Hips and Knees Quality, Utilization and Access Steering Committee** to increase capacity and strengthen components of the care continuum to reduce length of stay and improve patient outcomes; and guide development of a collaborative proposal among providers in our LHIN who are participating in the delivery of total hip and knee joint replacements.
- **Development of a Readiness Assessment on Chronic Disease Prevention and Management** which examines opportunities for implementation of a shared chronic disease framework.
- **Creation of a Performance Measurement Framework** which will guide monitoring and evaluation activities of the LHIN and enable development of specific outcomes and measures for integration priorities.
- **Support for the Critical Care Strategy** and other provincial initiatives.

## 2006 / 07 Activities

### LHIN Organization and Leadership

- Recruitment of staff to enable the South West LHIN to take on the full range of functions required to fulfill its mandate;
- Continue to develop a strong Board presence in the community and to establish appropriate Board committees to oversee the LHIN organization;
- Continue to develop Board governance; and
- Participate in and provide leadership to province-wide LHIN initiatives to ensure common approaches across LHINs and enable implementation of provincial priorities.

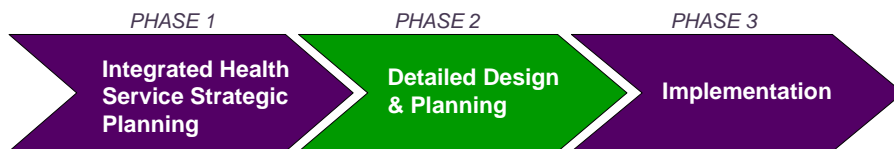
### Collaboration and Partnership

- Support the continued development of the Area Provider Table in the South;
- Engage existing networks and strengthen Area Provider Tables in each of the three geographic areas, to provide input into community engagement and support for IHSP implementation locally;
- Continue to support the work of Advisory Groups and Steering Committees to support local and provincial priorities; and
- Work with neighbouring LHINs to identify opportunities to share knowledge and ensure that residents can continue to move seamlessly across boundaries.

## Actions Going Forward


### Detailed Planning and Implementation by Priority Action Teams

For each integration priority, the South West LHIN has identified an overall goal, specific action objectives, and high level deliverables for the next 1-3 years (see Appendix H). For each of the 12 action objectives, a Priority Action Team will be established with expertise from across the LHIN to support detailed planning, define an implementation strategy, and establish performance and outcome measures.



- Detailed environmental scan
- Focused community engagement
- Options development & selection
- Strategic Implementation plan
- Implementation project plan
- Performance monitoring

**\*\* Integration Management Methodology** courtesy of PricewaterhouseCoopers LLP, Research and Health Promotion Practice, Advisory Services, 2006



Priority Action Teams will bring together partners from across the system that will play an active role in implementation. In each case, a selection process will be determined, and the charter and mandate of the group defined.

Three QUICK START Action Plans have been identified that will capitalize on the momentum of work already underway at the provincial level and move forward on “early win” opportunities for the South West:

- Implement a comprehensive chronic disease management program for individuals with diabetes, including those with mental health co-conditions, through a selected number of “pilot initiatives” across the South West LHIN.
- 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 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.

### **Opportunities for Back Office Integration**

“Back Office” functions are part of all organizations and typically include those administrative and support functions that are generally not accessible or visible to the customer or general public. For example, accounting, human resources, purchasing, materials management, and computer systems are often considered back office functions.

Several health service providers in the South West have benefited from having implemented integrated approaches to the delivery of back office functions. For example, in 1997 the London Hospitals established Healthcare Materials Management Services (HMMS) as a joint venture to integrate and consolidate the functions of purchasing, accounts payable, receiving and inventory management. A number of hospitals in the South West have partnered with HMMS to achieve the benefits of implementing a coordinated supply chain management approach.

The Senior Leadership of the South West LHIN and the leadership of HMMS have had preliminary discussions regarding opportunities to expand the HMMS partnership to include all hospitals within the South West. HMMS has initiated discussions with the other potential partners and is investigating the implications of this expansion for their operations. The achievements of HMMS provide an example of integration across hospitals. However, most of the back office functions currently provided by HMMS could also be coordinated among other health care providers along the continuum of care. Opportunities exist within the South West LHIN to work with providers and facilitate further progress towards improving coordination and efficiency of back office functions.



