

South West Local Health Integration Network

Annual Business Plan 2016/17

June 21, 2016

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TRANSMITTAL LETTER

To: Tim Hadwen, Assistant Deputy Minister
Health System Accountability and Performance Division

Subject: South West Local Health Integration Network – Annual Business Plan, 2016/17

I am pleased to submit the South West LHIN's 2016/17 Annual Business Plan, which details our action plans and key activities for the coming fiscal year.

This plan clearly defines the actions the LHIN, in partnership with health service providers, will take to improve the health outcomes of the people and patients within local geographies. Because of the dedication of our health service providers, there have been many successes that have resulted in improvements to the health system. But there is more work to do.

As you know, over the past decade, Ontario's health care system has improved significantly with reduced hospital wait times, improved access to primary care, and more care for people at home. However, there are still a number of areas where we need to do more. To support continued improvements to our health care system, Ontario introduced the proposed *Patients First Act* on June 2, 2016, that, if passed, will enable the continued evolution of locally integrated patient-centred health care delivery.

This year marks the first year implementing our Integrated Health Service Plan (IHSP) 2016-19 that guides us not only in achieving the vision outlined in our *Health System Design Blueprint: Vision 2022*, but also in carrying out the structural changes that may be ahead. We will work with local system partners and our provincial partners to move health system renewal forward.

The IHSP identifies strategic directions and steps required to make our overall vision of an improved health system a reality. After extensive engagement with stakeholders, health service providers and the general public throughout 2015, we established seven priorities to enhance population health, experience of care and value for money in the South West.

The IHSP's initiatives and actions fully align with provincial priorities and supports Ontario's plan for transformational change for the health system as detailed in *Patients First: Ontario's Action Plan for Health Care*. The South West LHIN is also committed to working with the government in its proposed plan for structural reform as outlined in the discussion paper *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* and the recently introduced *Patients First Act* while ensuring the continued delivery of high quality care to the people in our LHIN.

The South West LHIN Board continues to meet regularly with health service provider governors and our communities to promote integration, service coordination and quality improvement. We also have a strong online presence that fosters dialogue, transparency and accountability with valued partners and community members. In working with the Ministry of Health and Long-Term Care and health service providers, we are ready and well-positioned to continue our efforts to improve health care in the South West LHIN and throughout

Ontario. We are committed to our strategic plan deliverables and the work that is needed to improve the health of our communities.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jeff Low', with a stylized, cursive script.

Jeff Low, Chair
South West LHIN Board of Directors

cc: Michael Barrett, CEO, South West LHIN

1.0 CONTEXT

1.1 Mandate of the South West LHIN

Across Ontario, Local Health Integration Networks (LHINs), along with health service providers and partners, have the important responsibility of transforming the health system to put patients, clients, residents and caregivers at the centre of the system.

As outlined in the “*Patients First: A Proposal to Strengthen Patient-Centred Health Care*” discussion paper and the proposed *Patients First Act*, the province is calling for structural reform across the system to improve access, and ensure equity for all people needing health care. LHINs are prepared to deliver on this commitment to innovative system change and plans to transform the system are well underway.

To help guide this transformation, all LHINs produce a three year plan for the local health system. The plan, called an Integrated Health Service Plan (IHSP), identifies key strategies, priorities and outcomes required to make our overall vision of an improved health system a reality. The plan sets out both our goals for the health system and the direction for all health service providers over the next three years.

The South West LHIN shares the provincial view of *better patient care through better value from our health care dollars*, outlined in *Patients First: Ontario’s Action Plan for Health Care*. Our mission is to bring people and organizations together to build a health system that balances quality, access and sustainability to achieve better health outcomes.

The South West LHIN is also guided by our long-range plan, the Health System Design Blueprint, which works towards achieving an integrated health system of care by 2022. Our LHIN has committed to the pursuit of three system-level goals:

- Population Health
- Experience of Care
- Value for Money

These goals, aligned with Ontario’s Action Plan for Health Care set the direction for development of the Integrated Health Service Plan (IHSP) 2016-19. The 2016/17 Annual Business Plan (ABP) marks the first year of our 2016-19 IHSP. Over the next year, the South West LHIN will continue to progress actions from the previous IHSP, while implementing new initiatives and strategies associated with our next three year plan for 2016-19 and the direction outlined in the proposed Patients First Act which, if passed, will enable the continued evolution of locally integrated patient-centred health care delivery

1.2 Goals of the Organization

The following goals and objectives have been identified for 2016/17:

1.0 Health System is Transformed

1.1 Provide leadership and direction to implement the proposed Patients First Act

1.2 Create sub regions to advance integration across all areas of the health system

- 1.3 Prepare for the integration of the operations and governance of the South West CCAC into the South West LHIN
- 1.4 Build stronger links to Population Health and Public Health Units
- 1.5 Integrate the planning and performance management of primary care into the South West LHIN
- 1.6 Advance the strategic directions of the 2016-2019 IHSP to create an integrated system for all
- 1.7 Engage and inform communities within the South West LHIN
- 1.8 Assist in the creation of an effective governance structure for the enhanced LHIN
- 1.9 Lead provincial health initiatives on behalf of the LHIN system
- 2.0 Enhanced LHIN is a high-performing workplace of choice
 - 2.1 Create a new organizational structure for the enhanced South West LHIN
 - 2.2 Engage staff effectively during the transformation process
- 3.0 Taxpayer has assurance of value for money
 - 3.1 Evaluate and improve health system performance
 - 3.2 Optimize resources

In addition to these goals and objectives, Appendix A describes the LHIN's current organizational development plan.

1.3 Our Context

The South West LHIN population receives services from an array of LHIN and non-LHIN funded organizations across the community, long-term care and acute health sectors. Residents rely on these organizations for a variety of needs including home/social support, episodic, chronic and long-term care.

The following LHIN-funded organizations play a critical role in delivering services to its residents:

- 20 hospital corporations (33 sites)
- 78 long-term care homes
- 5 community health centres
- 1 Community Care Access Centre (South West CCAC)
- 54 agencies provide community support services
- 14 agencies provide assisted living supportive housing services
- 24 agencies provide mental health services
- 10 agencies provide addictions services
- 3 agencies provide acquired brain injury services

In addition, non-LHIN funded organizations (such as family health teams, family health organizations, family health networks, solo-physician offices, public health units, emergency medical services and labs) play a critical role in the delivery of primary care services.

It is estimated that there are 850 primary care physicians and 66 primary care groups (e.g. family health teams, family health organizations, etc.) in the South West LHIN. While these services do not currently fall under the LHIN's mandate, we are actively working to understand and partner with primary care providers to advance integration and coordination across the health continuum and make improvements to the local system.

[An environmental scan was completed as part of IHSP 2016-19.](#)

1.4 Overview of 2016-2019 Integrated Health Service Plan

In developing the South West LHIN's IHSP for 2016 to 2019, we identified the need to use a clear and consistent organizing framework that will also be used in all future plans. This will ensure that progress towards our long-term vision for the health system can be tracked over time and clearly communicated to all partners.

Consistent with our vision – *A health system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren* – we adopted the Institute for Healthcare Improvement's Triple Aim framework. These themes have always been a part of our IHSPs and are present in many health care plans from jurisdictions around the world.¹ In fact our vision's three key components – population health, experience of care, and value for money – reflect the dimensions of the Triple Aim framework.

Our collective plan for 2016 to 2019 outlines the strategies and priority populations all organizations, sectors and networks will need to consider in their strategic and operational plans to collectively advance health system changes for the South West LHIN. The IHSP provides an overview of *Ontario's Patients First: Action Plan for Health Care*, the South West LHIN's vision and plan for the local health system, and details on how we demonstrate and measure success in the LHIN.

In alignment with provincial priorities, [the IHSP 2016-19 identifies priorities, strategies, initiatives and measures that work towards making key improvements over the three year period.](#)

The [IHSP system view](#) describes the pursuit of population health, experience of care, and value for money, advancing five implementation strategies with a focus on seven priorities to ensure an integrated system of care for all LHIN residents with an emphasis on the following populations:

- Aboriginal populations (*includes: people who identify with First Nations, Inuit and Métis communities.*)
- Francophone populations (*includes: those persons whose mother tongue is French, plus those whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home*)
- People who are frail and/or have medically complex conditions/disabilities (*includes: seniors and adults with complex needs at high risk for losing their independence or*

¹ Stiefel M, Nolan K. *A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. (Available on www.IHI.org)

experiencing functional decline, children and transitional age youth living with medical complexity, people living in long-term care homes and individuals approaching end of life)

- People living with mental health and/or addiction issues (*includes: people who experience mental health and/or addiction challenges such as depression, anxiety, schizophrenia, mood disorders, dementia, responsive behaviours, substance abuse, and those who experience homelessness and/or contact with the legal system due to their mental health and addiction challenges*)
- People living with or at risk of chronic disease(s) (*includes: people living with or at risk of one or more chronic diseases or conditions such as diabetes, arthritis, asthma, cancer, chronic obstructive pulmonary disease, high blood pressure, heart disease, and those who live with the effects of stroke*)

2.0 CORE CONTENT

2.1 IHSP Implementation Strategies

To succeed in transforming the health care system, all health service providers and the LHIN must share a collective plan of action. Appendix B summarizes the five implementation strategies, their associated plans of action and identifies the ways in which these implementation strategies will be executed to drive future system improvements.

Every quarter, LHIN staff will assess the progress of these plans of action over the 3-year timeline. This will inform part of the LHINs quarterly reporting to the Ministry, the LHIN Board and the public.

Simultaneously embedding the following key strategies in all the work we do together to implement provincial, LHIN wide, and priority initiatives will ensure we achieve our vision at a system level:

- **Health equity:** Consistently apply a Health equity lens to enable access to quality care.
- **eHealth and Technology:** Leverage and expand the use of eHealth technologies to access and exchange health information, inform effective decision making, and enhance “hands on” care.
- **Integration and Collaboration:** Work together to better organize and connect services to meet the needs of the population and ensure optimal use of resources.
- **Quality Improvement and Innovation:** Partner with LHIN residents to understand their experiences of care and continuously collaborate with them to co-design improvements, broadly share quality evidence and best practices and demonstrate quality outcomes across the health care system.
- **Transparency and Accountability:** Strive for transparent decision-making and better performance by reporting on measures of success and holding individuals and organizations accountable for results.

2.2 IHSP Priorities and Initiatives

Over the next three years the South West LHIN will advance seven key priorities that align with provincial directions. Appendix C summarizes the seven priorities, their outcome objectives, planned initiatives to meet these objectives and how success will be measured. In addition, Appendix D describes the anticipated progress of each initiative. Appendix E

describes key Committee and Network partnership and accountability relationships that exist to advance the work while Appendix G and H provide the status of integrations and capital initiatives. In alignment with the *French Language Services Act* and the desire to support improvements to the health of Indigenous populations, the LHIN has specifically focused a number of improvement efforts to achieve better health outcomes for these populations as well as creating LHIN wide supports for health service providers including the French Language Services toolkit and Indigenous Cultural Competency Training. The Erie St.Clair/South West French Language Health Planning Entity and the South West LHIN Aboriginal Health Advisory Committee perform critical advisory roles to these improvement efforts.

The seven priorities include:

- Ensuring **primary health care** is strengthened and linking with the broader health care system
- Optimizing the health of people and caregivers living at **home, in long-term care and in other community settings**²
- Supporting people in **preventing and managing chronic conditions**
- Strengthening **mental health and addiction services** and their relationship with other partners
- Ensuring timely access to **hospital-based care** at the LHIN-wide, multi-community, and local level
- Enabling a **rehabilitative approach** across the care continuum
- Putting people with life-limiting illnesses and their families at the centre of **hospice palliative care**

To help understand the risks associated with implementing each initiative, the LHIN considers human resource availability and capability, funding availability, leadership champions, technological challenges, project management challenges, level of stakeholder commitment and challenges associated with change. Multiple risks are often associated with each initiative, which then requires careful planning and staging to assist with mitigating those risks.

2.3 Monitoring Progress and Measuring Results

The South West LHIN approaches performance management and improvement using a consistent method to planning, implementing, monitoring and measuring by leveraging and applying consistent processes, tools and mechanisms to demonstrate success as well as identify opportunities for further improvement.

The LHIN will continue to measure the performance of the health system to determine if we are successful in achieving these goals by monitoring big dot outcomes and system measures aligned to each IHSP priority. Our big dot and system measures listing can be found in our IHSP 2016-19.

² People living in community settings may also include those in temporary living accommodations, or who may be experiencing homelessness

Reporting and Monitoring Progress and Performance

- The responsibility to monitor progress and achieve results is a shared responsibility of HSPs and the LHIN. LHIN staff are aligned to IHSP priorities and initiatives and HSPs to ensure planning, implementing, measuring, and communication functions are met including involvement of other internal and external team members as required. An Alignment Team monitors system and priority performance, informs future direction setting, creates alignment and ensures the consistent coordination and implementation (internal/external) of initiatives and processes; ensuring continuous feedback mechanisms and effective “on the ground” execution. System level performance results are reported to the South West LHIN Board of Directors quarterly, and this information is publicly available. Strategic Performance Reviews are also held quarterly in order to review progress.
- Robust use of standardized project management tools, processes and technology (e.g. Situation, Background, Assessment, Recommendation (SBAR) template, Integrated Project Management Document, Quality Improvement Tools (Driver Diagrams, Measurement Plans, etc), SharePoint, Customer Relationship Management (CRM), and Expert Choice)
- Regular submission and review of project status reports that include performance indicators and measures, achievement of milestones, and identification of risks. Close-out reports are submitted at completion of the projects
- Regular review and communication of performance measures at the system and priority levels (see Appendix F) with LHIN staff, Board, and Health Service Providers to monitor progress and identify key actions for improvement
- Execution of regularly scheduled Value for Money assessments
- Optimization of data access processes, utilization and analysis

Driving Quality Improvement

- Focused efforts to leverage Quality Improvement Plans (QIPs) and Quality Based Procedures (QBP) to increase collective impact by informing, influencing and prioritizing cross-sector improvement work
- Use of standardized improvement tools and templates, including the South West LHIN Quality Improvement Enabling Framework (QIEF) when implementing large scale projects
- Leverage and spread of the provincial IDEAs program, and improvement methodology including process management, problem solving, as well as LHIN improvement tools and frameworks, including Experience Based Design
- Reduce variation and drive the use of evidence in supporting initiatives
- Empower patients and families to contribute to local health system design
- Continue to facilitate knowledge transfer through our annual Quality Symposium and recognition awards
- Increase quality improvement education and training to enhance capability and capacity

2.4 Accountability

As LHINs work with health service providers (HSP) to create a more integrated, sustainable, person-centered and results-driven local health care system, they must also ensure current and future fiscal resources are spent wisely on services and programs.

The *Local Health System Integration Act, 2006 (LHSIA)* provides for a Ministry-LHIN Accountability Agreement (MLAA), which establishes the accountability expectations associated with coordinating health care in local health systems and managing the health system at a local level effectively and efficiently. The standards, measures, and reporting requirements for this are provincially mandated. Obligations are articulated in the following areas:

1. Local health system management
2. Funding and allocations
3. Local health system performance
4. Integrated reporting

To align funding accountabilities and performance obligations within the health care system, LHINs enter into a Service Accountability Agreement (SAA) with each HSP. Currently, the South West LHIN manages ~187 SAAs with our hospitals, community sector agencies, and long-term care homes. The SAA supports the relationship between the LHIN and HSP and provides authority for the LHIN to fund a HSP and stipulates accountability and performance obligations for planning, integration and delivery of programs and services.

The SAAs have a strengthened performance improvement component that reflects both the individual service provision mandate of the provider and the provider's contributions to system improvements as part of shared accountability. The HSP is responsible for managing its performance obligations and the LHIN is responsible for working with the HSP to achieve those ends.

The LHIN uses the SAA as an instrument to maintain clear lines of accountability and performance expectations for individual and collective HSPs, the initiatives they contribute to, and the outcomes the LHIN is striving to achieve at initiative and system levels. The LHIN monitors monthly and close-out project reports and quarterly HSP service accountability agreement performance, financial and service level compliance with pre-established targets. LHIN staff review these reports and initiate the appropriate level of follow up action if risks, issues and/or performance obligations are not on track or have not been met.

Health System Funding Reform (HSFR) is changing how services and programs are being funded, shifting funding between HSPs, and providing best practice information and new quality indicators. Working with HSPs the LHIN is ensuring that service utilization and costs are aligned to the Health Based Allocation Model (HBAM) expected standards and that best practice and quality indicators as defined by Quality Based Procedures (QBP) clinical handbooks are adopted and monitored. Aligning programs and procedures to cost, practice and quality expectations is now a key clinical planning goal.

3.0 LHIN OPERATIONS

If passed, the *Patients FirstAct* would improve access to health care services by giving patients and their families faster and better access to care and putting them at the centre of a truly integrated health system.

It is anticipated that the 2016/17 fiscal year will be dedicated to ensuring that the LHIN and other impacted organizations are well prepared for implementation of the changes.

The *Patients First Act* would give Ontario's 14 local health integration networks (LHINs) an expanded role, including in primary care and home and community care. With an expanded mandate, the South West LHIN would:

- establish 5 sub-regions as the focal point for integrated service planning and delivery;
- be responsible for primary care planning and performance management,
- directly manage the delivery of home and community care by integrating the South West CCAC into the LHIN, and
- establish a formal relationship with public health units to strengthen health system planning.

As the above changes are advanced and the LHIN role expands, the LHIN will be working diligently to create an enhanced LHIN that is a high-performing workplace of choice.

To guide these early stages of change, the South West LHIN will put a project structure in place by April 1, 2016. This will include:

- creating a project team to implement the vision,
- establishing an executive committee to oversee and govern the transition including patient and family representation to ensure that change efforts are guided by and responsive to the needs and expectations of those who rely on the health care system,
- engaging broad multi-sector health service provider advisory groups to provide advice to the transition planning at the local level, and
- creating an internal team to implement the required organizational changes while beginning to lead and support staff through change.

A core set of sub-LHIN metrics will support the case for change and ensure the success of transformation activities.

