

Appendix A

Projects, Programs and Initiatives Related to Strategic Directions

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The following table provides a description of key projects, programs and initiatives that will advance the South West LHIN's strategic directions.

Project/ Program/ Initiative Name	Project/ Program/ Initiative Description	Enhancing Capacity and Integration of Primary, Specialized and Community-based Care, with a focus on the following populations:			Enhancing Access and Sustainability of Hospital-based Treatment and Care related to:		Key Enablers:		
		Seniors and adults with complex needs	People living with mental health and addiction challenges	People living with or at risk of chronic disease(s)	Emergency services	Medicine, surgical and critical care services	Multi-level system navigation	Information and clinical technology	Health human resources
Assisted Living in the Community	To provide a new model of supportive housing for people in their current home instead of needing to move to a supportive housing apartment. 24-hour, seven day per week availability of personal support services.	✓					✓		
Balance of Care Analysis	Collection and examination of InterRAI data for individuals who are waiting for long-term care home placement leading to an understanding of the best level of care required by people.	✓							
Benefits Realignment Project	Leveraging the power of group purchasing to achieve savings in the provision of employee benefits for participating hospitals in the South West LHIN.								✓
Build a system of interprofessional care for patients requiring long-term mechanical ventilation	To build a responsive system of interprofessional care and education (IPC/E), with clearly defined roles/processes, that extends outside of the walls of the intensive care units to effectively and safely transition longterm ventilation patients back to their communities, and ensure continuing care.	✓				✓	✓		✓
Career Network	Development of the South West LHIN Health Career portal through thehealthline.ca to support the establishment of a health human resources virtual network. The goal of the network will be to assist HSPs and local communities with their HHR recruitment efforts.								✓
Caregiver Connects	Provides any information, counselling support, and relief services required by caregivers.	✓		✓			✓	✓	✓
Centralized Access for complex continuing care beds	Current state analysis of the complex continuing care beds, creating admission and discharge criteria, gain an understanding of current access rules, and establish an optimal future model.	✓				✓	✓		

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Chronic disease self management phases 1, 2 and 3	Phase one involved development and implementation of a Self-management curriculum and toolkit for providers. Phase two involves developing self-management capacity throughout the South West LHIN using the Stanford model for chronic disease self-management and additional toolkit training sessions and development of a web-based community of practice for providers. Phase two also involves the development of a sustainability plan as an Aging At Home initiative. Phase three involves expansion of the self-management roll-out and implementing the sustainability plan.			✓			✓		
Common Desktop & Infrastructure (CDI)	As eHealth initiatives are identified and implemented it will be critical for health service providers to have adequate and compatible computer hardware and software. This will help expedite the implementation process. CDI will help identify the needs across the LHIN and create strategies to better position health service providers.							✓	
Common Order Sets	Physician orders trigger the engagement of multidisciplinary personnel, processes and systems to deliver and execute these orders. Common Order Sets will be the foundation for Computerized Physician Order Entry (CPOE) and will help ensure patients receive consistent care across the LHIN as clinicians use evidence based protocols for all patients.					✓	✓	✓	
Community Health Centre Development	Development of 3 CHCs: South East Grey CHC, Woodstock and area CHC, and Central CHC (Elgin)	✓	✓	✓			✓		✓
Community Stroke Rehab	To provide a team of rehabilitation specialists, across the South West LHIN, to assist individuals who have had a stroke to make further gains in their recovery after leaving the hospital so that they can continue to live independently.	✓		✓					
Community Support for ventilator dependent care	Supportive housing to provide support to alternate level of care (ALC) designated patients who are ventilator dependent.	✓		✓					
Community Support Services MIS Initiative	Provide assistance to community support service agencies to become compliant with Ontario Healthcare Reporting Standards.	✓	✓	✓				✓	

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Community Support Services Performance Indicator Project (phases 1 & 2)	Development of a robust performance measurement framework with standardized indicators for community support services (CSS) agencies in Southwestern Ontario in order to create stronger performance measurement tools for agency boards and staff; and help the South West LHIN to create performance indicators that can be used in the service accountability agreements for CSS agencies.	✓	✓	✓				✓	
Complex Continuing Care (CCC) and Rehabilitation Strategic Resources Study	The study summarized CCC and Rehab resources in the SW LHIN, described how they are used and identified potential opportunities (e.g., current practice) for their strategic use in the SW LHIN.	✓		✓			✓		
Diabetes Registry & e-Health Early Adopter	The Registry will serve as a tool to help people with diabetes and their care givers manage the disease better. The eHealth Portal will bring together an individual's health information from various clinical systems and provide a secure single access point for up-to-date information such as lab test results, drug history and diagnostic imaging reports.			✓				✓	
Emergency Neurosurgery Image Transfer System (ENITS)	The ENITS Shared PACS (ESP) project will provide an interim solution to improve patient access to care in the case of urgent head trauma. This is meant to be a short to mid term solution until full access to Provincial Diagnostic Imaging Repository (DI-r) is available. In cases where urgent neurosurgical consultation is required, a CT scan can be performed, and the images uploaded to a central PACS database in London. All 154 CT scanners across the province will be able to share information.				✓			✓	
Emergency/ Critical Care Strategy	The South West LHIN has a unique challenge of having a high number of 24/7 emergency departments but a lack of physicians and nurses available and willing to provide emergency department coverage. This project studies these issues in addition to implementing a dedicated Project Lead to help support the Emergency Department and associated Critical Care Strategies at the local LHIN level.				✓	✓			✓