## PART VI: ACTION PLANS

### 6.1 STRENGTHENING AND IMPROVING PRIMARY HEALTH CARE

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

Family Health Teams and Community Health Centres have the potential to improve access to primary health care by more effectively coordinating the health professionals available within the community; however, these groups are at varying stages of development and many have not yet been established within their communities. Our focus will be to support and facilitate implementation of these teams with a full understanding of the current service offerings and ensure optimal service delivery within the communities identified for these new teams.

Many primary health care physicians and other providers will continue to practice independently or in smaller, less-integrated groups. Unlike primary health care reform models, traditional fee-for-service (FFS) physician practices will not have direct access to allied health staff. Consequently, linkages between physicians, their patients and other allied health care providers across sectors will require a concerted effort and significant leadership to ensure that residents of the LHIN receive equitable and enhanced primary care services from FFS physician offices.

**Action Objective #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.**

Primary health care providers are often the first point of access for those suffering from mental health and addiction conditions. The focus of this action plan will be to develop local delivery systems that leverage current partnerships but also create new partnerships to enhance coordination for early diagnosis and intervention, including:

- Identifying opportunities to create system improvements at the first point of entry into the health care system;
- Developing linkages across the different levels;
- Defining clear shared responsibility and accountability among service providers to ensure roles and responsibilities of providers are clear so that services delivered are effective, efficient, seamless, responsive and accountable; and
- Addressing special age-specific population recommendations.



## 6.2 PREVENTING AND MANAGING CHRONIC ILLNESS

***Action Objective #1: Develop and implement a comprehensive chronic disease prevention and management program across the South West LHIN.***

Using Ontario's Chronic Disease Prevention and Management (CDPM) framework, this action plan will support the design of a service delivery model with an emphasis on partnering and redefining organizational scope to enable effective community-based care for people with chronic disease. Recommendations will identify formal and informal arrangements or agreements that clarify leadership, membership, roles and responsibilities of all sectors within the health care team and social support network in order to provide effective chronic disease prevention and management.

The development of a CDPM service delivery model will:

- Make use of the academic health science centres as a resource to inform the health and social service community of leading practices within chronic disease prevention and management;
- Foster adoption of evidence-informed practice guidelines throughout the South West LHIN by disseminating new knowledge to the broader health and social service community;
- Identify opportunities for coordination in order to prevent the development of “disease silos”;
- Incorporate ongoing evaluation and a commitment to clinical and best practice improvement;
- Support healthcare providers to promote patient empowerment and the acquisition of self-management skills.

***Action Objective #2: QUICK START: Implement a comprehensive chronic disease management program for individuals with diabetes, including those with mental health co-conditions, through a selected number of “pilot initiatives” across the South West LHIN.***

A quick start program for diabetes will leverage existing work in the South West LHIN, across Canada and beyond. There is momentum, interest and initiative amongst the providers within the South West LHIN to more effectively support individuals with chronic disease. Building on this good work and applying the lessons learned by organizations such as the Canadian Home Care Association's National Home Care and Primary Health Care Partnership Project will allow providers and most importantly clients to experience positive results quickly.

At least one of the selected pilot initiatives should focus specifically on strategies to support diabetes patients with a co-morbid mental health condition. People with diabetes are more likely to suffer from depression, and this has been associated with poor adherence to medication regimens, greater complications of diabetes, increased numbers of emergency room visits, and poorer physical and mental functioning.



### 6.3 BUILDING LINKAGES ACROSS THE CONTINUUM: ALL SENIORS, AND ADULTS WITH COMPLEX NEEDS

**Action Objective #1: Develop and implement an integrated continuum of care for seniors and adults with complex needs which will build a foundation for continuum design for other populations.**

To ensure that people can move through the system easily, service providers across the continuum must work collaboratively to achieve the optimal health outcomes for that population. There must be a sense of shared responsibility for population outcomes. If certain targets are not achieved, then providers must collectively determine appropriate responses to obtain improvement. An integrated continuum of care should provide the context for the delivery of comprehensive health and community-based services, and recognize the good work by community and provider partners within the South West LHIN.

Care coordination is a key aspect of the service delivery model and reflects a global trend towards increased acknowledgement of the need to support clients/patients in navigating the health system. Therefore, there will be a need to develop an enhanced care coordination role that:


- Enables care management as the consumer moves across the entire continuum of care;
- Focuses on seniors and adults with complex needs; and
- Exhibits passion and depth of knowledge in complex needs and system navigation.