3.1 Operations Spending Plan

Template B: LHIN Operations Spending Plan				
LHIN Operations Sub-Category (\$)	2015/16 Actual	2015/16 Allocation	2016/17 Planned Expenses	2017/18 Planned Expenses
Salaries and Wages	3,929,061	3,849,683	3,849,683	3,849,683
Employee Benefits				
HOOPP	361,810	346,490	346,490	346,490
Other Benefits	490,839	461,186	461,186	461,186
Total Employee Benefits	852,649	807,676	807,676	807,676
Transportation and Communication				
Staff Travel	84,032	73,000	73,000	73,000

Governance Travel	29,136	25,800	25,800	25,800
Communications	-	-	-	-
Other Benefits	-	-	-	-
Total Transportation and Communication	113,168	98,800	98,800	98,800
Services				
Accommodation (Lease costs plus other Accom exp)	325,924	306,081	306,081	306,081
Advertising & Public Relations	-	-	-	-
Banking	719	600	600	600
Community Engagement	68,182	100,418	100,418	100,418
Consulting Fees	78,934	13,900	13,900	13,900
Equipment Rentals	18,697	50,000	50,000	50,000
Governance Per Diems	120,807	116,400	116,400	116,400
LSSO Shared Costs & LHINC	428,521	436,840	436,840	436,840
Other Meeting Expenses	45,805	25,750	25,750	25,750
Other Governance Costs	17,925	37,800	37,800	37,800
Printing & Translation	12,721	49,500	49,500	49,500
Staff Development	68,397	81,000	81,000	81,000
Recruitment	84,067	10,000	10,000	10,000
Other overhead expenses	52,302	65,544	65,544	65,544
DRCC Physician Leads	112,056	190,000	190,000	190,000
Total Services	1,435,059	1,483,833	1,483,833	1,483,833
Supplies and Equipment				
IT Equipment	64,176	30,000	30,000	30,000
Office Supplies & Purchased Equipment	32,475	35,250	35,250	35,250
Total Supplies and Equipment	96,651	65,250	65,250	65,250
LHIN Operations: Total Planned Expense	6,426,587	6,305,242	6,305,242	6,305,242
Annual Funding Target		6,305,242	6,305,242	6,305,242
Variance		-	-	-

Notes

1. Includes DRCC, FLS, Aboriginal, and ER/ALC FTEs

2. Implementation of directions contained in the Patients First Act introduced in June 2016 would impact Operations Spending Plan beyond 2016/17

3.2 Staffing Plan

Template C: LHIN Staffing Plan (Full-Time Equivalents)				
Position Title	2015/16 Actual FTEs	2016/17 Forecast FTEs	2017/18 Forecast FTEs	2018/19 Forecast FTEs
Administrative Assistant to Senior Director	2.0	2.0	2.0	2.0
Business Assistant	1.0	1.0	1.0	1.0
Chief Executive Officer	1.0	1.0	1.0	1.0
Communication & Community Engagement Specialist	2.0	2.0	2.0	2.0
Communication & Web Specialist	1.0	1.0	1.0	1.0
Controller / Manager of Corporate Services	1.0	1.0	1.0	1.0
Corporate Services & HR Assistant	1.0	1.0	1.0	1.0
Director, Communications & Community Engagement	1.0	1.0	1.0	1.0
Executive Office Assistant	1.0	1.0	1.0	1.0
Executive Office Coordinator to CEO	1.0	1.0	1.0	1.0
Financial Analyst (one contract)	5.0	4.0	4.0	4.0
Financial Coordinator (contract)	-	1.0	1.0	1.0
Health Data & Performance Analyst (Initiative funding 1 FTE)	2.6	2.6	2.6	2.6
Performance Improvement Lead	1.0	1.0	1.0	1.0
Program Assistant	3.0	3.0	3.0	3.0
Program Lead	1.0	1.0	1.0	1.0
Project Coordinator (contract)	-	-	-	-
Quality Specialist	1.0	1.0	1.0	1.0
Quality Improvement Lead	1.0	1.0	1.0	1.0
Receptionist	1.0	1.0	1.0	1.0
Senior Director	2.0	2.0	2.0	2.0
System Design & Integration Lead	4.0	4.0	4.0	4.0
System Design & Integration Specialist: Planners	4.0	4.0	4.0	4.0
Team Lead, Finance	1.0	1.0	1.0	1.0
Team Lead, Performance Improvement	1.0	1.0	1.0	1.0
Team Lead, System Design & Integration	1.0	1.0	1.0	1.0
French Language Coordinator (Initiative funding)	1.0	1.0	1.0	1.0
Aboriginal Lead (Initiative funding)	1.0	1.0	1.0	1.0
Total FTEs	42.6	42.6	42.6	42.6

Includes DRCC, FLS, Aboriginal, and ER/ALC FTEs

4.0 COMMUNICATIONS AND COMMUNITY ENGAGEMENT

4.1 Communications Plan

Communications Goal

Communities within the LHIN are informed and engaged on the actions the LHIN, in partnership with health service partners, will take to enhance health care delivery for all residents of our LHIN.

Communications Objectives

- Promote the contents of the Annual Business Plan for 2016/17 and how the LHIN is working to create a sustainable and accountable health system.
- Offer opportunities for key audiences to engage with the LHIN to build a better understanding of how they can align to the Annual Business Plan and more broadly with the IHSP.
- Offer opportunities for dialogue with health service providers and other system partners as planning associated with the proposed *Patients First Act* unfolds over the coming months.
- Uphold the LHIN's commitment to be open, transparent, and accessible to the public on LHIN priorities and initiatives.

Context

All communications and engagement products/activities align with provincial priorities. This includes those priorities listed in the mandate letter addressed to the Minister of Health and Long-Term Care. Initiatives and programs build on the Ministry's *Patients First: Action Plan for Health Care*, which focuses on four key objectives: improve access, connect services, support people and patients, and protect our universal public health care system. *Patients First: A Roadmap to Strengthen Home and Community Care* is a 10-point plan to strengthen the home and community care sector over the next three years.

In December 2015 the Ministry of Health and Long-Term Care issued *Patients First: A proposal to strengthen patient-centred health care in Ontario*, outlining proposed structural changes to the health care system.^b

Communications and community engagement form a vital public service where the LHIN has a duty to provide information and listen to the public it serves. This contributes to building a system that better understands and meets the needs of our patients. The South West LHIN's core communications activities include:

- Opportunities for audiences to participate in engagement around core business activities for the South West LHIN.
- Frequent communications with audiences on the activities of the LHIN and results being achieved.
- An active online presence to connect and interact with audiences, allow 24-hour access to information, and help foster public dialogue.
- Strong relationships with media with every effort made to accommodate requests for both information and interviews.
- Prompt, courteous and responsive person-focused customer service.

Audiences

Primary

- Health Service Providers, funded and non-funded
Priorities: primary health care, home and community care, long-term care, managing chronic conditions, mental health and addiction services, hospital-based care, rehabilitative services and hospice palliative care
- Governance leaders
- Public (patients, clients, residents and caregivers)

Secondary

- LHIN staff
- Elected officials (federal, provincial and municipal)
- Media

Key Messages

Patients First

- On June 2, 2016, Bill 210, an act to amend various Acts in the interest of patient-centred care, was introduced at first reading and has been given the title, the *Patients First Act, 2016*.
- The Act, if passed by the Ontario Legislature, would amend the *Local Health System Integration Act, 2006* (LHSIA) and the *Home Care and Community Services Act, 1994* (HCCSA), among other statutes.
- If passed, the *Patients First Act* will enable the next stage of the Patients First Action Plan for Health Care.
- The *Patients First Act* would give Ontario's 14 local health integration networks (LHINs) an expanded role, which includes a greater mandate for both primary care and home and community care.
- If passed, the legislation would improve access to health care services by giving patients and their families faster and better access to care and putting them at the centre of a truly integrated health system.
- We look forward to building on our progress to date and leveraging our expertise, as we move towards achieving an integrated health system in Ontario.
- These proposed changes would enhance our ability to truly integrate our local health care system for the benefit of patients.
- The *Patients First: Action Plan for Health Care*, released in February 2015, sets clear and ambitious goals for Ontario's health care system in order to put patients at the centre of our health care system by improving the health care experience:
 - Access
 - Improve access - providing faster access to the right care.
 - Connect
 - Connect services - delivering better coordinated and integrated care in the community closer to home; providing better home and community care.
 - Inform
 - Support people and patients - providing the education, information and transparency Ontarians need to make the right decisions about their health.
 - Protect

- Protect our universal public health care system - making decisions based on value and quality, to sustain the system for generations to come.
- As the next logical step in the *Patients First Action Plan*, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* proposes a path toward providing better access to care no matter where you live by better connecting health care services.

LHINs

- We are building a system that better understands and meets the needs of patients – no matter their background, their income, or where they live.
- Patients, clients and residents belong at the heart of the health care system.
- Health system renewal that improves equitable access to high quality, patient-centred care for all population groups is the right thing to do.
- Redesigning health care is undeniably one of the most important responsibilities we must uphold in order to place the needs of patients, clients and residents first in Ontario.
- We must work together to explore every opportunity available to us to provide better care for the patients, clients and residents we serve across the South West LHIN.
- The health system's long-term success depends on attaining quality care, improved health and better value.

Implementation Strategies

Health equity	<ul style="list-style-type: none"> • Every person, no matter who they are, where they live or how much money they make, deserves health services that address the barriers that are often experienced by certain populations
Integration and collaboration	<ul style="list-style-type: none"> • A fully integrated system from end-to-end means individuals and organizations intentionally work together to better organize and connect services to meet the needs of the population and ensure optimal use of resources. • We must align services and processes so that the health care system is coordinated, accessible and high quality. • All health service providers must identify opportunities to integrate services for the benefit of the people we serve and the health system.
Accountability and transparency	<ul style="list-style-type: none"> • LHINs have built a strong foundation of transparency, performance and accountability as these are fundamental expectations of what Ontarians want from their health care system. • The LHIN strives to ensure that health care dollars are spent efficiently and effectively, yielding the best results possible and overall value for money.
Quality improvement and innovation	<ul style="list-style-type: none"> • Creating a culture that is relentless in its pursuit of quality improvement requires stakeholders to be continuously involved in improving the experience of care of those who use health care services.

	<ul style="list-style-type: none"> We must work together to improve experiences of care, implement required changes, study results and make refinements.
eHealth and technology	<ul style="list-style-type: none"> Using innovative information and clinical technologies in health care is a key contributor in advancing health care quality in the LHIN. eHealth technologies allow for access to and exchange of health information, inform effective decision making, and enhance “hands-on” care
Priorities	
Stronger primary health care that is linked with the broader health care system	<ul style="list-style-type: none"> Organized around a defined population, patient-centred care requires different parts of the health system to be integrated and coordinated to meet the needs and preferences of individuals and families. A significant focus for the LHIN will be to work with the Ministry to implement a multi-year reform strategy in collaboration with primary care providers and other partners to strengthen primary care across the South West LHIN.
Optimized health for people and caregivers living at home, in long-term care and in other community settings	<ul style="list-style-type: none"> A significant focus continues to be on meeting the needs of people who are frail, have medically complex conditions/disabilities, and/or live with chronic diseases. We will work to transform home and community care, building on efforts in the community to improve access to coordinated, integrated, quality care for nursing, personal support, therapies, day programs and supportive housing as well as ongoing efforts to address disparities between old and new long-term care homes.
Supporting people in preventing and managing chronic conditions	<ul style="list-style-type: none"> Ontario recognizes the need for greater coordination of care for people with multiple complex conditions. By strengthening local partnerships where care providers work together to coordinate quality care for patients with complex needs, the LHIN and health service providers will be able to better support people in preventing and appropriately managing chronic conditions.
Stronger mental health and addiction services and relationships with other partners	<ul style="list-style-type: none"> To deliver high quality care to people and their caregivers who are impacted by mental health, addictions, and/or responsive behaviours, the LHIN and health service providers will ensure services and supports in mental health and addictions are easier to access and continually improving.
Timely access to hospital-based care at the LHIN-wide,	<ul style="list-style-type: none"> A significant focus for the LHIN is to optimize hospital-based resources in order to build capacity and access to quality treatment and care throughout the LHIN.

multi-community, and local level	<ul style="list-style-type: none"> To maintain high quality, publicly accessible and cost-effective hospital care, the LHIN also continues to move forward with implementing Health System Funding Reform (HSFR) within the hospital and CCAC sectors.
A rehabilitative approach across the care continuum	<ul style="list-style-type: none"> For those suffering from injury, illness, or chronic disease, equitable access to quality rehabilitative services will support better patient experience, clinical outcomes, and transitions of care by optimizing the physical, mental and social well-being of individuals.
People with life-limiting illnesses and their families at the centre of hospice palliative care	<ul style="list-style-type: none"> Improving equitable access to coordinated, effective, efficient quality services and supports will place individuals with life-limiting illnesses and their families at the centre of care to optimize their quality of life.

Strategic Approach

- All communications will reflect our core vision, mission and values and they will be shared in a way that is clear, relevant and useful.
- The LHIN will employ a variety of ways and means to communicate and provide information in a variety of formats to accommodate diverse audiences and geographies in the South West LHIN.
- While the draft legislation makes its way through the legislature, the South West LHIN will continue to engage and consult with patients, caregivers, health care providers, stakeholder associations, Indigenous peoples and other system partners to gather feedback on the proposed legislation.
- Communications planning and delivery will be equitable and reflect best practices for both the health sector and communications – delivered in a way that consistently honours the LHIN's commitment to equity and person-centred care.
 - Support French Language and Aboriginal engagement as required
 - Offer resources and information in French on demand
 - Maintain access to information online in French
- Work will continue with other LHINs when necessary to make sure there is a consistent approach that is adapted to reflect the local environment.
- Communications will adhere to the policies of the Ministry of Health and Long-Term Care as outlined in the MOHLTC-LHIN Memorandum of Understanding and the Ministry-LHIN Accountability Agreement (MLAA).

Tactics

The communication and engagement tactics flow from the overarching communications plan that guides and aligns all audience- and initiative-specific communications plans. The South West LHIN will employ a variety of ways and means to communicate to accommodate the diverse needs of our audiences.

- Offer significant opportunities for audiences to participate in engagement around core business activities for the South West LHIN.

- Communicate frequently with audiences on the activities of the LHIN and results being achieved.
 - Annual Report (2015/16), Community Bulletin (2015/16), Exchange Newsletter
 - Area Provider Table updates
 - Report on Performance Scorecard and performance indicators on website
- Maintain an active online presence using Southwestlhin.on.ca, Twitter, Facebook, YouTube
- Meet and liaise with MPPs in the South West on an ongoing basis to provide updates on the activities of the LHIN.
- Prepare events and announcements as required to inform the public about significant South West LHIN initiatives or investments.
- Engage employees using effective internal communications

4.2 Community Engagement

Offer significant opportunities for partners to participate in engagement around core business activities for the South West LHIN.

- Quality Symposium (June 2016)
- Governance education sessions (Fall 2016)
- Board meetings (held in a different community each month)
- Congresses and forums (through the year)
- Local evening network sessions (held every other month)
- Advisory groups, committees, liaisons (ongoing)
- Targeted engagement for priority audiences around significant South West LHIN or provincial initiatives (as required)

Offer opportunities for dialogue with health service providers and other system partners as planning for the proposed *Patients First Act* under the *Patients First: Action Plan for Health Care* unfolds over the coming months.

Evaluation

- Assess feedback (phone calls, emails, social and web traffic) after distributing key publications
- Assess turnaround time, tone and number of customer service calls and media inquiries.
- Ongoing monitoring of overall satisfaction, number of events each year, number of participants, achievement of objectives.
- Ongoing monitoring of media coverage, social conversation, stakeholder feedback and public inquiries log.
- Analytics and engagement rates (website, newsletter and social media)

WE ARE A TEAM

To be a high performing team, we must have a culture that is aligned, dynamic, and engaged:

What are we trying to achieve? Goals/Objectives:	How will we monitor progress? Key Outcomes:
Use engagement strategy tools and continue to support the engagement of all staff	<ul style="list-style-type: none"> Kolbe / StrengthsFinder assessments and reports are conducted on new employees and shared with employees and leaders
Break down barriers between functional and cross-functional teams to encourage open communication and the strengthening of internal relationships	<ul style="list-style-type: none"> The overall score of team vitality continues to improve
Embed and encourage a no-blame culture where continuous reflection is commonplace and continuous improvement is our collective goal	<ul style="list-style-type: none"> The behaviours within LEADS domains "Lead Self" and "Engage Others" are modelled by team members
Create opportunities for, and proactively encourage, all staff to learn and share knowledge	<ul style="list-style-type: none"> The behaviours within LEADS domain "Engage Others" are modelled by team members
Meetings are more effective	<ul style="list-style-type: none"> Principles of effective meetings are implemented and meetings become more effective

THE STRATEGY THAT GUIDES US

What are we trying to achieve? Goals/Objectives:	How will we monitor progress? Key Outcomes:
Ensure there is human capacity and capability to support the organization's goals and objectives	<ul style="list-style-type: none"> The LHIN meets 95% of the annual goals of the ABP as outlined in the IHSP
Provide structure, compensation, policies, standards, reward systems, benefit programs and grievance handling	<ul style="list-style-type: none"> HR policies and procedures are reviewed annually Pan-LHIN CEOs review merit process and salary structure annually
Cultivate a culture where staff want to come to work	<ul style="list-style-type: none"> I am satisfied with my decision to work here >= 3.93 I feel more committed to a career with the organization this year than I did a year ago >= 2.95
Shift from an organization building credibility to a learning culture where we can improve quality and performance using quality assurance techniques	<ul style="list-style-type: none"> The organization encourages me to offer innovative ideas to improve our performance >= 3.21
Create an appropriate work environment that complies with legislation and is sensitive to both management's and employees' needs	<ul style="list-style-type: none"> I can depend on the integrity of my leader >= 4.13 I am satisfied with the Senior Leadership's execution and implementation of the organization's strategy >= 3.49

HOW WE ARE STRUCTURED

To be the facilitator of collaboration, cooperation, and coalitions among diverse groups and perspectives aimed to improve health outcomes:

What are we trying to achieve? Goals/Objectives:	How will we monitor progress? Key Outcomes:
Flexible to address emerging initiatives and provincial directions and ability to grow	<ul style="list-style-type: none"> Overall organization goals and objectives are communicated regularly >= 3.77
Understand individual, team and organizational responsibilities	<ul style="list-style-type: none"> I understand what the team needs to do to achieve its goals >= 4.07
Availability of leaders to effectively coach, delegate, direct, and support	<ul style="list-style-type: none"> My leader coaches and helps me to continuously develop my skills >= 3.68 My leader provides me regular feedback about my performance >= 3.97 I receive recognition from my leader for a job well done >= 3.92 My leader is available when I need them >= 3.87

OUR SYSTEM PROVIDES TOOLS AND RESOURCES

To provide employees with the tools & resources – including policies and procedures – in order to effectively and efficiently complete their work to achieve the goals and objectives of the organization:

What are we trying to achieve? Goals/Objectives:	How will we monitor progress? Key Outcomes:
Ensure staff are appropriately train on existing and new tools, process and technologies so they can maximize their use to move the work of the LHIN forward	<ul style="list-style-type: none"> New systems and processes are adopted by employees 100% I receive the training I need to do my job >= 3.88 I have the equipment & tools needed to do my job >= 4.07
Replace manual processes with electronic systems and automate workflows and implement systems that integrate well together to provide a cohesive user experience and reduce manual duplication	<ul style="list-style-type: none"> Processes are reviewed annually IT requirements are clearly communicated to LSSO I feel comfortable suggesting ideas to improve our processes and products >= 3.37
Monitor, evaluate, and improve internal policies and procedures to ensure adherence to government directives and reporting requirements	<ul style="list-style-type: none"> I have access to the appropriate policies and procedures to do my job >= 4.53
Keep IT systems and business applications at current vendor-supported versions	<ul style="list-style-type: none"> Annually laptops and cell phones are refreshed on a 3-year cycle Upgrade software in a timely manner to ensure the latest vendor-supported versions are in use

DRAFT

Organizational Development Plan 2015/16

“A Healthier Tomorrow”

Rollout December 2015

November 2015

PURPOSE

Our Organizational Development (OD) Plan outlines how we as an organization can achieve a strong, cohesive, outcome driven team to meet the goals of the South West LHIN. The goals of the organization, outlined below, guide what we do, how we are driven, and ensure the LHIN can deliver on its mandate. The organization's goals are to:

- effectively manage and transform the health system;
- inform and engage the communities within the LHIN;
- optimize resources; and
- continuously improve the organization.