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Enhancing Access to Team Based Care (Diabetes Strategy)	The LHIN will be working closely with the MOHLTC to implement the provincial Diabetes Strategy beginning with the goal of enhancing access to team based care for people with diabetes. A model for chronic disease prevention and management has been developed and includes components such as LHIN-wide and multi-community coordination along with the creation of "Centre's of Excellence"	✓	✓	✓			✓		✓
Expansion of FLO Collaborative – Improvement Advisors	The South West LHIN, over the past year, has supported two collaborative patient 'Flo' projects with Grey Bruce Health Services/CCAC and St. Thomas Elgin General Hospital/CCAC. This project focuses on expanding this collaborative and leveraging the expertise of the Improvement Advisors, as well as the experience and success of the teams to date, either at the original two sites, and/or into additional sites in the South West.	✓	✓	✓		✓	✓		
First Link™	First Link™ is a direct referral program that links the person with dementia and their family members/caregivers to coordinated learning, services and support from the point of diagnosis and throughout the continuum of the disease. The First Link™ program targets seniors "at risk" in the community due to the debilitating and isolating nature of the disease and associated stigma.	✓	✓	✓			✓		
GAIN CD Screener Training	LHIN-wide training on the Global Appraisal of Individual Needs – Short Screener (GAIN-SS), a tool to facilitate universal screening for concurrent disorders.		✓				✓	✓	
Geriatric Emergency Management (GEM)/Integrated Case Management Model	The fundamental goal of the GEM initiative is to improve health care delivery to seniors presenting in Emergency Departments. GEM nurses screen and assess elderly patients at high risk and coordinate further assessment, care and follow-up, serve as consultants and in some cases, direct caregivers for elderly patients as well as their advocates.	✓	✓	✓	✓		✓		
Grey Bruce Falls Prevention and Intervention Program	To provide a falls prevention program that screens seniors who are at risk of falling, that provides awareness and education, and provides exercise services to those at risk in their homes through the assistance of their personal support worker.	✓		✓			✓		
Health System Design (Blueprint Project)	The South West LHIN has undertaken a comprehensive planning process to establish a framework, the Blueprint, that would guide future decisions regarding the alignment of programs and services at a local, multi-community and LHIN-wide levels	✓	✓	✓	✓	✓	✓	✓	✓

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Hips and Knees Care Path/Guidelines/Education	This initiative has three main goals: to develop and implement an evidence based (or informed) guideline that can be used by Family Physicians to aid them in their decision making regarding when to refer a patient to an orthopaedic surgeon; to confirm and disseminate an in-hospital care path to hospitals and providers across the LHIN; and to develop and disseminate education tools to be provided to patients who need a joint replacement within our LHIN.					✓	✓		✓
Home at Last	A LHIN wide service that is being initiated in selected communities that offers seniors transportation and assistance to safely settle back home following a stay in hospital. Prescription pick-up, groceries, and banks are often destination points when transported home.	✓		✓			✓		
Huron Perth Mental Health TeleHomeCare	The Huron Perth Health Alliance TeleHomeCare Program will use communication and information technology to provide remote care and monitoring for mental health patients within the Huron Perth region.		✓					✓	
Improving cancer surgery wait times	Improving cancer surgery wait times by improving data quality and patient queuing practices			✓		✓			
Improving Services for Aboriginal Communities	Aboriginal Health Lead to build relationships with Aboriginal communities in both the South West and Erie St Clair LHIN to improve the coordination of working relationships	✓	✓	✓					
LHINs 1, 2, 3, 4 Diagnostic Image Repository (DI-r)	Provides access to diagnostic images from any hospital in LHINs 1, 2, 3 and 4 allowing for region-wide consultation	✓	✓	✓	✓	✓		✓	
LHIN-wide wound management initiative	Development of: an integrated wound care framework; an integrated education framework; and a sustainable structure for the selection of wound supplies and products	✓		✓		✓			
North-South Health Information Access Layer (HIAL) Connectivity Project	The North South HIAL Connectivity Project is the first phase of a larger implementation that will eventually create a platform for the development of the electronic health care record incorporating community and primary health care services. The first phase will establish a connection between the North (Grey Bruce Health Services) and South (Thames Valley, Exeter, Wingham/Listowel) to provide access to patient clinical data.	✓	✓	✓	✓	✓	✓	✓	