**Action Objective #2: Focus on rehabilitation across the continuum.**

Rehabilitation for seniors and adults with complex needs is often required as a preventative measure to enhance and maintain an individual's quality of life and as a reactivation measure after an acute episode. The availability of these types of services has a significant impact on the individual's ability to maintain or resume a functioning life style, and can help people to avoid or delay admittance to long-term care homes. Thus the focus of this action plan is to enhance rehabilitation services across the continuum of care for the specific target population – seniors and adults with complex needs.

**Action Objective #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.**

An effective integrated health system facilitates the delivery of care to people in the most appropriate setting for their needs. Long Term Care (LTC) services play a unique role in the health system for seniors and adults with complex needs who are no longer able to live independently in their own home. Within the South West LHIN there are significant challenges associated with timely placement



in Long-Term Care homes and there has been the suggestion that some placements occur because more appropriate alternatives are not available. Thus a full review and analysis is needed to better understand the demand for LTC home placement and any alternative approaches that could enable the system to provide the required services at the appropriate place and time. Strategies would then be developed to implement the recommendations.

#### **6.4 ACCESSING THE RIGHT SERVICES, IN THE RIGHT PLACE, AT THE RIGHT TIME, BY THE RIGHT PROVIDER**

***Action Objective #1: Improve the understanding of the availability of and access to health services for children and youth (pre-natal to 18 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.***


For many families caring for an ill child, it can be difficult to know what children's and youth's services are available and how to access them. Whether an illness is mild or acute, children and youth have unique needs that are often not fully met by a system geared to adults. Families and primary health care professionals need a better understanding of services at the community, secondary and tertiary levels, and providers need to improve their understanding of the needs of children and youth in order to identify and address service gaps.

Children and youth in hospitals are being treated for increasingly complex health issues, while the number of children and youth being treated in community settings is increasing. This change in service delivery has meant that paediatric health providers now work in smaller, community based organizations, and hospital providers are dealing with sicker children and youth. These changes have resulted in decreased access to education about evidenced-based treatment and best practices for community providers. Also, community hospitals lack a "critical mass" to offer educational programs.

***Action Objective #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.***

Coordination and efficiencies across the South West cannot be achieved without collaboration among provider partners and enabling systems to manage information and share knowledge. Consumers and providers alike need to know what services are available and how to access them - locally, within a geographic area, LHIN wide and across LHINs.

Strong linkages already exist between rural hospitals, specialized services and tertiary care centres.



However relationships with community partners are often less developed. Fostering these linkages and innovating to break down barriers will enable services to be delivered closer to home for consumers and their families. Pressure on the larger urban providers to deliver services that would be better situated in the community will also be reduced. To achieve its goals the South West LHIN will need a longer term outlook and a roadmap to build consensus on objectives, define a detailed plan and identify performance targets for access improvements.

**Action Objective #3: QUICK START: 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 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.**

The government of Ontario has a number of initiatives aimed at improving the delivery of health care, enabling coordination across the health system, and enhancing accountability of providers for health outcomes. Central to these initiatives is the Wait Time Strategy, which will hold providers accountable to reduce wait times with a focus on five key areas: cardiac procedures, cancer treatments, hip and knee and cataract surgery, MRIs and CT scans. Within the South West, organizations engaged in the Wait Time Strategy have begun to make significant advancements that are resulting in reduced wait times and system improvements. The LHIN is working with these providers to support local solutions that will reduce wait times, as well as other strategies to improve the quality of and access to care. Two targeted initiatives will provide the South West LHIN with valuable learning that can then be expanded to other areas:

- A. South West LHIN has formed a Steering Committee that is working collaboratively and on behalf of the South West to share local approaches and identify, prioritize and support the implementation of strategies to increase access to and decrease wait times for hip and knee total joint replacements.
- B. Critical care is a pivotal service that has the potential to “make or break” other hospital services. If critical care is not available, surgeries can be delayed or cancelled, and wait times for surgeries increased. The Ontario government is implementing a province-wide Critical Care Strategy aimed at improving access and quality, and creating better linkages across the system. A local Critical Care Strategy Group has been established in the South West to support this initiative by developing a profile of local issues, facilitating planning and enabling intra-hospital cooperation.