Under each of these goals, there are several objectives and measures of success that will be used to determine our progress in advancing our organization. The goals of the organization are further defined through the Integrated Health Service Plan (IHSP), the Annual Business Plan (ABP), the obligations of the Ministry-LHIN Performance Agreement (MLPA), and the OD Plan. Since 2005 the South West LHIN has led the planning and implementation of initiatives to transform the health system.

Our OD Plan supports LHIN employees in achieving current provincial and South West LHIN plans. LHIN employees play a key role in achieving the objectives of these transformational plans. The fiscal year 2015/16 will be the initial launch of the OD Plan and is aligned to the IHSP. The OD Plan outcome measures will be reviewed annually and updated as required. As this Plan is implemented, best practices will be identified and refined in a spirit of continuous improvement. The progress of goals will be visually displayed to employees.

OVERVIEW

The seven elements of the Organizational Development Plan are the competencies, skills, and resources required to achieve the goals of the organization. The LEADS in a Caring Environment framework takes the black and white competencies (skills that look the same for each individual) and adds the grey capabilities (behaviours like how to motivate and are different for each individual) and develops strong leaders essential to improving the healthcare system.

The seven Elements¹ include:

Our shared values

Our values are the guiding principles that drive our behavior and actions as people and as an organization.

Who we are	What we do (<i>Our foundation</i>)
We are leaders Shared leadership will empower individuals and embed leadership in the culture.	How we are structured The organization, infrastructure and governance of the LHIN.
We are a team Everyone on the team is moving in the same direction. The team's time and energy is aligned.	The strategy that guides us We will evolve and adapt to be effective in achieving our objectives.
We all have talent Nurturing excellence will foster engaged employees who are fulfilled and work to their full potential.	Our system provides tools and resources The tools, resources and processes that will help us meet our objectives.

The five domains of the LEADS include:

Achieve Results: Leaders who Set Direction, Strategically Align Decisions with Vision, Values, and Evidence, Take Action to Implement Decisions, and Assess and Evaluate.	
Lead Self: Leaders who are Self-Aware, Manages Self, Develops Others, and Demonstrates Character.	Develop Coalitions: Leaders who Purposefully Build Partnerships and Networks to Create Results, Demonstrate a Commitment to Customers and Service, Mobilize Knowledge, and Navigate Socio-Political Environments.
Engage Others: Leaders who Foster Development of Others, Contribute to the Creation of Healthy Organization, Communicate Effectively, and Build Effective Teams.	Systems Transformation: Leaders who Demonstrate Systems / Critical Thinking, Encourage and Support Innovation, Orient Themselves Strategically to the Future, and Champion and orchestrate Change.

¹ The OD Plan was developed using the McKinsey 7-S model as a framework

OUR OBJECTIVES & KEY OUTCOMES

OUR SHARED VALUES

To create a sense of belonging and harness commitment and talent:

What are we trying to achieve? Goals/Objectives:	How will we monitor progress? Key Outcomes:
Promote and develop a culture of excellence, commitment and respect	<ul style="list-style-type: none"> During my time with the LHIN, the organization has demonstrated the principles & elements of a Workplace of Choice $\geq 3.55^3$ During my time with the LHIN, the organizational culture has moved towards being more positive ≥ 3.58
Provide an environment where all staff can excel, flourish and succeed	<ul style="list-style-type: none"> GallupQ12² mean score ≥ 3.95 (4.00 or more indicates a highly engaged workforce)
Facilitate achieving the LHIN's mission and vision and foster a culture that reflects the organization's values	<ul style="list-style-type: none"> I understand the LHIN's vision and mission ≥ 4.64 The mission or purpose of the LHIN makes me feel my job is important ≥ 3.95
Provide an environment where teams can strive and achieve their team mandates and weave the 5 team responsibilities into our culture	<ul style="list-style-type: none"> The individuals in my functional team model the 5 Team Responsibilities ≥ 2.30 The individuals in my portfolio team model the 5 Team Responsibilities ≥ 2.27 The Senior Leadership Team models the 5 Team Responsibilities ≥ 3.24 100% of team mandates are updated by March 2016

WE ARE LEADERS

To define our leadership style and develop leadership at all levels:

What are we trying to achieve? Goals/Objectives:	How will we monitor progress? Key Outcomes:
Adopt the LEADS capability framework into our culture and emphasize leadership development	<ul style="list-style-type: none"> LEADS Five domain workshops and 360 Assessments are phased into the organization by March 2017
Create learning development plans that focus on the LEADS capabilities	<ul style="list-style-type: none"> 100% Employees feel they are modelling the LEADS behaviours / capabilities 95% Employees rate the 360 Diagnostic Assessment tool as effective 100% Senior leaders incorporate the LEADS learning plans into their 2016/17 performance plans and access their training allocations 100% Employees incorporate the LEADS learning plans into their 2017/18 performance plans and access their training allocations
Define the scope of decision-making for all LHIN staff through the RASCI tool	<ul style="list-style-type: none"> The RASCI tool is utilized and refreshed annually to align with organizational changes
Cultivate a climate where initiative on assignments is acknowledged	<ul style="list-style-type: none"> Use of the term "micromanagement" is no longer part of the culture
People leaders are effective and give employees discretion and autonomy over their tasks	<ul style="list-style-type: none"> My leader has the necessary people management skills to manage our team ≥ 3.71 My leader effectively handles crisis situations ≥ 3.97

WE ALL HAVE TALENT

To grow our talent and recognize our employees:

What are we trying to achieve? Goals/Objectives:	How will we monitor progress? Key Outcomes:
Support and challenge others to achieve professional goals	<ul style="list-style-type: none"> 85% Employees utilized professional development allocation My leader reinforces a learning culture ≥ 4.00
Maintain staff retention within industry standards	<ul style="list-style-type: none"> Annual staff turnover is $< 10\%$
Continue to implement and enhance the staff professional development program in alignment with current policy and procedures	<ul style="list-style-type: none"> LEADS 360 assessment becomes part of the annual learning and development plan and is linked to LEADS capabilities and performance starting in 2017/18
Build a workplace culture where staff have the support and skills to operate and innovate at a local level by enhancing and expanding the use of LEADS	<ul style="list-style-type: none"> The behaviours within LEADS domains "Develop Coalitions" and "System Transformation" are modelled by team members
Ensure LHIN employees are fairly compensated compared to similar roles in Ontario	<ul style="list-style-type: none"> LHINs participate in the pan-LHIN Market Compensation Review to determine the level of pay equity compared to the industry by March 2016
Support internal capacity building related to improvement	<ul style="list-style-type: none"> # of staff trained in IDEAs (2 day); IDEAs (9day Advanced) # of staff participating as Alumni Mentors # of projects submitted for 9 day advanced acceptance % of projects accepted for 9 day advanced program # of awards

² GallupQ12 questions measure employee engagement

³ Key Outcomes include questions in the staff engagement survey and represent prior benchmark scores

THE STRATEGY THAT GUIDES US

The LHIN's strategic directions and objectives are defined through the IHSP and the obligations of the MLPA. Our strategy helps us to set priorities, focus our resources and make sure we are working towards common goals. The OD Plan defines the people and organization goals.

People Goals

The LHIN is committed to providing guidance, training, leadership, tools & resources to all team members to create a strong, cohesive, outcome-driven team. The LHIN strives to achieve its goals of building team effectiveness and stronger organizational culture to become firmly positioned as a Workplace of Choice.

Organization Goals

The four goals of the South West LHIN organization guide what we do, how we are driven, and ensure the LHIN can deliver on its mandate. As stated earlier in this documents, the goals are to:

- *Effectively manage and transform the health system*
- *Inform and engage the communities within the LHIN*
- *Optimize resources*
- *Continuously improve the organization*

What will we need to do?

- Finalize and implement strategies identified in the OD Plan to ensure employee engagement and commitment to the organization.
- Support autonomy and empower decision makers, hold staff accountable, listen and support.
- Use the training from the LEADS framework to begin changing the culture from building credibility to a learning culture.

HOW WE ARE STRUCTURED

The LHIN is structured to support the goals of the IHSP. The organization is structured in a way to help achieve our goals and ensure the pieces of the LHIN fit together strategically.

Board of Directors

The board of directors is entrusted with the stewardship of the resources to oversee the planning, coordination, integration, and funding of health service providers. The board regularly monitors and discusses its own process and performance to ensure continuity of board improvements and the ability of members to govern. This includes completing an annual board evaluation process.

Chief Executive Officer

As the sole employee of the South West LHIN board of directors, the Chief Executive Officer (CEO) is charged with ensuring the administrative and organizational integrity of the organization. No single board member or committee has authority over the CEO – this responsibility rests with the entire board.

Senior Leadership

The senior leadership team is comprised of the CEO, two senior directors, the director of communications and community engagement, and the controller / manager, corporate services. The performance objectives of the CEO and the goals of the organization are cascaded down through the organization through the work of the senior leadership team. To be successful in moving the LHIN mandate forward, the senior leadership team must provide strong, cohesive, consistent support to staff.

Teams

The LHIN teams comprise functional and cross-functional teams. Teams are aligned with the broader organization work under a team mandate – a concise, clear definition of why the team exists and what needs to be accomplished. Where performance plans describe what individual members of the team will do; a mandate is a statement that addresses only what the team must do together.

What will we need to do?

- Revisit team mandates by March 2016 to ensure alignment with the 2016-19 IHSP.
- Evaluate the organization structure for improved performance management, and to allow senior leaders the time for better coaching and supporting opportunities between leaders and direct reports.

OUR SYSTEM PROVIDES TOOLS AND RESOURCES

There are 14 LHINs in Ontario that together offer a core pan-LHIN Information technology (IT) system for all 14 LHINs. The South West LHIN is responsible for our local systems, processes and tools while leveraging the pan-LHIN infrastructure, resources and tools.

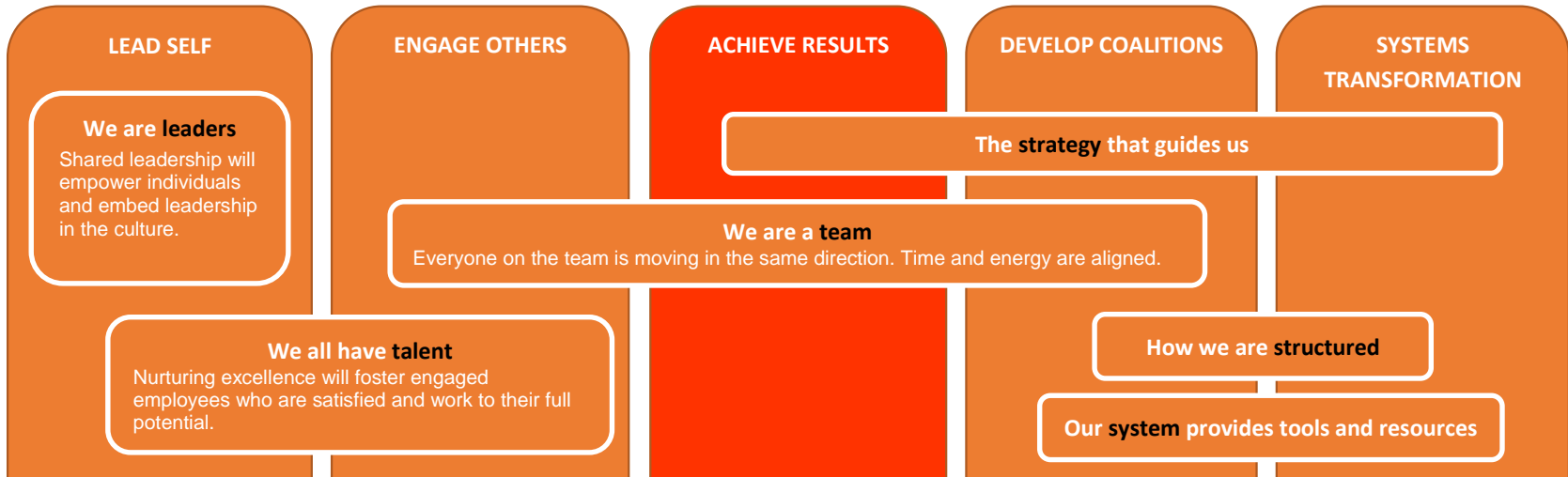
What will we need to do?

- The LHIN will strive to engage and train staff during the rollout of CRM while managing the changes and impact to staff and their roles.
- Align CRM and the PMO working groups into one working group.
- Evaluate the project management tool and determine next steps.
- Introduce a suggestion box to allow staff to provide ideas for opportunities for improvements.

OUR VALUES are the guiding principles that drive our behaviour and actions as people and as an organization.
Compassion • Courage • Evidence-informed • Innovation • Integrity • Trust & Respect • Culture & Diversity

Who we are

Our foundation



LEADS in a Caring Environment Framework

- | | | | | |
|--|---|--|---|--|
| <ul style="list-style-type: none"> • Self-aware of values, principles, strengths and limitations. • Takes responsibility for performance and health. • Actively seeks opportunities and challenges for personal learning, character building and growth. • Models honesty, integrity, resilience and confidence. | <ul style="list-style-type: none"> • Supports and challenges others to achieve professional goals. • Creates engaging environments where others have meaningful opportunities to contribute. • Listens well and encourage open exchange of information and ideas. • Facilitates collaboration and cooperation to achieve results. | <ul style="list-style-type: none"> • Identifies, establishes and communicates clear and meaningful expectations and outcomes. • Align decisions with vision, values and evidence. • Actions are guided by its values for effective, efficient public-centered service. • Measures and evaluates outcomes. • Holds themselves and others accountable for results achieved. | <ul style="list-style-type: none"> • Creates connections, trust and shared meaning with individuals and groups. • Facilitates collaboration, cooperation and coalitions among diverse groups and perspectives aimed to improve service. • Uses methods to gather intelligence, encourages the open exchange of information and used quality evidence to influence action across the system. • Politically astute and negotiates through conflict to gain support. | <ul style="list-style-type: none"> • Thinks analytically and conceptually, questions and challenges the status quo, to identify issues, solve problems, and design and implement effective processes. • Creates a climate of continuous improvement and creativity aimed at systemic change. • Scans the environment for ideas, best practices and emerging trends that will shape the system. • Actively contributes to change that will improve health service delivery. |
|--|---|--|---|--|

(Individual Focus)

(Outcome)

(Macro Focus)

OUR SHARED VALUES

Our values are the guiding principles that drive our behavior and actions as people and as an organization. Over the next year (2015/2016), the five (5) team responsibilities³ and the behaviours will be woven into the culture. Our team will lead the work to achieve the LHIN's internal goals – build team effectiveness and strengthen organizational culture – to become firmly positioned as a workplace of choice. It will take everyone in the organization working together to achieve our internal goals – we all have a role in implementing the OD Plan.

Refreshing the OD Plan to align with the overall direction of our organization's mission, vision and values will continuously tighten the link between human needs with business needs. The people elements of the OD Plan are flexible to respond to opportunities, changes and risks in both external and internal environments.

Core Values

- **Compassion** – Our actions have real implications for people and communities
- **Courage** – We make difficult decisions and challenge the status quo when required
- **Evidence-informed** – Our decisions are guided by the best available information
- **Innovation** – We encourage and support new thinking and sharing new knowledge”
- **Integrity** – We act in a fair, consistent and unbiased manner
- **Trust and Respect** – We believe in mutual trust and respect
- **Culture and Diversity** – We respect the unique context, experiences, and needs of diverse populations and communities

What will we need to do?

- Continue to live the values of the organization demonstrated in our day-to-day behaviours
- Define the minimum expectations of team building to encourage continuous movement towards a positive, engaged culture

WE ARE LEADERS

Shared leadership will maximize the human resources within our LHIN by empowering individuals and giving them an opportunity to demonstrate their leadership skills within their areas of expertise. The LHIN has adopted the LEADS in a Caring Environment framework and will begin work in 2015 to fully implement. The LEADS framework enhances the key skills, abilities, and knowledge required to lead at all levels of an organization. It aligns and consolidates the competency and capabilities frameworks and leadership strategies that are found in Canada's health sector and other progressive organizations.

What will we need to do?

Working with the Canadian College of Health Leaders, the LHIN will develop leaders in the organization using the LEADS in a Caring Environment framework. The following activities will commence in fiscal 2015/16:

- Host “Bringing LEADS to Life” workshop for senior leadership team
- Begin rolling out LEADS 360 Diagnostic Assessments
 - Senior Leadership Team target date November 2015 Phase I
 - LHIN employees target start date June 2016 Phase III
- LEADS coaches will meet with individual employees to debrief assessments and to share and discuss individual LEADS Learning Plans. Target start date January 2016 (SLT), October 2016 (Staff).
- Leadership styles (coaching, directing, delegating, and supporting) are defined and modelled

WE ARE A TEAM

When we come together as a team we can benefit from team synergies – arriving at solutions and outcomes that are superior because of the contribution of the respective team members – no one individual possesses all of the skills, abilities, knowledge, and experience to achieve the optimal outcome independently – through the collective contributions of team members we are able to increase performance and address complex challenges. Everyone on the team is moving in the same direction – teamwork builds momentum, unity and support.