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Nurse Led Long-Term Care Outreach Program	This project builds on the South West CCAC / London Health Sciences Centre Advanced Home Care Team (AHCT). Nurse Practitioners (NPs) linked closely with area family physicians, provide service to clients with increased acuity to divert these clients from Emergency rooms and hospitals. This project allows the AHCT to expand to individuals who live in LTC homes.	✓		✓			✓		
ONE® Mail	E-mail that will allow health care professionals to send patient information quickly, confidently and securely between registered users	✓	✓	✓				✓	
Ontario Lab Information System (OLIS)	OLIS is an early step in moving the health system away from paper-based to electronic records. It has been built to electronically store test results from Ontario's medical laboratories, making them quickly available to authorized health care practitioners.	✓	✓	✓	✓	✓	✓	✓	
Paediatric complex care pilot project	Enhancing overnight support for medically fragile children through a technology based inter-disciplinary team approach.			✓				✓	✓
Partnerships for Health	Partnerships for Health is a demonstration project that puts the Ontario Chronic Disease Prevention and Management (CDPM) framework into practice through our work with adults with diabetes. The project hopes to show improvement in four key areas: developing partnerships; empowering patients; improving clinical outcomes; and, improving communication and information sharing through information technology. The project is central to both the eHealth and Diabetes Strategy implementations for our LHIN.	✓	✓	✓			✓	✓	✓
Program and services inventory	The Program and Service Inventory project is the first step in moving toward the vision of an online data repository with secure query and report capabilities. This project will produce a Microsoft Access database containing information on South West LHIN Health Service Providers. The information will then be accessed using standard Microsoft Access functionality.	✓	✓	✓	✓	✓	✓	✓	
Rapid Emergency Assessment for Community Transition (REACT)	To prevent inappropriately admitting this population to the hospital, this project mobilizes a multidisciplinary team of: advanced skills RN coordinator (team lead), social worker, pharmacist, physiotherapist, occupational therapist, respiratory therapist and CCAC case manager.	✓	✓	✓	✓		✓		
Residential Hospice Development	Development of residential hospices for terminally ill people in Grey and Bruce Counties, London, and Woodstock and area.	✓		✓					

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Safe at Home	A program that assists frail seniors through visits from a nurse practitioner, additional nursing and personal support visits to review medication, how the caregiver is coping, and to provide the medical and personal assistance to keep them safe and living independently in their home.	✓		✓			✓		
Share the Care	Share the Care is a detailed step-by step model that shows how to create a unique caregiver “family” from friends, relatives, neighbours, co-workers and acquaintances to pool their talents, time and resources to assist a friend or loved one facing a health or medical crisis.	✓		✓			✓		✓
Southwest Physician Office Interface to Regional EMR System (SPIRE)	This initiative allows Lab results, Diagnostic Imaging results and transcribed reports from the Cerner hospital information system in the Thames Valley Hospital Planning Partnership to be sent electronically to physician offices electronic medical records. Currently these results are sent by fax/mail/ telephone. This project mirrors the successful implementation in Grey Bruce.	✓	✓	✓	✓	✓	✓	✓	
Strengthening our Aboriginal communities	Continue the partnership between the South West LHIN and Erie St Clair LHIN to fund the Aboriginal Health Lead position for the remainder of 2009/10 and 2010/11.	✓	✓	✓					
Supply Chain Integration	The South West LHIN integrated Supply Chain Management (iSCM) Model will: strengthen supply chain leading practices; improve efficiencies and operations to generate cost savings through economies of scale; standardize products, services, suppliers, processes, forms, policies and procedures; achieve further innovation through automation and advanced technology; improve performance measurement, and create opportunity to leverage expertise and synergies. This iSCM Model will bring the remaining health care organizations (hospital first) in the South West LHIN into the region-wide strategy.					✓		✓	✓
Supportive Housing	Supportive housing to provide support to alternate level of care (ALC) designated patients who have significant physical disabilities.	✓		✓					

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Tier 2 & 3 Divestment	Working with the MOHLTC, LHIN and partners to facilitate Tier 2 divestment (transfer) of psychiatric beds and associated services by the Tier 1 receiving public hospital to other public hospitals, as directed by the HSRC. Tier 3, refers specifically to the transfer of non-bedded programs and services from Tier 1 and 2 receiving hospitals to community mental health agencies, where appropriate		✓				✓		✓
Transitional Care beds in hospital, long-term care homes and retirement homes	Creation of transitional care beds to assist people to move to a more appropriate level of care rather than remain in an acute care hospital bed when that level of care is no longer required. Includes partnership to facilitate the discharge process to the Transitional Care Unit in hospital or beds in long-term care homes and retirement homes.	✓		✓			✓		
Transportation Coordination	Improved coordination will be investigated and implemented through a variety of methods such as an updated inventory of resources, best practices and innovative solutions like centralized management and dispatch of existing vehicles	✓	✓	✓			✓	✓	
Wait Time Information System (WTIS)	Provincially driven wait time data collection includes hospital-based services				✓	✓		✓	
Wellness for Seniors	A collaborative effort to provide and standardize physical activity and wellness education for seniors.	✓		✓			✓		
Wrap Around for Immigrants and Francophone Community	The aim of this program is to create individualized supports for culturally diverse seniors through professionals and community members from those communities based on the unique needs of the senior.	✓	✓	✓			✓		