## 6.5 ENABLING PRIORITIES: HEALTH HUMAN RESOURCES

***Action Objective #1: Support implementation of all integration priorities with an improved understanding of health human resources issues across the South West LHIN.***

Implementation of the South West LHIN's integration priorities and achievement of an integrated service delivery model will require innovative approaches to human resources to overcome the challenges of the current environment. A wealth of expertise exists in the South West on education and training, retention and recruitment, among providers and academic leaders. The South West LHIN will play an important convening role to bring these resources together to provide critical input for the Priority Action Teams of each of its integration priorities. The South West LHIN Health Human Resources Advisory Group will be established to plan for integration priorities and provide expert advice on implementation.

***Action Objective #2: Foster academic involvement in implementation of integration priorities and build linkages between academic leaders and providers across the South West LHIN.***

A strategic goal of the South West LHIN is to enhance the academic health care culture across the South West and strengthen leadership in education, rural health research and the knowledge transfer to support service innovation. Academic health centres play a critical role in delivering specialized care to consumers, and are an important resource for innovation and information on leading practices across the health care system. Building better linkages between academic leaders and providers offers the potential not only to share these leading practices across the South West LHIN, but also to create opportunities for those in academic centres to learn first hand about providing services in community and rural settings.

The responsibility for training the future health professionals and health care workers rests with academic leaders and as such there will need to be a clear alignment between the strategic priorities and directions of our academic partners and the South West LHIN. The South West and Erie St. Clair LHINs (LHIN 1 and 2) have joined forces to create the South Western Ontario Academic Liaison Group in order to develop a shared understanding of priorities and approaches with respect to research and education. This group will meet regularly to discuss training and education issues arising from the work of the LHINs, and will contribute participants to the Health Human Resources Advisory Group of the South West LHIN.



## GLOSSARY

The following terms are used in the integrated health service plan. Technical terminology can be found at the end of Appendix D: Environmental Scan.

**Consumer:** the term is used to include patients, clients or user of the health care system.

**Providers:** all health care organizations, professionals and workers providing care within their communities. **Health Service Providers** that will be responsible to the LHIN include Hospitals, Community Care Access Centres (CCACs), Community Support Services, Mental Health Agencies, Addictions Agencies, Community Health Centres, and Long Term Care Homes.

**Partners:** includes providers and health consumers, health professionals, Family Health Teams, Public Health Units, and other partners such as university and colleges, and other community sectors partners (Housing, Environment, Education, Transportation, Judicial).

**Community:** our definition of community is broad and includes any collection of individuals that is tied together by geography, common characteristics or a shared interest.

**Community Engagement:** the process of working collaboratively with and through groups of people that have been brought together by geographic proximity, common characteristics, or a special interest in order to address issues affecting the well-being of their community.

**Quick Start:** Initiatives that the South West is already working on or areas where we have an opportunity to build on work already underway.

**Priority Action Teams:** Teams of providers, public and other partner representatives that will come together to complete the detailed design and implementation planning for the various IHSP action plans.

**Integration Priorities:** areas of focus to connect the different parts of the health care system to provide improved health care delivery.

**Enabling Priorities:** foundational elements that need to be in place to enable us to deliver on the integration goals that we've identified.

**Implementation Imperative:** represents a key issue to be considered or addressed through the detailed planning and implementation related to all integration priorities. These imperatives reflect strengths that we can build on within our LHIN or challenges that will need to be overcome as we continue our integration journey.



## **PART VII: APPENDICES**

**APPENDIX A: PROVINCIAL PRIORITIES**

**APPENDIX B: COMMUNITY ENGAGEMENT FRAMEWORK AND PLAN**

**APPENDIX C: SUMMARY OF COMMUNITY ENGAGEMENT ACTIVITIES**

**APPENDIX D: PERFORMANCE MANAGEMENT FRAMEWORK (*IN DEVELOPMENT*)**

**APPENDIX E: ENVIRONMENTAL SCAN**

**APPENDIX F: READINESS ASSESSMENTS**

**APPENDIX G: METHODOLOGY TO IDENTIFY INTEGRATION PRIORITIES**

**APPENDIX H: DETAILED INTEGRATION PRIORITY ACTION PLANS**

**APPENDIX I: SUMMARY OF SUBMISSIONS RECEIVED FROM CLINICAL AND  
POPULATION NETWORKS**