When a team is aligned, there is a clear understanding of purpose and it works to add value for both the organization and the client. The team's processes, structure and performance measures are complementary. When there is healthy team dynamic people feel they're adding value; doing meaningful work; rewarded in a way that matters; working with people they respect, etc. “Dynamic” is the culture and environment that supports employee engagement. Our work must include a culture of belonging and engagement. We value the achievements and contribution of all staff. Employee engagement is a key indicator of their involvement and dedication to the LHIN.

StrengthsFinder and Kolbe

To help our people embrace their talents, improve productivity, enrich relationships and understand their team dynamics we have committed to talent development using both Strengths Finder and Kolbe as assessment tools. StrengthsFinder and Kolbe will be used to guide personal learning and will be one tool to help define how the organization works.

³ Five Team Responsibilities as defined by Knightsbridge: Start with a positive assumption / Add my full value / Amplify other voices / Know when to say no / Keep conflict health

What will we need to do?

- Clearly define the expectations and minimum required use of Kolbe and StrengthsFinder
- Educate and remind staff on applying Kolbe and StrengthsFinder and for each to take responsibility resulting in all staff exceling
- Implement and use new processes and tools, like CRM, to create alignment and synergies within teams
- Gather, monitor, and summarize the Plan, Do, Study Act (PDSA) A small tests of change outcomes to address work life balance
- Develop consistent tools and processes to measure the effectiveness of teams

WE ALL HAVE TALENT

It will be essential to create a culture where excellence is nurtured and “growing our own talent” is embraced. We need to be a workplace where employees feel valued and recognized for their contributions to the work of the organization. People who feel valued will want to come to work and want to continuously improve their knowledge, skills and competencies so they can be a contributing member of the LHIN. Leaders that have the skills and time to grow and support staff are essential in building a positive work environment. The overall goal is to make the LHIN a place where people want to come to work.

Valuing and Recognizing Employee Contribution

- Encourage employees to participate in workplace decisions and issues;
- Support employees to participate in the LHIN continuing education opportunities
- Celebrate team, individual and project successes;
- Capitalize on employee differences by supporting all employees to reach their full potential and use their strengths (Kolbe, StrengthsFinder, and 5 Team Responsibilities);
- Recognize employees as the LHIN's most valuable resource; and
- Value employees' efforts and respect who they are and what they do.

What will we need to do?

- LEADS coaches will meet with individual employees assist them with developing Learning Plans. Target start date February 2016 (SLT) and October 2016 (staff).
- Establish a regular day of learning. Eg. Effective meetings, LEADS, etc.
- Using a recruitment specialist, recruit the most talented individuals for each position in the LHIN. Aim to recruit, select and retain talent, while operating in a diverse and inclusive environment.
- Schedule LEADS workshops focusing on each domain.



Appendix B: Summary of Implementation Strategies

Health Equity	
	Work alongside health service providers to develop culturally competent Boards and organizations through Continuous Cultural Competency training (including ongoing Indigenous/Aboriginal cultural and linguistic competency training and Francophone cultural competency training) and board/staff development focused on increasing awareness about key equity issues.
	Continue to engage with key stakeholders and health service providers in developing an approach to equity and an implementation plan that outlines foundational equity expectations such as: deploying tools, training requirements, staff expertise, prominence of equity considerations in organizational strategic and operational plans, development and monitoring of equity indicators and targets as part of quality improvement, collection of socio-demographic data/community profiles to advance equity, advancement of targeted equity initiatives, services and/or policies, and identification of best practices and resources.
	Apply an equity lens to decision-making by developing guidelines to increase the application of the Health Equity Impact Assessment tool,[1] including when developing and accessing health programs and services and for all major financial decisions and integrations at the LHIN.
Integration & Collaboration	
	Work alongside Health service providers to pursue opportunities to transform the health system to integrate population and public health planning with other services to create stronger links to health promotion and disease prevention; to provide integrated, population-based care by strengthening end to end integration at a multi-community and local level across the South West LHIN
	Work alongside health service providers to pursue opportunities for Integrated Funding Models. This will promote high quality person-centred care across the care continuum by bundling payment to encourage coordination of care, reduce variation of care pathways, increase efficiency, and improve outcomes.
	Engage health service providers Work alongside health service providers in capacity planning activities to improve and increase access to care and use resources more efficiently by and act on opportunities to integrating/aligning services and resources.
	Continue to evaluate integration activities to ensure they are in the best interest of the public. Proposed integrations must demonstrate how they will positively impact on population health, experience of care and value for money.
	Proactively work with health service provider governance through Board-to-Board engagement to intentionally identify and support integration activities related to service, administration and governance
	Provide tools to assist health service providers to continually assess quality of health services, organizational health, human resources, finances and performance outcomes to identify and successfully advance integration and collaboration opportunities.
	Work with health service providers to improve back office services, make the best use of public resources, and plan for future health system transformation.

Quality Improvement & Innovation	
	Work with health service providers to develop a coordinated approach to engage people who receive services and determine experience of care measures.
	Work alongside health service providers to implement best practices (e.g. Quality Based Procedures, Adult Day Program Redesign) and reduce variation within and among organizations to improve outcomes and value for money.
	Work with health service providers to advance quality outcomes for identified priorities and initiatives.
	Encourage health service providers to embed quality improvement within their organizations through processes such as accreditation and use tools such as the Quality Improvement Enabling Framework
	Continue to integrate and standardize improvement tools and templates into the LHIN's project management approach.
	Continue to acknowledge and stimulate quality improvement efforts through the LHIN's annual quality symposium and awards.
	Work alongside health service providers to leverage provincial quality improvement learning opportunities (e.g. IDEAS program--Improving and Driving Excellence across Sectors) by implementing an approach and roadmap to identify improvement projects.
	Engage a Quality Improvement community of practice to continue to build a culture of continuous quality improvement and broadly share quality evidence.
	Work alongside health service providers to consistently embed patient engagement approaches (e.g. Experience Based Design) to advance quality improvement.
	Provide leadership in establishing shared quality improvement strategies through Quality Improvement Plans across and within sectors to advance key priorities.
Transparency & Accountability	
	Work alongside health service providers to implement, evaluate, monitor, and enhance the impact of initiatives within each priority to improve the health of the focused population, their experience of care and the value for money for the care provided.
	Work with health service providers to optimize data processes to improve access, use and analysis of data to make data sharing for improvement easier and to communicate progress against measurement plans and benchmarking targets.
	Continue to implement and enhance value for money assessments of LHIN-wide initiatives in order to understand impact of investments and direct alignment of initiatives to outcomes.
	Establish a plan to strengthen cross-sector integration and shared accountability by leveraging Service Accountability Agreements (SAA) and enhanced improvement and compliance monitoring.
	Increase transparency with publicly-available performance reporting, enhanced outcome-based reporting aligned to key initiatives, and scorecards (system-level and priority-based)

	Improve public-friendly communication and posting of information including key reports and performance results.
eHealth/ Technology	
	Optimize eHealth technologies (e.g. Telemedicine) for timelier access to services, reduced travel time and to avoid unnecessary transfers.
	Enhance Telehomecare to give people with chronic diseases the self-management and remote communication methods to receive the care they need, right in their home.
	Implement the regional clinical viewer, ClinicalConnect, to support high-quality, safe and timely care allowing an individual's healthcare information to be securely available to healthcare providers across the continuum of care.
	Implement eHealth tools (e.g. Health Links Care Coordination Tool) to allow clinicians to collaborate with other care team members and maintain shared, coordinated care plans.
	Advance hospital reporting systems so that primary care providers, specialists and nurse practitioners anywhere in Ontario can receive patient reports electronically from participating hospitals or Independent Health Facilities
	Enhance eHealth technologies (e.g. Integrated Assessment Records) to improve collaboration among health service providers involved in an individual's care through access to timely and secure assessment information.
	Implement eConsultation and eReferral processes to reduce unnecessary referrals to specialists and give primary care physicians more timely access to specialists.
	Implement a system to improve timely access to surgery.

Priorities for the Integrated Health Service Plan 2016-19 (updated June 8, 2016)

Ensuring primary health care is strengthened and linked with the broader health care system		
What are we trying to accomplish? Ensure equitable access to primary health care (including multidisciplinary care) by: enhancing inter-professional collaboration between primary health care models and the broader integrated system of care and; supporting quality improvement initiatives that will improve health outcomes and the experience of care.		
Outcome Objectives: Population Health <ul style="list-style-type: none"> To improve access to primary care To improve early identification and intervention Experience of Care <ul style="list-style-type: none"> Reduce readmission rates for defined populations To improve patient experience To improve care coordination throughout the journey of care Value for Money <ul style="list-style-type: none"> To reduce unnecessary hospitalization To reduce avoidable emergency department visits or revisits 	What will we measure to know we have been successful? Population Health <ul style="list-style-type: none"> Attachment to a primary care provider Access to weekend/ afterhours care <i>Cancer Compliance Rates</i> <i>Influenza vaccination Rates</i> Experience of Care <ul style="list-style-type: none"> Patient Involvement in Care Decisions Primary Care Follow-up Post Hospital Discharge <i>Increased utilization of coordinated care plans</i> Value for Money <ul style="list-style-type: none"> Hospital Readmission Rates Avoidable Emergency Department Visits 	
Projects/Initiatives:	Duration:	
Access to Primary Health Care: Improve access to primary health care by implementing recommendations from the Understanding Health Inequities and Access to Primary Health Care in the South West LHIN Project and build capacity for Primary Care	Beyond 36 Months	
Partnering for Quality: Improve primary care provider capacity to identify patients with chronic conditions and support patients to provide chronic disease management	Beyond 36 months	
Primary Care and Mental Health and Addictions (MH&A) strategy: Strengthen relationships between MH&A services and primary care and increase service capacity with existing primary care structures	25-36 months	
eConsultation: Provide primary care physicians with more timely access to specialist input, potentially avoiding referrals for consultation where applicable.	12-24 months	
Primary Care Network Structure: Continue to strengthen primary care network structure	Beyond 36 months	

Optimizing the health of people and caregivers living at home, in long-term care and in other community settings¹

What are we trying to accomplish?

Improve the care experiences and optimizing the health of people and caregivers living at home, in long-term care and in other community settings, being responsive to changing needs and supporting safe and independent living in a way that is sustainable/effective(ness)

Outcome Objectives:

Population Health

- To increase adoption of evidence based care (High-Level)
- To increase number of people receiving care in the community

Experience of Care

- To increase access to inter-professional teams (High-level)
- To improve access to integrated systems of care for particular populations
- To improve care coordination throughout the journey of care

Value for Money

- To reduce unnecessary variation in service delivery
- To prevent unnecessary long-term care admission

What will we measure to know we have been successful?

Population Health

- *Intensive Hospital to Home and Home First volumes*
- Independent seniors hospitalization rate (65+)
- *In development: compliance to or adoption of care standards being developed for H&CC policy changes*

Experience of Care

- % of Home Care patients with complex needs who received their first personal support visit within 5 days of the date that they were authorized
- % of home care patients who received their first nursing visit within 5 days of the date they were authorized
- CCAC 90th percentile wait times from community for CCAC in-home services
- *In development: number of client transitions from CCAC and Community Support Services (CSS) and vice versa*
- % of home care clients with an unplanned, less urgent ED visit within the first 30 days of discharge from hospital
- % of home care clients who had an unplanned to readmission hospital within 30 days of discharge from hospital

Value for Money

- Alternate Level of Care (ALC) rate
- *In development: standard service packages for like type services between CSS provision to low acuity clients and CCAC provision to moderate and high acuity patients*

¹ People living in community settings may also include those in temporary living accommodations, or who may be experiencing homelessness

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Optimizing the health of people and caregivers living at home, in long-term care and in other community settings ¹	
Projects/Initiatives:	Duration:
Home and Community Care: Implement provincial home and community care road map and policy changes related to the provision of Personal Support Services to support an integrated system of care	25-36 months
Adult Day Programs (ADP): Enhance ADPs including specialized stroke programming and to ADP related transportation	Beyond 36 months
Transitional and Life-Long Care Clinic Model: Spread model that improves transitions from the pediatric system of care to adult services where families typically experience a significant loss of support	12-24 months
Congregate Residential Living: Expand 24/7 assisted Living services for younger adults with complex needs	12-24 months
Long-Term Care (LTC) Home Redevelopment: Ensure equitable access, quality and safety for residents living in LTC	Beyond 36 months
Assisted Living Hubs: Increase access to assisted living supports through implementation of hubs (multiple phases)	Beyond 36 months
Special Needs Strategy: Plan and implement coordinated care planning and integrated rehabilitation services across multiple ministries (Ministry of Children and Youth Services, Ministry of Community and Social Services, Ministry of Health and Long Term Care, Ministry of Education) for shared populations	Beyond 36 months
Dementia Care Strategy: Plan and implement the South West LHIN Dementia Strategy in alignment with the provincial dementia strategy	Beyond 36 months
Oneida Long-Term Care Empowerment: Transition the management of LTC admission process to Oneida First Nation	Beyond 36 months
Elder Abuse Strategy: Reduce abuse within the seniors community aligned with the goals identified in the Provincial Elder Abuse Strategy recommended by the Ontario Senior's Secretariat and the South Western Ontario Regional Elder Abuse Network	25 – 36 months

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Supporting people in preventing and managing chronic conditions		
What are we trying to accomplish? Support people in the prevention and appropriate management of chronic conditions through optimizing care coordination, enhancing accessibility, maximizing provider collaboration, in a cost effective and efficient manner		
Outcome Objectives: Population Health <ul style="list-style-type: none"> To reduce the burden the illness To increase education and training To improve self-management among individuals Experience of Care <ul style="list-style-type: none"> To improve system navigation and care coordination To improve patient experience Value for Money <ul style="list-style-type: none"> To reduce unnecessary hospitalizations and readmissions To Increase care in the community 	What will we measure to know we have been successful? Population Health <ul style="list-style-type: none"> Chronic Disease Prevalence and Incidence <i>Service utilization of self-management and diabetes education programs Confidence scores for patients with a Coordinated Care Plan</i> Experience of Care <ul style="list-style-type: none"> <i>Number of identified users with high care needs on active care plan</i> Primary care follow-up post hospital discharge <i>Time from referral to home care visit for patients with high care needs</i> <i>Support and respect scores for patients with a coordinated care plan</i> Value for Money <ul style="list-style-type: none"> <i>Hospital readmission rates</i> <i>Utilization of acute and ambulatory services for residents with active care plans</i> Hospitalization rate for Ambulatory Care Sensitive Conditions <i>Average cost of patients with high care needs (long term)</i> Rate of ER visits best managed elsewhere 	
	Projects/Initiatives:	Duration:
LHIN wide Integrated Chronic Disease Prevention & Management Model: Develop model		Less than 12 months
Optimized Access for Chronic Condition Management Programs and Services: Develop/implement a model for coordinated access to diabetes management programs and services Expand and align model to programs and services for other chronic conditions as appropriate		Beyond 36 months
Integrated System of Care: Develop/implement standardized care pathways across the continuum for people with chronic conditions, leveraging Health Links, Integrated Funding Models (IFMs) and Quality Based Procedures (QBP) best practice, reduce variation and increase standardization of best practices among and within system partners for vision care, wound care (including diabetes foot care), chronic kidney disease (CKD), congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).		25-36 months
Health Links: Support development and spread of the provincial Health Links coordinated care plan and associated electronic tools; Utilize experience based design methods in improvement processes of each local Health Link as part of the Health Links program implementation		25-36 months
Diabetic Foot Care Project: Continue the planning and implementation of foot care model		12- 24 months

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Supporting people in preventing and managing chronic conditions	
Tele-homecare Program: Pilot and spread the use of tele-homecare technologies for people with certain chronic conditions across the LHIN using self-management and remote communication tools people can use in their own homes	Less than 12 months
South West Self-Management Program: Build system capacity to support people to attain their goals for their health	Beyond 36 months
Francophone Chronic Disease Self-Management: To enhance and/or build on services for the management and prevention of chronic diseases, in person or through Ontario Telemedicine Network (OTN)	25 – 36 months
Culturally Safe Care for Aboriginal Populations: In partnership with First Nations, Aboriginal, and Metis people advance culturally safe chronic disease care including the planning and implementation of culturally safe approaches to Health Links	Beyond 36 months
Francophone Health Link Strategy: identify strategy to support Health Link implementation related to meeting the needs of the francophone population consistent with the Health Link, health equity impact assessment findings	25 – 36 months

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Strengthening mental health and addiction services and their relationship with other partners

What are we trying to accomplish?

Ensure services and supports are continually improving, easier to access and translate into high quality care where people and their caregivers, impacted by mental health and/or addictions and/or responsive behaviours can thrive.

Outcome Objectives:

Population Health

- To reduce the burden of illness
- To enhance capacity planning to increase the number of people receiving care in the community

Experience of Care

- To improve access to integrated systems of care
- To improve patient experience

Value for Money

- To optimize utilization of resources
- To reduce unnecessary variation in service delivery

What will we measure to know we have been successful?

Population Health

- Access to primary care (TBD)
- *Change in behavioural symptoms among Long-Term Care (LTC) Home residents [Behavioural Supports Ontario (BSO) legacy measure]*
- *Police & Emergency Medical Services (EMS) involvement/time on call (TBD)*
- Mental illness hospitalization rate

Experience of Care

- Repeat unscheduled Emergency Room (ER) visits within 30 days – Mental Health
- Repeat unscheduled ER visits within 30 days – Substance Abuse
- Access to inter-professional teams e.g. follow-up appointment booked within 30 days of discharge from hospital (before discharge) (TBD)
- 30 day readmission rates
- Wait-times for access to services, specialists (e.g. mental health and addictions case management and community treatment for substance abuse from Connex)
- Patient experience: [future: from Ontario Perceptions of Care (OPOC)]

Value for Money

- *Service efficiency: unit cost or Intensive Case Management (ICM) measure*
- LTC Home transfer rate to ED for behavioural/mental health conditions (Form 1) – may need to refine [e.g. by Canadian Triage and Acuity Scale (CTAS)]
- Number of Alternate Level of Care (ALC) Days and Cases with Behavioural and Mental Health Specialized Needs & Barriers
- Prevent unnecessary LTC admission (TBD)

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Strengthening mental health and addiction services and their relationship with other partners	
Projects/Initiatives:	Duration:
Mental Health and Addictions (MH&A) Crisis Services: Continue to refine what the crisis services needs are in each geographic area to ensure equitable access, consistency and quality of crisis services across the LHIN and reduce reliance on police and emergency departments(EDs) for those experiencing a crisis	12-24 months
MH&A Supportive Housing: Implement provincial program and leverage municipal partnerships to increase supports within housing	25-36 months
MH&A: Care Pathways: Develop/implement standardized care pathways for people with mental health and/or addiction issues and for people with high needs responsive behaviours	25-36 months
MH&A Services Standardization: Develop recommendations for service alignment and potential investments based on a review of present capacity, function and utilization of MH&A services	25-36 months
Intensive MH&A Case Management: Evaluate pilot program / evidence based model to create sustainable outcomes for spread consideration	12-24 months
Coordinated Access for MH&A Services: Continue to implement and improve coordinated screening & intake and waitlist processes to streamline access to services as well as create a common portal of entry for people accessing mental health and addiction services. Facilitate the coordination of Aboriginal MH&A services with main stream MH&A services	Less than 12 months
Ontario Perceptions of Care (OPOC) Tool: Implement the OPOC tool which seeks to understand and improve experience of care for people impacted by mental health and/or addiction issues	12-24 months
MH&A Peer Support Strategy: Development and implement a Regional Peer Support strategy based on the recommendations in the “Development of a Peer Support Strategy for the South West LHIN” 2015 report.	12-24 months
Strategy for Moderate Mental Illness: Develop a strategy to respond to the increasing demand for services from moderately mentally ill clients and identify the role of primary care in supporting individuals with mild to moderate mental health problems.	12-24 months
Emergency Department (ED) Mental Health Access and Flow: Formalize processes to enable the safe and timely referral, assessment and repatriation of Form 1 Mental Health patients from Emergency Departments to appropriate Mental Health Services and Schedule 1 facilities	12-24 months
New Staged Screening and Assessment Screening for Addictions: Improve the screening and assessment of clients receiving substance use services through the implementation of a staged protocol across the South West LHIN and support sustainable implementation through coaching, fidelity monitoring and evaluation.	12-24 months
MH&A Education Strategy: Conduct an education needs and readiness assessment for MH&A providers to identify key topics and priority areas for education	12-24 months
Long-Term Care Home Specialized Units: Implement process to create specialized units for people with responsive behaviours	Beyond 36 months
Behavioural Supports Ontario (BSO) System of Care: Continue to meet the needs of older adults with or at risk of responsive behaviours due to mental health and addictions, dementia, or other neurological conditions to maintain or improve their quality of life and that of their caregivers by improving equitable access to coordinated, effective and efficient services and supports	Beyond 36 months
Francophone Strategy: Ensure French language service capacity for key service functions (case management, counseling, crisis response, treatment, tier/bedded capacity, maintenance, family services and support); Optimize MH&A service delivery, including BSO, for the Francophone population in London	25-36 months

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Ensuring timely access to hospital-based care, LHIN-wide, multi-community, and local level

What are we trying to accomplish?

Timely access to high quality, effective and efficient hospital-based treatment and care appropriately aligned at the LHIN-wide, multi-community and local level

Outcome Objectives:

Population Health

- To increase adoption of evidence based care

Experience of Care

- To decrease wait times for access to services, specialists and/or procedures
- To improve patient experience
- To improve care coordination throughout the journey of care

Value for Money

- To optimize utilization of resources

What will we measure to know we have been successful?

Population Health

- % of hospitals have implemented (or are in progress) to address issues of delirium (target 100%)*
- % of hospitals have participated in regional SFH activities (networking days, webcasts, and steering committee) (target 100%)*
- % of hospitals will participate in the provincial ACTION program and those hospitals will showcase their work in a SW LHIN forum to build capacity, share learnings across the region (target 75%)*
- QBP implementation progress, adoption of QBP best practice/ clinical best practice pathways (Survey) (TBD)

Experience of Care

- Rate of readmissions to hospital within 30 days for selected Case Mix Groups (CMGs)
- % of cases completed in target wait time: CT, MRI, hip, knee, cancer, cardiac, cataract
- Timeliness of discharge summary communication within 48 hours
- Maintaining access and discharge practices in peak periods: admission/discharge throughput*
- Length of stay for patients in emergency departments
- Time to inpatient bed, ICU avoidable days
- % Life or Limb transfers in 4 hours
- % of hospitals have patient experience as a measure in their quality improvement plans (target 100%)*

Value for Money

- Actual to expected Hospital Based Allocation Methodology (HBAM) cost (CCC, rehab, ED, acute/day surgery)
- Actual to expected cost for key identified clinical services planning streams*
- Actual to expected cost for select Quality Based Procedures*
- Actual to expected length of stay*
- ALC throughput
- Wait Times & QBP volumes: allocated versus completed*

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Ensuring timely access to hospital-based care, LHIN-wide, multi-community, and local level	
Projects/Initiatives:	Duration:
Clinical Services Planning: Develop a coordinated and standardized approach to the implementation of Quality Based Procedures, patient care planning, admission/discharge/transition processes and capacity planning across the continuum of care to ensure implementation of the recommendations related to Stroke (hospital and community based care), vision care, perinatal care, and diagnostic imaging; including the development, implementation and spread of Integrated Funding Models (IFMs) based on experience from CHF and COPD.	25-36 months
Waitlist Management Strategies: Implement a surgical eBooking, wait list management, automated (complex) WTIS reporting and pre-op standardization system. Investigate strategies to improve Wait 1 and Wait 2 in priority areas	25-36 months
Critical Care Strategy (Critical Care Services Ontario): Improve timely access and quality of care through capacity management (PHRS), sustainability of Life or Limb – No Refusal Policy, and implementation of clinical best practice guidelines.	12 – 24 months
Chronic Mechanical Ventilation (CMV) System of Care: Implementation of CMV recommendations across continuum of care (Acute, Sub-Acute, Community) and LTV feasibility study, exploration of new service delivery models and standardize data capture and reporting.	12-24 months
Senior Friendly Hospital Strategy: Grow and sustain Senior Friendly Hospital strategy (organizational support, processes of care, emotional and behavioral environment, ethics in clinical care and research, physical environment)	12-24 months
Patient Flow Strategies: Optimize patient flow (access, efficiency, effectiveness) within and across Hospitals. through a targeted improvement approach including establishment of a Learning Collaborative to align with the ED pay for results and knowledge transfer sites to enable sustainability and spread of leading practices	0-24 months
Antimicrobial Stewardship: Create opportunities to spread best practices for antimicrobial stewardship across hospitals to reduce hospital acquired infections (e.g. C. difficile)	TBD

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Enabling a rehabilitative approach across the care continuum		
What are we trying to accomplish? Supporting improved patient experiences, clinical outcomes, and transitions through improved access , efficiency, effectiveness, quality, integration, value and equity in the delivery of rehabilitative services across the care continuum		
Outcome Objectives: Population Health <ul style="list-style-type: none"> To improve early identification and intervention Experience of Care <ul style="list-style-type: none"> To improve access to integrated systems of care for particular populations To improve patient experience Value for Money <ul style="list-style-type: none"> To reduce unnecessary variation in service delivery To improve service efficiency To reduce unnecessary hospitalization 	What will we measure to know we have been successful? Population Health <ul style="list-style-type: none"> Early identification & intervention (Assess and Restore - TBD) Change in Functional Independence Measure (FIM) score (TBD) LHIN-wide implementation of assess and restore guidelines LHIN-wide adoption of provincially standardized definitions and eligibility criteria for bedded rehabilitation Experience of Care <ul style="list-style-type: none"> Falls in last 30 days among LTC home residents Rate of ER visits resulting from falls (per 100,000 population 65 and over) Hip & Knee (Total Joint Replacement) Wait I Hip & Knee (Total Joint Replacement) Patient Experience <i>Assess and Restore measure (TBD)</i> % of unplanned, less-urgent ED visit within the first 30 days of discharge from hospital % of unplanned readmissions to hospital within 30 days of discharge Value for Money <ul style="list-style-type: none"> % ALC days/rate for ALC rehab Length of stay efficiency % eligible patients in rehab beds <i>Coordinated access: wait from referral to bed acceptance/decline</i> Assess and restore—avoidable hospitalizations (TBD) 	
	Projects/Initiatives:	Duration:
Falls Prevention Strategy: Support spread of the South West Falls Prevention Strategy including opportunities to meet Francophone needs.		12-24 months
Rehabilitation Capacity Plan and Implementation: Plan and implement the adoption of provincially standardized bedded rehabilitation definitions and eligibility criteria, and plan and implement a bedded rehabilitation capacity plan		12-36 months
Community Physiotherapy Reform: transition funding and accountability for publicly funded physiotherapy clinics from MOHLTC to LHINS.		12-24 months
Coordinated Access: Support ongoing implementation and improvement of Coordinated Access thru CCAC.		12-24 months
Assess and Restore: Plan and implement the provincial Assess and Restore Guideline in collaboration with other LHINs and in alignment with Ministry of Health and Long-Term Care expectations		Beyond 36 months

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

Putting people with life-limiting illnesses and their families at the centre of hospice palliative care		
What are we trying to accomplish? To put individuals with life-limiting illnesses and their families at the centre of care to optimize their quality of life by improving equitable access to coordinated, effective, efficient quality services and supports.		
Outcome Objectives: Population Health <ul style="list-style-type: none"> To improve early identification and intervention To reduce the burden of illness To increase # of people receiving care in the community Experience of Care <ul style="list-style-type: none"> To increase access to inter-professional teams To improve patient experience To improve care coordination throughout the journey of care To support patient choice in place of death Value for Money <ul style="list-style-type: none"> To increase # of people receiving care in the community 	What will we measure to know we have been successful? Population Health <ul style="list-style-type: none"> Average Palliative Performance Scale (PPS) on Admission to residential hospice Average Length of Stay (LOS) in residential hospice Experience of Care <ul style="list-style-type: none"> % of palliative care clients receiving home support upon discharge (by region by Fiscal Quarter) % of Palliative care clients with hospital readmission within 30 days by region by Fiscal Quarter End of Life Report - % of patients die in their place of choice <i>In development: Long-Term Care measure</i> <i>Source of Admission to residential hospice</i> Value for Money <ul style="list-style-type: none"> Palliative care length of stay (LOS) in acute care settings % of palliative care clients that were discharged from hospital that were seen in the ER within 30 days by region by Fiscal Quarter % of palliative care clients that died in hospital by region by Fiscal Quarter <i>Occupancy rate in residential hospice setting</i> 	
	Projects/Initiatives:	Duration:
Grey Bruce Hospice Palliative Care Outreach: Spread hospice palliative care secondary level outreach consultation support throughout the LHIN		Beyond 36 months
Integrated Hospice Palliative Care (HPC) System: Continue to develop an integrated system of HPC aligned with provincial Declaration of Partnership		Beyond 36 months
HPC Capacity Planning: Build and implement recommendations for bedded and non-bedded palliative resources in a variety of care settings		12 – 24 months
HPC Education: Develop and implement a strategic approach to educating providers and communities about HPC		12 – 24 months
Aboriginal Approach to HPC: In partnership with First Nations, Aboriginal, and Metis people plan and implement culturally safe approaches to Aboriginal Hospice Palliative Care		Beyond 36 months

** Indicators in the “how will we know we have been successful” section in *italics* may move to the Project/initiative level in the future

2016-2019 Annual Business Plan/ Integrated Health Service Plan Priorities & Initiatives Progress						
Initiative Code	IHSP Initiative/Sub-Initiative	IHSP Priority	Duration	Planned End Date	Progress (%) at Mar. 31, 2016	Status at Mar. 31, 2016
1	LHIN-wide Integrated Chronic Disease Prevention & Management Model: Develop model- This initiative has been integrated into #3	Chronic Disease	Beyond 36 months	TBD	10%	Initiate
2	Optimized Access for chronic condition management programs and services: Develop/implement a model for coordinated access to diabetes management programs and services Expand and align model to programs and services for other chronic conditions as appropriate	Chronic Disease				
2.1	<i>Diabetes Coordinated Access</i>	Chronic Disease	12 to 24 months	March 31, 2017	10%	Plan
3	Integrated Chronic Disease System of Care: Develop/implement integrated chronic disease prevention and management strategies across the continuum of care for people living with chronic conditions to improve access and coordination and increase standardization of best practices among and within system partners.	Chronic Disease	Beyond 36 months	TBD	5%	Initiate

4	Health Links: Support development and spread of the provincial Health Links coordinated care plan and associated electronic tools; Utilize experience based design methods in improvement processes of each local Health Link as part of the Health Links program implementation	Chronic Disease	25 to 36 months	March 31, 2019	See sub-initiatives	See sub-initiatives
4.1	<i>London Middlesex Health Link implementation</i>	Chronic Disease	12 to 24 months	March 31, 2017	40%	Execute
4.2	<i>North and South Grey Bruce Health Links implementation</i>	Chronic Disease	12 to 24 months	March 31, 2017	10%	Execute
4.3	<i>Oxford Health Link implementation</i>	Chronic Disease	25 to 36 months	March 31, 2018	0%	Not Started
4.4	<i>Elgin Health Links implementation</i>	Chronic Disease	25 to 36 months	March 31, 2018	0%	Not Started
5	Diabetic Foot Care Project: Continue the planning and implementation of foot care model	Chronic Disease	12 to 24 months	TBD	30%	Execute
6	Tele-homecare Program: Pilot and spread the use of tele-homecare technologies for people with certain chronic conditions across the LHIN using self-management and remote communication tools people can use in their own homes	Chronic Disease	Less than 12 months	March 31, 2017	60%	Execute
7	South West Self-Management Program: Build system capacity to support people to attain their goals for their health	Chronic Disease	Beyond 36 months	TBD	90%	Monitor
8	Francoophone Chronic Disease Self-Management: To enhance and/or build on services for the management and prevention of chronic diseases, in person or through Ontario Telemedicine Network (OTN)	Chronic Disease	25 to 36 months	March 31, 2019	0%	Not Started

9	Culturally Safe Care for Aboriginal populations: In partnership with First Nations, Aboriginal, and Metis people advance culturally safe chronic disease care including the planning and implementation of culturally safe approaches to Health Links	Chronic Disease	Beyond 36 months	TBD	10%	Initiate
10	Francophone Health Link strategy: identify strategy to support Health Link implementation related to meeting the needs of the francophone population consistent with the Health Link, health equity impact assessment findings	Chronic Disease	25 to 36 months	March 31, 2019	10%	Plan
11	Home and Community Care: Implement provincial home and community care road map and policy changes related to the provision of Personal Support Services to support an integrated system of care	Home LTC Community	25 to 36 Months	March 31, 2019	10%	Initiate
11.1	<i>In alignment to the Patients First LHIN responsibilities, the LHIN will develop and implement the LHIN-wide strategy to transfer the essential home care functions from the CCAC to the LHIN and integrate Care Coordinators within the appropriate areas of the health system.</i>	Home LTC Community	Beyond 36 Months	TBD	0%	Not Started
11.2	<i>Plan and implement the Patients First sub-LHIN strategy to transfer the essential home care functions from the CCAC to the LHIN and integrate Care Coordinators within the appropriate areas of the health system in Elgin County</i>	Home LTC Community	Beyond 36 Months	TBD	0%	Not Started

11.3	<i>Plan and implement the Patients First sub-LHIN strategy to transfer the essential home care functions from the CCAC to the LHIN and integrate Care Coordinators within the appropriate areas of the health system in Oxford County</i>	Home LTC Community	Beyond 36 Months	TBD	0%	Not Started
11.4	<i>Plan and implement the Patients First sub-LHIN strategy to transfer the essential home care functions from the CCAC to the LHIN and integrate Care Coordinators within the appropriate areas of the health system in London Middlesex</i>	Home LTC Community	Beyond 36 Months	TBD	0%	Not Started
11.5	<i>Plan and implement the Patients First sub-LHIN strategy to transfer the essential home care functions from the CCAC to the LHIN and integrate Care Coordinators within the appropriate areas of the health system in Grey Bruce</i>	Home LTC Community	Beyond 36 Months	TBD	0%	Not Started
11.6	<i>Plan and implement the Patients First sub-LHIN strategy to transfer the essential home care functions from the CCAC to the LHIN and integrate Care Coordinators within the appropriate areas of the health system in Huron Perth</i>	Home LTC Community	Beyond 36 Months	TBD	0%	Not Started
11.7	<i>Implementation of Collaborative Assessment and Referral Model Recommendations</i>	Home LTC Community	Less than 12 Months	March 31, 2017	75%	Plan
12	Adult Day Programs (ADP): Enhance ADPs including specialized stroke programming and to ADP related transportation	Home LTC Community	Beyond 36 Months	March 31, 2020	20%	See sub-initiatives

12.1	<i>Adult Day Program Redesign Review</i>	Home LTC Community	12 to 24 Months	March 31, 2018	25%	Execute
12.2	<i>ABI Specialized ADP: Kensington Village</i>	Home LTC Community	12 to 24 Months	March 31, 2017	30%	Plan
12.3	<i>ADP Stroke Programming in the Community linked with hospital-based programming</i>	Home LTC Community	Beyond 36 Months	March 31, 2021	0%	Not Started
13	Transitional and Life-Long Care Clinic Model: Spread model that improves transitions from the pediatric system of care to adult services where families typically experience a significant loss of support	Home LTC Community	Beyond 36 Months	March 31, 2019	5%	Not Started
14	Congregate Residential Living: Expand 24/7 assisted Living services for younger adults with complex needs	Home LTC Community	12 to 24 Months	March 31, 2019	75%	Not Started
15	Long-Term Care (LTC) Home Redevelopment: Ensure equitable access, quality and safety for residents living in LTC	Home LTC Community	Beyond 36 Months	December 31, 2025	5%	Plan
15.1	<i>Support LTC Homes Planning to Redevelop Immediately</i>	Home LTC Community	25 to 36 Months	March 31, 2019	5%	Plan
16	Assisted Living Hubs: Increase access to assisted living supports through implementation of hubs (multiple phases)	Home LTC Community	Beyond 36 Months	March 31, 2020	20%	See sub-initiatives

16.1	<i>Further Execution of AL Hubs in Phase 1 Communities: Meaford, Woodstock, London, St. Thomas, Strathroy</i>	Home LTC Community	Beyond 36 Months	March 31, 2020	30%	Execute
16.2	<i>Further Execution of AL Hubs in Phase 2 Communities: Goderich, Kincardine, Listowel, Ingersoll, Tillsonburg, Stratford</i>	Home LTC Community	Beyond 36 Months	March 31, 2020	20%	Execute
16.3	<i>Subsequent phasing of AL Hub implementation to cover IHSP cycle</i>	Home LTC Community	Beyond 36 Months	March 31, 2020	0%	Not Started
17	Special Needs Strategy: Plan and implement coordinated care planning and integrated rehabilitation services across multiple ministries (Ministry of Children and Youth Services, Ministry of Community and Social Services, Ministry of Health and Long Term Care, Ministry of Education) for shared populations	Home LTC Community	25 to 36 Months	March 31, 2019	0%	Not Started
18	Dementia Care Strategy: Plan and implement the South West LHIN Dementia Strategy in alignment with the provincial dementia strategy	Home LTC Community	Beyond 36 Months	March 31, 2020	5%	Initiate
19	Oneida Long-Term Care empowerment: Transition the management of LTC admission process to Oneida First Nation	Home LTC Community	Beyond 36 Months	March 31, 2020	0%	Not Started
20	Elder Abuse Strategy: Reduce abuse within the seniors community aligned with the goals identified in the Provincial Elder Abuse Strategy recommended by the Ontario Senior's Secretariat and the South Western Ontario Regional Elder Abuse Network	Home LTC Community	Beyond 36 months	March 31, 2020	10%	Initiate

21	Grey Bruce Hospice Palliative Care Outreach: Spread hospice palliative care secondary level outreach consultation support throughout LHIN	Hospice Palliative Care	Beyond 36 Months	March 31, 2020	See sub-initiatives	See sub-initiatives
21.1	<i>Grey Bruce HPC Outreach Model</i>	Hospice Palliative Care	Less than 12 months	March 31, 2017	75%	Monitor
21.2	<i>Oxford & Elgin HPC Outreach</i>	Hospice Palliative Care	Less than 12 months	March 31, 2017	15%	Execute
21.3	<i>Huron Perth & London Middlesex HPC Outreach</i>	Hospice Palliative Care	12 to 24 months	March 31, 2018	0%	Not Started
22	Integrated Hospice Palliative Care (HPC) System: Continue to develop an integrated system of HPC aligned with provincial Declaration of Partnership	Hospice Palliative Care	Beyond 36 Months	March 31, 2020	40%	Execute
23	HPC Capacity Planning: Build and implement recommendations for bedded and non-bedded palliative resources in a variety of care settings	Hospice Palliative Care	25 to 36 months	March 31, 2019	25%	Plan
24	HPC Education: Develop and implement a strategic approach to educating providers and communities about HPC	Hospice Palliative Care	12 to 24 Months	March 31, 2018	10%	Initiate
25	Aboriginal Approach to HPC: In partnership with First Nations, Aboriginal, and Metis people plan and implement culturally safe approaches to Aboriginal Hospice Palliative Care	Hospice Palliative Care	12 to 24 months	March 31, 2017	50%	Plan

26	Clinical Services Planning: Develop a coordinated and standardized approach to the implementation of Quality Based Procedures, patient care planning, admission/discharge/transition processes and capacity planning across the continuum of care to ensure implementation of the recommendations related to Stroke (hospital and community based care) vision care, perinatal care and diagnostic imaging; including the development, implementation and spread of Integrated Funding	Hospital-based Care	25 to 36 months	March 31, 2019	See sub-initiatives	See sub-initiatives
26.1	<i>Stroke Phase 1 - Implementation and Evaluation of Directional Recommendations</i>	Hospital-based Care	12 to 24 months	March 31, 2018	25%	Plan
26.2	<i>Stroke Phase 2 - Community Capacity (Development and Implementation of Recommendations)</i>	Rehabilitative Care	25 to 36 months	March 31, 2019	15%	Plan
26.3	<i>Vision Care - Development of a case-based approach to clinical decision-making and coordination of care to people with complex eye problems and people with complex medical conditions</i>	Hospital-based Care	Less than 12 months	March 31, 2017	90%	Plan
26.4	<i>Vision Care - Development and testing of a process to collect pre- and post-cataract surgery visual acuity scores as a way to measure the clinical outcome of cataract surgery</i>	Hospital-based Care	Less than 12 months	March 31, 2018	0%	Not Started

26.5	<i>Vision Care - Development and testing of a strategy to improve visual screening rates among people living with diabetes in the South West LHIN</i>	Hospital-based Care	Less than 12 months	March 31, 2018	0%	Not Started
26.6	<i>Regional Medical Imaging Integrated Care project</i>	Hospital-based Care	12 to 24 months	March 31, 2018	5%	Initiate
26.7	<i>Orthopaedic System of Care</i>	Hospital-based Care	12 to 24 months	TBD	5%	Initiate
27	Waitlist Management Strategies: Implement a surgical eBooking, wait list management, automated (complex) WTIS reporting and pre-op standardization system. Investigate strategies to improve Wait 1 and Wait 2 in priority areas	Hospital-based Care	25 to 36 months	March 31, 2019	See sub-initiatives	See sub-initiatives
27.1	<i>Cross-LHIN Implementation of Novari</i>	Hospital-based Care	25 to 36 months	March 31, 2019	10%	Plan

27.2	<i>Wait 1 strategies: Improve access to acute care services through primary care implementation of booking and scheduling of appointments in acute care; bring visibility to surgical waitlists in primary care offices with a focus on patient choice; investigate opportunities for improved waitlists through centralized booking/queuing</i>	Primary Health Care	25 to 36 months	TBD	0%	Not Started
28	Critical Care Strategy (Critical Care Services Ontario): Improve timely access and quality of care through capacity management (PHRS), sustainability of Life or Limb – No Refusal Policy, and implementation of clinical best practice guidelines.	Hospital-based Care	12 to 24 months	June 31, 2019	100%	Monitor
29	Chronic Mechanical Ventilation (CMV) System of Care: Implementation of CMV recommendations across continuum of care (Acute, Sub-Acute, Community) and LTV feasibility study, exploration of new service delivery models and standardize data capture and reporting.	Hospital-based Care	12 to 24 months	March 13, 2019	See sub-initiatives	See sub-initiatives
29.1	<i>To document the barriers and resources required by LTC Homes to support residents with tracheotomies, chronic non-invasive mechanical ventilation (NIV) and/or cough assist; to develop strategies to address barriers and develop care processes to support solutions.</i>	Home LTC Community	Less than 12 months	March 31, 2017	90%	Monitor

29.2	<i>To work in partnership with the Ontario Ventilator Equipment Pool and Hamilton Health Sciences Centre (operator of IDS) to identify the steps needed to link VEP and IDS data – primarily by using VEP patient identifiers and to take the necessary steps to create the interface.</i>	Hospital-based Care	Less than 12 months	March 31, 2017	90%	Execute
29.3	<i>To investigate the opportunity and implications of using an Integrated Funding Model approach to funding on-going operations focused on adults living with CMV.</i>	Hospital-based Care	Less than 12 months	March 31, 2017	0%	Not Started
29.4	<i>To support participation in the Institute for Healthcare Improvement's (IHI) Open School to enhance system planning and quality improvements.</i>	Hospital-based Care	12 to 24 months	June 31, 2017	0%	Not Started
30	Senior Friendly Hospital Strategy: Grow and sustain Senior Friendly Hospital strategy (organizational support, processes of care, emotional and behavioral environment, ethics in clinical care and research, physical environment)	Hospital-based Care	12 to 24 months	March 31, 2017	60%	Execute

31	Patient Flow Strategies: Optimize patient flow (access, efficiency, effectiveness) within and across Hospitals. through a targeted improvement approach including establishment of a Learning Collaborative to align with the ED pay for results and knowledge transfer sites to enable sustainability and spread of leading practices	Hospital-based Care	12 to 24 Months	April 1, 2018	30%	Plan
32	Antimicrobial Stewardship: Create opportunities to spread best practices for antimicrobial stewardship across hospitals to reduce hospital acquired infections (e.g. C. difficile)	Hospital-based Care	Less than 12 months	March 31, 2017	50%	Plan
33	Mental Health and Addictions (MH&A) Crisis Services: Continue to refine what the crisis services needs are in each geographic area to ensure equitable access, consistency and quality of crisis services across the LHIN and reduce reliance on police and emergency departments(EDs) for those experiencing a crisis	Mental Health & Addictions	12 to 24 months	March 31, 2017	See sub-initiatives	See sub-initiatives
33.1	<i>Crisis Centre: Completion of capital renovations to allow crisis stabilization beds to move to the Centre; monitoring of impact of new Centre</i>	Mental Health & Addictions	12 to 24 Months	TBD based on Capital	85%	Execute
33.2	<i>London Middlesex Enhanced Crisis Working Group (phase 2): Continued enhancement of partnership and QI related to how crisis services are provided, in coordination, in London Middlesex</i>	Mental Health & Addictions	12 to 24 Months	March 31, 2017	10%	Initiate

34	MH&A Supportive Housing: Implement provincial program and leverage municipal partnerships to increase supports within housing	Mental Health & Addictions	25 to 36 months	March 31, 2019	See sub-initiatives	See sub-initiatives
34.1	<i>2016/17 investments in support of the implementation of the Mental Health & Addiction Strategy – Phase 2, 1,000 New Supportive Housing Units</i>	Mental Health & Addictions	12 to 24 Months	March 31, 2017	0%	Not Started
34.2	<i>Evaluation related to the 3 year Provincial strategy impacts: Anticipate a provincial evaluation strategy re the 3 years of investments into the Province-wide 1,000 Supportive Housing Units</i>	Mental Health & Addictions	25 to 36 Months	March 31, 2019	0%	Not Started
35	MH&A: Care Pathways: Develop/implement standardized care pathways for people with mental health and/or addiction issues and for people with high needs responsive behaviours	Mental Health & Addictions	25 to 36 months	March 31, 2019	20%	Plan
36	MH&A Services standardization: Develop recommendations for service alignment and potential investments based on a review of present capacity, function and utilization of MH&A services	Mental Health & Addictions	25 to 36 months	TBD	See sub-initiatives	See sub-initiatives
36.1	<i>Crisis Standardization LHIN-Wide Project: establishment of equitable access to MH&A Crisis services across the South West LHIN based on: Standardized service delivery criteria/ description; Consistent application of service expectations ; Targets (e.g. Staff/client ratios); Outcomes; and LHIN funding/functional centre</i>	Mental Health & Addictions	12 to 24 Months	March 31, 2018	10%	Plan

37	Intensive MH&A Case Management: Evaluate pilot program / evidence based model to create sustainable outcomes for spread consideration	Mental Health & Addictions	12 to 24 months	March 31, 2018	75%	Monitor
38	Coordinated Access for MH&A Services: Continue to implement and improve coordinated screening & intake and waitlist processes to streamline access to services as well as create a common portal of entry for people accessing mental health and addiction services. Facilitate the coordination of Aboriginal MH&A services with main stream MH&A services	Mental Health & Addictions	Less than 12 months	March 31, 2017	50%	Execute
39	Ontario Perceptions of Care (OPOC) Tool: Implement the OPOC tool which seeks to understand and improve experience of care for people impacted by mental health and/or addiction issues	Mental Health & Addictions	12 to 24 months	March 31, 2018	20%	Plan
40	MH&A Peer Support Strategy: Development and implement a Regional Peer Support strategy based on the recommendations in the "Development of a Peer Support Strategy for the South West LHIN" 2015 report.	Mental Health & Addictions	12 to 24 months	March 31, 2018	10%	Plan
41	Strategy for Moderate Mental Illness: Develop a strategy to respond to the increasing demand for services from moderately mentally ill clients and identify the role of primary care in supporting individuals with mild to moderate mental health problems.	Mental Health & Addictions	12 to 24 months	March 31, 2019	0%	Not Started

42	Mental Health & Addictions Capacity Planning Phase 1: Conduct a current state review of Schedule 1 inpatient MH beds, review length of stay and occupancy rates, and identify opportunities to optimize resources. Standardize intake tools, surge protocols, and inter-hospital referrals and repatriation of patients.	Mental Health & Addictions	12 to 24 months	March 31, 2018	30%	Plan
43	New Staged Screening and Assessment Screening for Addictions: Improve the screening and assessment of clients receiving substance use services through the implementation of a staged protocol across the South West LHIN and support sustainable implementation through coaching, fidelity monitoring and evaluation.	Mental Health & Addictions	12 to 24 months	March 31, 2018	25%	Initiate
44	MH&A Education Strategy: Conduct an education needs and readiness assessment for MH&A providers to identify key topics and priority areas for education	Mental Health & Addictions	12 to 24 months	TBD	0%	Not Started
45	Long-Term Care Home Specialized Units: Implement process to create specialized units for people with responsive behaviours	Mental Health & Addictions	Beyond 36 months	TBD	See sub-initiatives	See sub-initiatives

45.1	<i>McGarrell Place: Creation of proposal to submit to Ministry to receive designation of specialized unit, implementation and evaluation of unit</i>	Mental Health & Addictions	Beyond 36 months	TBD	50%	Plan
45.2	<i>Development of other BSUs: With focus initially in Grey Bruce and Middlesex, then spread to Oxford, Elgin and Huron Perth, creation of proposals to submit to Ministry to receive designation of specialized units, implementation and evaluation of units</i>	Mental Health & Addictions	Beyond 36 months	TBD	20%	Initiate
46	Behavioural Supports Ontario (BSO) System of Care: Continue to meet the needs of older adults with or at risk of responsive behaviours due to mental health and addictions, dementia, or other neurological conditions to maintain or improve their quality of life and that of their caregivers by improving equitable access to coordinated, effective and efficient services and supports	Mental Health & Addictions	Beyond 36 months	TBD	75%	Execute
new	Grey Bruce MH&A Integration & Collaboration Project: Working with MH&A Senior Leaders and Boards in Grey Bruce to identify opportunities for Board to Board engagement, education and further integration of MH&A services to improve care.	Mental Health & Addictions	12 to 24 months	March 31, 2018	10%	Initiate
new	Review the Continuum of Addictions Services: Understanding of current state and identifying gaps to ensure clients needs are met along the continuum of addictions (e.g. withdrawal management, managed alcohol, drug strategy, community treatment).	Mental Health & Addictions	12 to 24 months	March 31, 2018	10%	Initiate

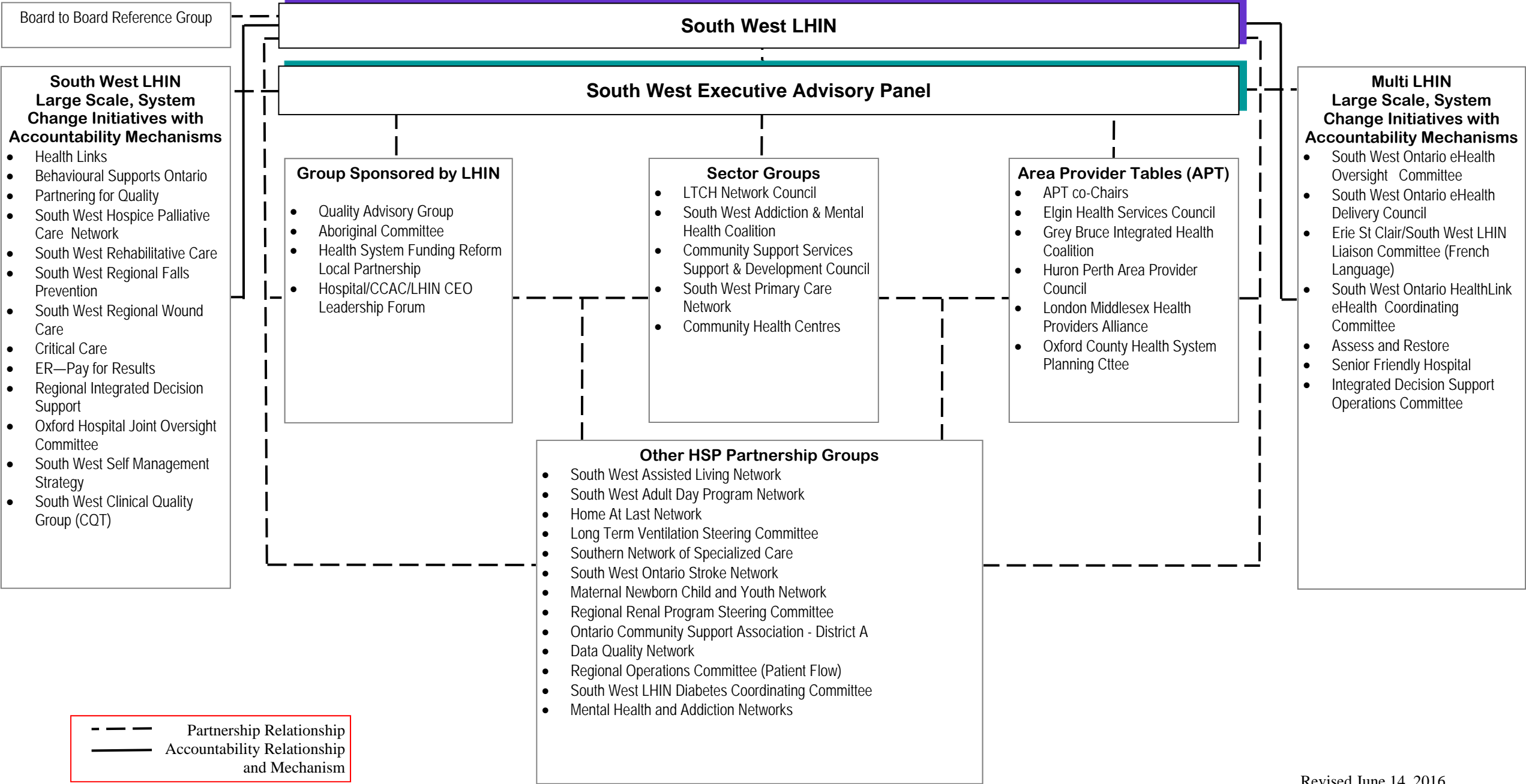
new	<i>Current state review of withdrawal management and treatment services in London Middlesex (e.g. methadone clinics, saboxone)</i>	Mental Health & Addictions	Less than 12 months	March 31, 2017	0%	Not Started
47	Francophone Strategy: Ensure French language service capacity for key service functions (case management, counseling, crisis response, treatment, tier/bedded capacity, maintenance, family services and support); Optimize MH&A service delivery, including BSO, for the Francophone population in London	Mental Health & Addictions	25 to 36 months	March 31, 2019	25%	Plan
48	Access to Primary Health Care: Improve access to primary health care by implementing recommendations from the Understanding Health Inequities and Access to Primary Health Care in the South West LHIN Project and build capacity for Primary Care	Primary Health Care	Beyond 36 months	TBD	90%	Plan
48.1	<i>In alignment to the Patients First LHIN responsibilities, the LHIN will develop and implement a LHIN-wide strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of each community</i>	Primary Health Care	Beyond 36 Months	TBD	5%	Initiate
48.2	<i>Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of Elgin County</i>	Primary Health Care	Beyond 36 Months	TBD	0%	Not Started

48.3	<i>Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of Oxford County</i>	Primary Health Care	Beyond 36 Months	TBD	0%	Not Started
48.4	<i>Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of London Middlesex</i>	Primary Health Care	Beyond 36 Months	TBD	0%	Not Started
48.5	<i>Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of Grey Bruce</i>	Primary Health Care	Beyond 36 Months	TBD	0%	Not Started
48.6	<i>Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of Huron Perth</i>	Primary Health Care	Beyond 36 Months	TBD	0%	Not Started
49	Partnering for Quality: Improve primary care provider capacity to identify patients with chronic conditions and support patients to provide chronic disease management	Primary Health Care	Beyond 36 months	TBD	90%	Monitor

50	Primary Care and Mental Health and Addictions (MH&A) strategy: Strengthen relationships between MH&A services and primary care and increase service capacity with existing primary care structures	Primary Health Care	25 to 36 months	TBD	0%	Not Started
51	eConsultation: Provide primary care physicians with more timely access to specialist input, potentially avoiding referrals for consultation where applicable.	Primary Health Care	12 to 24 months	TBD	15%	Plan
52	Primary Care Network Structure: Continue to strengthen primary care network structure	Primary Health Care	Beyond 36 months	TBD	60%	Execute
53	Falls Prevention Strategy: Support spread of the South West Falls Prevention Strategy including opportunities to meet Francophone needs.	Rehabilitative Care	Less than 12 Months	March 31, 2017	80%	Monitor
53.1	<i>Creation of new Exercise & Falls Prevention classes in Retirement Homes (through Physiotherapy Reform)</i>	Rehabilitative Care	Less than 12 Months	March 31, 2017	80%	Monitor

54	Rehabilitation Capacity Plan and Implementation: Plan and implement the adoption of provincially standardized bedded rehabilitation definitions and eligibility criteria, and plan and implement a bedded rehabilitation capacity plan	Rehabilitative Care	25 to 36 Months	March 31, 2019	5%	Plan
55	Community Physiotherapy Reform: transition funding and accountability for publicly funded physiotherapy clinics from MOHLTC to LHINS.	Rehabilitative Care	25 to 36 Months	March 31, 2018	0%	Not Started
56	Coordinated Access: Support ongoing implementation and improvement of Coordinated Access thru CCAC.	Rehabilitative Care	12 to 24 Months	March 31, 2017	75%	Execute
57	Assess and Restore: Plan and implement the provincial Assess and Restore Guideline in collaboration with other LHINs and in alignment with Ministry of Health and Long-Term Care expectations	Rehabilitative Care	25 to 36 Months	March 31, 2018	20%	Execute

South West LHIN Committee's and Networks



IHSP 2016-19 - Measurement Plan

Measure	Short Description
the BIG DOTs	
Self-Reported Health Status: Proportion of respondents who reported their health as "Excellent" or "Very Good" or "Good"	Proportion of respondents who reported their health as "Excellent" or "Very Good"
Faster Access to Care: Proportion of priorities providing faster access to care when needed	Proportion of key indicators aligned to populations with faster access to care when needed
Satisfied With How Care Was Provided: Proportion of respondents who reported their most recent experience with their primary care provider as "Excellent" or "Very Good"	Proportion of respondents who reported their most recent experience with their primary care provider as "Excellent" or "Very Good"
Value realized by reducing proportion of unnecessary visits/readmissions to the hospitals	Reducing proportion of unnecessary visits/readmissions to the hospitals
MENTAL HEALTH AND ADDICTIONS	
1 Wait Times for Case Management	Average number of days an individual waits for the provision of case management services
2 Repeat unscheduled emergency visits within 30 days for mental health conditions	Percent of repeat emergency visits following a visit for a mental health condition within 30 days
3 Repeat unscheduled emergency visits within 30 days for substance abuse conditions	Percent of repeat emergency visits following a visit for a substance abuse condition
4 Rate of hospitalization for mental health illness	Rate of individuals 18 years or older admitted to hospital for a mental illness (per 10,000 people)
HOME AND COMMUNITY	
5 5 day wait for Personal Support Worker service	Proportion of complex patients who received their first personal support service within 5 days of the service authorization date
6 ALC rate	Proportion of inpatient days in acute and post-acute care settings that are spent as ALC in a specific time period
7 Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services	Proportion of complex patients who received their first personal support service within 5 days of the service authorization date
8 Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services	Proportion of complex patients who received their first nursing visit within 5 days of the service authorization date
9 90th percentile wait time from community for community care access centres (CCAC) in-home services: Application from community setting to first CCAC service (excluding case management)	90th percentile wait time from application for service to first CCAC in-home care visit
10 Percentage of alternate level of care (ALC) days	Percentage of inpatient days where a physician has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of their treatment
11 Percent of home care clients with an unplanned, less urgent Emergency Department visit within the first 30 days of discharge from hospital	Percentage of home care patients who were seen for an unscheduled ED visit with less acuity within 30 days of being discharged from an inpatient setting
CHRONIC DISEASE PREVENTION AND MANAGEMENT	
12 Avoidable hospitalizations for Ambulatory Care Sensitive Conditions/100,000 pop age <75	Hospitalization rate for ambulatory care sensitive conditions
13 Readmissions within 30 days for selected HBAM Inpatient Grouper (HIG) conditions	Risk-adjusted readmission ratio within 30 days for patients with an acute inpatient hospital stay for select chronic conditions
HOSPICE PALLIATIVE CARE	
14 Percent of palliative care clients receiving home support upon discharge (by region by Fiscal Quarter)	Proportion of palliative patients who were discharged home or to a home setting with support services
HOSPITAL-BASED SERVICES	
15 Emergency Department wait time for complex patients	The total ED length of stay where 9 out of 10 complex patients completed their visits
16 90th percentile emergency department length of stay for minor/uncomplicated patients	90th percentile wait time to receive care for non-complex patients
17 Percent of priority 2, 3 and 4 cases completed within access target for computed tomography (CT) scan	Percentage of priority 2, 3 and 4 CT scans completed within access target
18 Percent of priority 2, 3 and 4 cases completed within access target for magnetic resonance imaging (MRI) scan	Percentage of priority 2, 3 and 4 MRI scans completed within access target
19 Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	Percentage of priority 2, 3 and 4 hip surgeries completed within access target
20 Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	Percentage of priority 2, 3 and 4 knee surgeries completed within access target
21 HBAM Cost/Service Efficiency (CCC, Rehab, ED, acute, day surgery + CCAC)	Ratio between actual cost per unit of service and HBAM expected cost (average of the ratio for all HBAM hospitals – each component calculated separately)
22 Hospital Standardized Mortality Rate (HSMR)	Ratio of the actual to expected number of deaths among patients in acute care hospitals
PRIMARY CARE	
23 Percent of patients able to see their primary care provider on the same or next day when they are sick	Percent of patients able to see their primary care provider on the same or next day when they are sick
24 Avoidable Emergency Department visits Best Managed Elsewhere (per 1000 population aged 1-74)	Emergency visits for conditions that could be treated in alternative primary care setting
25 Post discharge follow-up with primary care with-in 7 days	Percentage of patients who saw a primary care physician within seven days of an acute hospital discharge for select chronic conditions
REHABILITATIVE CARE	
26 Length of stay efficiency	The average change in Total Function Score per day of client participation in the inpatient rehabilitation program

APPENDIX G – Integration Activities

Many LHIN initiatives result in better integration of health services to benefit patients and families across the LHIN, however, integration activities may not always come forward as formal integrations. This section captures the formal integration processes that have been or will be brought forward to the LHIN Board for review, consistent with the legislation and protocols defined through LHSIA.

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
Huron Perth Healthcare Alliance (HPHA) – Vision 2013	Vision 2013 is a multifaceted plan to create a sustainable healthcare system now and into the future. The Vision 2013 planning process is based on four principles: Retain four sites with viable roles; Ensure standards of quality and safety; Support equitable standards of quality and patient safety for patients; Live within our means	Health Service Provider Initiated Service Integration	<p>Realignment of Services</p> <ul style="list-style-type: none"> Consolidation of adult outpatient physiotherapy from 4 sites to 2 sites completed in 2012 (Seaforth and Clinton sites). Interprofessional practice model of care (implementation to be completed Dec. 2014) Consolidation of cataracts at Clinton site (May 2014) <p>Bed Redistribution</p> <ul style="list-style-type: none"> Redistribute beds amongst the sites to better utilize capacity across the sites. Includes relocation of CCC and Rehab beds and shifts in the number of medical and surgical beds to result in a net decrease of 17 beds. 	2010 – 2016/17 Implementation will continue into 2016/17 as there are dependencies on CCC/Rehab shifts associated with Access to Care.
Access to Care: Complex Continuing Care / Rehabilitation Bed Realignment	As part of the Access to Care (ATC) strategy to help people move out of acute hospitals and into other care settings as quickly, smoothly and safely as possible, the Complex Continuing Care and Rehabilitation (CCC/Rehab) initiative will ensure that these valuable services are provided consistently and equitably across the region.	South West LHIN Facilitated Service Integration	<p>This initiative will improve outcomes for patients and families, and for the health system as a whole. It will:</p> <ul style="list-style-type: none"> Develop the CCAC role as the one point of access easier so that patients/clients across the South West get the right care at the right time and place. Ensure that admission to CCC/Rehab beds is based on consistent assessment processes and criteria. Ultimately, this work will reduce wait times and improve utilization for CCC and rehab beds, and reduce the number of patients designated as ALC. The goal is to provide the right care in the right place at the right time, which when combined with local strategies, is anticipated to reduce the volume of alternate level of care days in the long term and provide for the best possible outcomes for individuals and their families 	<p>Phase 1 Realignment during fiscal 2014/15. Phase 1 realignment completed by March 31, 2015.</p> <p>Phase 2 Stage 1 shifts are effectively complete. Future phases of realignment will be dependent on refreshing the projection model with more current data and information. Future data refreshes</p>

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
				will include information gained through the Evidence Informed Bedded Rehabilitation Capacity Plan, the Rehabilitative Care Alliance Bedded Definitions Framework Project and impacts of the Stroke Phase I Realignment Recommendations. Implement further realignment phases over next 2 – 4 years
London Enhanced Crisis Services: MH&A Crisis Centre	Comprehensive community based crisis service to improve the client experience, better coordinate resources, streamline access to service, reduce ED repeat visits, reduce police intervention, and provide the right care at the right time in the right place	Health Service Provider Initiated Service Integration	<ul style="list-style-type: none"> • Currently 5 LHIN funded organizations and 2 non-LHIN funded organizations have partnered to provide a comprehensive continuum of crisis services including face: face, telephone, mobile and crisis beds. • The partners are now working to consolidate operating resources and functions within 1 physical plant. It is expected that the co-location of London-Middlesex Enhanced Crisis Services will serve to divert visits to the ED and re-direct residents of London-Middlesex to community based Crisis Services. • The desired result is to ensure that consumers receive the right level of care, at the right time, in the right place to meet their needs with an overall expected outcome of increased access to Mental Health and/or Addiction Services and a reduction in reliance on hospital based services. 	Crisis group has been functioning as a team since November 2012, however the next phase is the further development of crisis beds and co-located services. This phase is still underway with expected completion date TBD (depending on Capital approval process and related allocations).

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
Back Office Collaboration and Integration Project (BOCIP)	The BOCIP will focus on enabling effective and efficient use of system resources to achieve the highest quality back office services by identifying best practice parameters to inform provider back office operations	South West LHIN Facilitated Service Integration	<p>Phase 1: 2015/16</p> <ul style="list-style-type: none"> • Third party consultant will be engaged to leverage expert resources and define best practices and minimum standards in the seven (7) identified administrative service areas: <ol style="list-style-type: none"> 1. Financial Management [accounting, bookkeeping, payroll, management information system (MIS)] 2. Information Technology and Support 3. Materials Management (purchasing, contract management, logistics support) 4. Human Resources (recruitment, hiring, benefits management, training/learning management systems and labour relations) 5. Legal services 6. Risk Management and Privacy 7. Facilities Management <p>Phase 2: 2016/17 – 2018/19</p> <ul style="list-style-type: none"> • Conduct a current state assessment/survey to gain an understanding of where all South West LHIN funded agencies currently stand against the identified (phase 1) best practices and minimum standards in each of the 7 administrative areas • Leveraging the report that defines the best practices and minimum standards in the 7 administrative areas and the current state information, the South West LHIN will define the expectations for LHIN funded agencies to move towards minimum standards and/or best practices • LHIN funded health service providers will have to move towards defined expectations by end of the 2016-2019 Integrated Health Service Plan period (by March 31, 2019) 	2015/16 - 2018/19
Integrated Funding Model: Connect Care to Home	Patients with moderate intensity needs related to COPD and CHF discharged home from London	Integration through funding	<ul style="list-style-type: none"> • Improved quality outcomes for patients (e.g., keeping people at home, reducing ED visits, reducing readmissions, ALC) • Improved patient, caregiver, and provider experience 	2015/16 – 2017/18

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
	Health Sciences Centre will experience an integrated and coordinated system of care based on evidence-based practice as they transition from hospital to the community for up to 60 days. Focused on integrating current hospital and CCAC funding, patients will be supported by an innovative eShift model that allows for remote monitoring of patients and other technology, 24/7 access to the clinical team, navigator, clinical care coordinator, dedicated home care provider, ambulatory clinics, and electronic medical record as well as connections with specialists and primary care.		<ul style="list-style-type: none"> Improved efficiencies and value for money 	
Palliative Care Integration	Realignment of current palliative care beds and resources from an acute setting at LHSC to a non-acute setting at Parkwood Institute, St. Joe's.	Health Service Provider Initiated Service Integration	<ul style="list-style-type: none"> Right care in the right place at the right time: It has been identified that there are patients in acute care palliative care beds whose needs would be better met outside of acute care. The outcome of this will better align resources to needs of the patients. Patient experience: The renovation will create 18 single rooms in a home or hospice-like environment overlooking the grounds at Parkwood Institute. This creates more privacy and a much more respectful, peaceful, patient-centred environment for patients and families. 	The hospitals will begin to implement the bed transfer, contingent on approval and completion of the Capital renovation. Goal is to complete transition no later than June 30, 2016.
Grey Bruce Restorative Care Integration	Reduction and redistribution of restorative care beds across the Grey Bruce area	Health Service Provider Initiated Service Integration	<ul style="list-style-type: none"> Regional approach to care Coordinated Access via CCAC (standardized eligibility criteria, one waitlist, one referral form) Right care, right place (Home First) Improved utilization of existing resources 	Currently working to implement single point of access (one wait list) by July 2016.

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
			<ul style="list-style-type: none"> • SBGHC reduction of Restorative Care Beds from 10 to 5 (completed) • Hanover District Hospital creation of 2 Restorative Care Beds (completed) • GBHS Restorative Care Beds accessible within regional approach (completed) 	Monitoring and quality improvement to continue 16/17.
Mental Health & Addictions Coordinated Access	<p>MH&A providers in the South (Oxford, Elgin and Middlesex) are working collaboratively to develop and implement a coordinated access model that includes:</p> <ul style="list-style-type: none"> • Coordinated screening and intake process • Shared calendar using Connex Ontario or other tool • Coordinated waitlist relief strategies • Coordinated referral process(es) • Use of evidence based screening and assessment tools including Internet, Gaming Disorder and Problem Gambling • One number access for entire South including warm transfers to local crisis teams and electronic referrals to community MH&A agencies 	Health Service Provider Initiated Service Integration	<ul style="list-style-type: none"> • General MH&A information <ul style="list-style-type: none"> ○ Information and referral services • Request for access to treatment <ul style="list-style-type: none"> ○ Direct calendar access to LHIN funded MH&A providers in South ○ GAIN Short Screener in web-based format for screening and sharing of the screening information with referral • Crisis support <ul style="list-style-type: none"> ○ Warm transfer protocols between provider and the participating crisis services (medium risk referral to ED/Crisis Centre or warm transfer to mobile crisis as appropriate and imminent or high risk to 911). Suicide risk assessment/violence risk assessment ○ Supportive listening/brief intervention and support through volunteers • Bilingual services as well as access to Language Line Services, 24/7/365 offering translation to over 170 languages • Possible growth of the model to other counties and/or LHINs 	Goal is to be completed by end of fiscal 2016/17
Mental Health & Addictions Peer Support	Improving Existing Models of Peer Support at the sub-LHIN level: A phased approach will be utilized to explore integration opportunities at the sub-LHIN level.	South West LHIN Facilitated Service Integration	<ul style="list-style-type: none"> • Enhanced Governance and infrastructure of CSIs • Strengthened PEER Network (Peers Envisioning and Empowering Recovery across the South West) structure, with involvement of Mental Health & Addictions (MH&A) community partners to become 	Goal is to be completed by end of fiscal 2017/18

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
	<ul style="list-style-type: none"> Phase 1 (February 2016 – June 2017) London-Middlesex Phase 2 (June 2016 – June 2017) Oxford and Elgin Phase 3 (September 2016 – June 2017) Huron Perth and Grey Bruce 		<ul style="list-style-type: none"> the regional support for strategic oversight of peer support South West LHIN facilitated integration and collaborations between CSIs and community MH&A organizations to implement formal linkages Implement identified promising practices (identified in the “Development of a Peer Support Strategy for the South West LHIN” report) 	
Prostate Cancer Diagnostic Assessment Program Integration	LHSC and SJHC are working towards realignment of prostate cancer diagnostic assessment resources from LHSC to SJHC	Health Service Provider Initiated Service Integration	<ul style="list-style-type: none"> A single point of access for suspect prostate cancer assessment designed according to Cancer Care Ontario (CCO) best practice guidelines. Streamlined scheduling and coordination of diagnostic tests and consultations using a model consistent with best practice and designed by the clinicians. The consolidation of diagnostic prostate biopsy procedures to SJHC. Patient navigation practice will be instituted to ensure relevant and timely information and support for the patients throughout the assessment process to treatment options including hospital based treatments of surgery, radiation and systemic therapy. 	Pending motion at June 21, 2016 South West LHIN Board of Directors meeting, goal is to be completed by late summer 2016/17

APPENDIX H – Capital Projects

County	Capital Project	Background/Description	Current Status
Hospital Capital Projects			
Grey	Grey Bruce Health Services (GBHS) – Markdale Site <i>Stage: Stage 2</i>	<p>The original submission proposed a new 72,000 square foot Rural Health Centre located in Markdale, Ontario on a green field site. This joint planning with GBHS South East Grey Community Health Centre and the South West LHIN followed the completion of functional and master planning for a hospital re-build project which was submitted to the Health Capital Investment Branch (HCIB) in October 2007 in response to a Planning and Design grant approved in May 2006.</p> <p>November 2011 – South West LHIN Board endorsed combined Stage 1 and 2, Part A for Rural Health Centre</p> <p>November 1, 2013 – GBHS submitted Markdale Rural Health Centre Scoping document to HCIB with options for the proposed project. The preferred option would defer the co-location of the CHC from the project, eliminate inpatient beds (creating short stay beds), and reduce the outpatient surgical program to a minor procedure service. The proposed facility will utilize approximately 47% less space than the original proposed option.</p> <p>September 16, 2014 – The ministry approved a new hospital for Markdale</p> <p>January 28, 2015 – LHIN received Stage 2 submission from GBHS</p> <p>June 21, 2016 – South West LHIN endorsed Stage 2, Part A</p>	Stage 2, Part A under MOHTLC review
Bruce	Grey Bruce Health Services (GBHS), Southampton Site – Emergency Department and Laboratory Capital Redevelopment Project <i>Stage: Stage 5</i>	<p>The proposed Emergency and Laboratory (ED/LAB) Capital Redevelopment Project (CRP) at the Southampton site of the GBHS involves a combined 9,700 square foot renovation and new addition.</p> <p>The ministry's commitment to support the implementation of the ED/LAB CRP is contingent on GBHS maintaining ED coverage at the Southampton site 24 hours per day and seven days per week until March 31, 2013. It is also contingent on GBHS keeping the Southampton ED open with <i>local</i> coverage of at least 75% by March 31, 2012 and 100% by March 31, 2013. GBHS is required to submit a GBHS Board approved plan in regards to these requirements no later than October 15, 2011.</p> <p>August 2011 – Project received ministry <u>support</u> and will be subject to Legislative appropriation and all applicable approvals of the ministry</p> <p>September 26, 2012 – South West LHIN Board endorsed Stage 1, Part A</p> <p>April 23, 2013 – LHIN and GBHS received letter from ADM indicating approval to proceed to Stage 2</p> <p>July 19, 2013 – LHIN received Stage 2 submission from GBHS</p> <p>December 11, 2013 – Alignment meeting #1 held between LHIN and HCIB to discuss comments and concerns from respective reviews of Stage 2 submission</p>	Under construction

		<p>December 2013 – GBHS identified issue with ED physician coverage. A number of ED physicians recently left or reduced hours at the Southampton ED. GBHS has reapplied to the Emergency Department Coverage Demonstration Project to receive ED locum coverage as an interim measure. This is expected to be a temporary issue. GBHS had successfully met the previous condition set by HCIB of maintaining 24/7 ED coverage until March 31, 2013.</p> <p>January 21, 2014 – South West LHIN Board endorsed Stage 2, Part A submission</p> <p>March 2014 – Ministry approved Stage 2 submission</p> <p>Fall 2014 – Ministry approved Stage 3 submission</p> <p>Fall 2015 – Ministry approved Stage 4 submission</p>	
Bruce	<p>South Bruce Grey Health Centre (SBGHC), Kincardine Site – Infrastructure Upgrades</p> <p><i>Stage: Pre-Capital</i></p>	<p>June 5, 2015 – LHIN received a Pre-Capital submission from SBGHC for Infrastructure Renewal. This project did not have any program or service impacts requiring review by the LHIN. However, given the critical infrastructure requirements described in the submission and the potential for such infrastructure failures to significantly impact SBGHC Kincardine Site operations, the South West LHIN is supportive of the project for review and consideration for Capital funding by the Health Capital Investment Branch, Ministry of Health and Long-Term.</p>	SBGHC is in process of developing summary of infrastructure needs
Huron	<p>Wingham and District Hospital (WDH) – Facility Redevelopment Project</p> <p><i>Stage: Stage 4</i></p>	<p>The redevelopment will be completed in four phases and is staged in such way that the highest priority programs are accommodated in the first phase. Phase 1 aims to redevelop or add new construction in the areas of Emergency, Surgical program, Ambulatory Care and Diagnostic Imaging in order to address deficiencies and inadequacies in the existing facility that supports these core services.</p> <p>September 26, 2012 – South West LHIN Board endorsed Pre-Capital, Part A submission</p> <p>January 24, 2013 – HCIB and LHIN decided that four WDH Self-Funded projects could be added to the current Pre-Capital submission provided there were no changes to programs or services and that the Self-Funded projects presented were consistent with the original 2009 Master Plan endorsed by South West LHIN Board</p> <p>March 12, 2013 – LHIN sent letter to HCIB indicating that, based on review of Self-Funded projects and 2009 Master Plan, there were no changes to programs and services and that the Self-Funded projects were consistent with the 2009 Master Plan. For these reasons, it was determined that the Pre-Capital submission does not need to go back to the South West LHIN Board for further endorsement.</p> <p>April 2013 – LHIN, HCIB, WDH met and agreed that the starting point for this Facility Redevelopment project (previously the Pre-Capital submission for ED/Ambulatory Care and the self-funded projects) should be considered Stage 2 as the content was consistent with the original Master Plan as previously approved by the South West LHIN Board</p> <p>October 2013 – LHIN received Stage 2 submission</p> <p>January 15, 2014 – Alignment meeting #1 held between LHIN and HCIB to discuss comments and concerns from respective reviews of Stage 2 submission</p> <p>March 18, 2014 – South West LHIN Board endorsed Stage 2, Part A submission</p>	Stage 4.1 under MOHLTC review

		<p>August 14, 2014 – Ministry approved Stage 2 submission</p> <p>April 9, 2015 – Ministry approved Stage 3.2 submission</p> <p>February 9, 2016 – Ministry received Stage 4.1</p>	
Oxford	<p>Tillsonburg District Memorial Hospital (TDMH) Redevelopment</p> <p><i>Stage: Pre-Capital</i></p> <p>TDMH Infrastructure Renovation Project</p> <p><i>Stage: Pre-Capital</i></p>	<p>Redevelopment Project</p> <p>Through Master Plan work, TDMH will examine programs and services to determine future scope of services and opportunities for further integration over the next 10 and 20 years. It is anticipated “that services will not change drastically, but simply grow to accommodate community need (either unmet currently or due to a growth in population). Significant study will also be given to program/services that could be better provided in a community setting, if possible.”</p> <p>January 26, 2011 – South West LHIN Board endorsed Pre-Capital submission</p> <p>September 2012 – Submission put on hold pending the completion of Joint Services Planning underway in Oxford County</p> <p>May 28, 2014 – LHIN received letter from TDMH indicating that, given the completion of the Oxford Hospitals’ Joint Services Planning work, a revised Capital submission will be developed</p> <p>June 2014 – HCIB indicated that TDMH would be required to resubmit a revised Pre-Capital proposal</p> <p>February 15, 2015 – LHIN received Pre-Capital submission</p> <p>Infrastructure Renovation Project</p> <p>December 2012 – TDMH identified immediate infrastructure needs from above project in a Pre-Capital submission</p> <p>August 2013 – HCIB received Pre-Capital submission and project was added to the ministry prioritization list. HCIB and LHIN agreed that no formal review is required since only infrastructure items. LHIN sent letter of support for infrastructure needs.</p>	<p>Redevelopment Project</p> <p>Pre-Capital, Part A under LHIN review</p> <p>Infrastructure Renovation Project</p> <p>Project has been added to MOHLTC priority list</p>
Middlesex	<p>London Health Sciences Centre (LHSC) – Diagnostic Imaging Department Interim Renewal Plan</p> <p><i>Stage: Pre-Capital</i></p>	<p>Since its inception in 1972, the physical plant of the Medical Imaging (MI) Department, Radiology on the second floor of University Hospital has remained essentially unchanged. The Department requires structural modifications to the physical plant in order to meet the following regulatory requirements and goals:</p> <ul style="list-style-type: none"> • Regulatory rules for radiation safety • Current standards in structural engineering • Environmental safety including staff and patient safety (asbestos abatement, sewage drainage) • Patient accessibility and privacy • Better workflow for patient care <p>April 2015 – LHIN received Pre-Capital, Part A submission from LHSC</p> <p>February 2016 – South West LHIN Board endorsed Pre-Capital, Part A submission</p>	<p>Pre-Capital, Part B under MOHLTC review</p>

Middlesex	London Health Sciences Centre (LHSC) – Paediatric Emergency Department Addition <i>Stage: Pre-Capital</i>	<p>Located on the Victoria Hospital (VH) campus, the Paediatric Emergency Department (Paed ED) operates 24/7 and serves as the Paediatric Trauma Centre for the Southwestern region. The Paed ED treats 2,300 to 2,500 patients on a monthly basis.</p> <p>In 2005, the Adult ED was relocated from LHSC's South Street campus to VH and became collocated with the Paed ED. With this collocation, access to both EDs is shared; the safety and security of paediatric patients can be negatively affected as they are exposed to events associated with the Adult ED patient population. Inadequate space and lack of capability to expand the Paed ED has also negatively impacted LHSC ability to continue to provide high-quality patient-centred care. As such, LHSC is proposing to establish a separate Paed ED at VH.</p> <p>The proposed new location for the Paed ED will require renovation of existing infrastructure (currently Paediatric General Clinics) and the development of new infrastructure (proposed building addition at the north face of the existing Children's Hospital), both areas on Level 1. This location is in close proximity to most support services, such as Paediatric Diagnostic Imaging and Hospital Pharmacy. The new addition will also have decanting space for Paediatric General Clinics on Level 2.</p> <p>March 2015 – LHIN received Pre-Capital, Part A submission from LHSC</p> <p>March 2016 – South West LHIN Board endorsed Pre-Capital, Part A submission</p>	Pre-Capital, Part B under MOHLTC review
Middlesex	London Health Sciences Centre (LHSC) – Post Milestone 2 Redevelopment <i>Stage: Stage 1</i>	<p>The LHSC submission addresses the need for facility redevelopment to accommodate current programs, not substantial expansion or changes to programs or services. The proposed redevelopment will allow LHSC to address the needs of programs and services that were not considered as part of the Health System Restructuring Commission recommendations.</p> <p>April 27, 2011 – South West LHIN Board endorsed Pre-Capital submission</p> <p>June 2013 – LHIN received Stage 1 submission</p>	Stage 1, Part A under LHIN review. LHIN review of Part A expected to go to LHIN Board of Directors following LHIN-MOHLTC Alignment meeting (date TBD).
Middlesex	St. Joseph's Health Care – Post Milestone 2 Redevelopment <i>Stage: Stage 1</i>	<p>The SJHC submission addresses the need for facility redevelopment to accommodate current programs, not substantial expansion or changes to programs or services. The proposed redevelopment will allow SJHC to address the needs of programs and services that were not considered as part of the Health System Restructuring Commission recommendations.</p> <p>April 27, 2011 – South West LHIN Board endorsed Pre-Capital submission</p> <p>June 2013 – LHIN received Stage 1 submission</p>	Stage 1, Part A under LHIN review. LHIN review of Part A expected to go to LHIN Board of Directors following LHIN-HCIB Alignment meeting (date TBD).
Middlesex	St. Joseph's Health Care – Parkwood Site, Palliative Care Unit <i>Stage: Pre-Capital</i>	<p>The SJHC capital initiative is required to advance the Palliative Care voluntary integration between London Health Sciences Centre and SJHC reviewed by the South West LHIN Board of Directors in November, 2015. In alignment with the transfer of 4 Palliative Care beds from London Health Sciences Centre to Parkwood Institute, SJHC is planning to renovate a clinical unit to move their current palliative care beds from a unit that has 6 private rooms and two ward rooms (14 beds in total) to create a unit that will have 18 funded single rooms.</p> <p>November 2015 – South West LHIN Board endorsed Pre-Capital submission</p> <p>April 2016 – South West LHIN Board endorsed combined Stage 1 and 2 submission, Part A</p>	Combined Stage 1 and 2, Part B under MOHTLC review

Elgin	<p>St. Thomas-Elgin General Hospital (STEGH) – Emergency, Ambulatory and Mental Health Redevelopment Project</p> <p><i>Stage: Stage 5</i></p> <p>STEGH – Renovations for Replacement of CT Scanner</p> <p><i>Stage: Pre-Capital</i></p>	<p>Redevelopment Project</p> <p>The redevelopment project includes a new 15-bed acute mental health inpatient unit and an outpatient mental health day hospital; new emergency, ambulatory care, surgical services, and central supply departments; and improvements to the hospital's main entrance and circulation through the hospital campus.</p> <p>July 22, 2009 – South West LHIN Board endorsed Phase 1 (Programs and Services component)</p> <p>August 7, 2012 – STEGH received MOH approval to proceed to Stage 2 planning for Emergency, Ambulatory and Mental Health Redevelopment Project (per rescoped submission)</p> <p>October 2013 – LHIN received Stage 2 submission</p> <p>January 17, 2014 – Alignment meeting #1 held between LHIN and HCIB to discuss comments and concerns from respective reviews of Stage 2 submission</p> <p>March 18, 2014 – South West LHIN Board endorsed Part A of the Stage 2 submission</p> <p>May 2, 2014 – Ministry approved Stage 2 submission</p> <p>Fall 2014 – Ministry approved Stage 3 submission</p> <p>March 2015 – Ministry approved Stage 4.1 submission</p> <p>CT Scanner Renovations</p> <p>When current renovation project is complete, renovate space to accommodate new replacement CT scanner.</p>	<p>Redevelopment Project: Under construction</p> <p>CT Scanner Renovations Project: MOHLTC review pending</p>
Community Capital Projects			
Oxford	<p>Woodstock and Area Community Health Centre – Redevelopment</p> <p><i>Stage: New CHCP process</i></p>	<p>Woodstock and Area Community Health Centre (WACHC) submitted a Stage 1 proposal in December 2010 for a permanent site.</p> <p>November 23, 2011 – South West LHIN Board endorsed Stage 1 proposal and confirmed additional funding for WACHC staff positions</p> <p>October 16, 2012 – WACHC submitted an addendum to the Stage 1 submission indicating that the proposal is now an expansion to their interim clinic instead of a completely new site</p> <p>November 2, 2012 – HCIB confirmed that the South West LHIN's original Letter of Endorsement dated November 23, 2011 is sufficient</p> <p>February 2013 – HCIB provided comments regarding the proposal</p> <p>October 31, 2013 – WACHC provided a response to HCIB's comments</p> <p>September 2014 – HCIB and LHIN working with CHC to finalize revisions to submission</p> <p>October 2015 – WACHC submitted revised Stage 1; LHIN confirmed that previous endorsement still stands</p> <p>June 2016 – HCIB decision to move WACHC project into new Community Health Capital Policy and work with the new CHCP toolkit.</p>	<p>WACHC populating new toolkit</p>

Middlesex	London Intercommunity Health Centre – Leasehold Improvement <i>Stage: Pre-Capital</i>	<p>The London Intercommunity Health Centre (LIHC)’s submission addresses the need for facility redevelopment and expansion to accommodate projected growth in current programs and services. Although renovations have been made to the existing space to improve access to care for clients, there still remain significant limitations in the existing building that cannot be addressed without major renovations. Renovation of existing space would include the following: Clinical services would be consolidated into one half of the building while renovations are underway in the other half, and vice versa. If required, clinical space may be rented and other community space (e.g., community centres, and churches) may be used for community programs. LIHC would work to minimize impact on clients through effective interdisciplinary team communication and planning.</p> <p>September 2011 – South West LHIN Board endorsed Pre-Capital, Part A submission</p> <p>November 2013 – LIHC submitted final Part B to HCIB</p> <p>March 31, 2014 – Ministry approved Pre-Capital submission</p> <p>Summer 2015 – Focus of project moved from renovation of existing location to redevelopment of a new location (TBD); LIHC advised to submit revised Pre-Capital proposal</p> <p>November 27, 2015 – LHIN received revised Pre-Capital submission</p> <p>December 15, 2015 – South West LHIN Board endorsed Pre-Capital, Part A submission</p>	Pre-Capital under MOHLTC review
Middlesex	Southwest Ontario Aboriginal Health Access Centre – London Site Project <i>Stage: Combined Stage 1 & 2</i>	<p>As a result of new and expanded programming, Southwest Ontario Aboriginal Health Access Centre (SOAHAC) has outgrown its original downtown London site. The current site is comprised of two old houses that were joined together to make one building. The layout has produced significant challenges in the delivery of quality and collaborative services. In July 2014, SOAHAC submitted a combined Stage 1 and 2 proposal for the relocation of client programs and administration from the current site to a nearby renovated location that will allow for an integrated model of care, provide continuity of access for SOAHAC clients, and accommodate the growth of SOAHAC’s programs.</p> <p>April 21, 2015 – South West LHIN Board endorsed combined Stage 1 & 2, Part A</p> <p>April 15, 2016 – Ministry approved Stage 1 & 2</p>	SOAHAC preparing Stage 3.1 submission
Middlesex	Canadian Mental Health Association Middlesex (CMHA) – Mental Health Crisis Centre <i>Stage: Stage 2</i>	<p>The Canadian Mental Health Association (CMHA) Middlesex, Mission Services of London, London District Distress Centre (LDDC), London Health Sciences Centre (LHSC), London Police Services (LPS), Addiction Services of Thames Valley (ADSTV), St. Leonard's Community Services London and Region (SLCS) and London Community Addiction Response Strategy (CAREs) are all partners of the London Middlesex Enhanced Mental Health Crisis and Case Management Services project. This is a collaborative project between community partners to develop a comprehensive community based crisis service aimed at realigning existing resources and delivering enhanced services for mental health and addiction clients in London-Middlesex to better coordinate those services that do exist as well as build new protocols for improved service delivery.</p> <p>The Capital project will include the renovation of a LHSC owned building (former Red Cross Building #24) on the Victoria Hospital site of LHSC for the development of a Crisis Centre which includes co-location of existing Mental Health and Addictions crisis services and space for crisis stabilization beds.</p> <p>May 20, 2014 – South West LHIN Board endorsed Pre-Capital, Part A submission</p>	Stage 2, Part A under LHIN review

		<p>November 9, 2015 – Ministry approved Pre-Capital submission; Project to move directly to Stage 2</p> <p>June 2016 – LHIN received Stage 2 submission</p>	
Elgin	<p>Central Community Health Centre – Leasehold Improvement</p> <p><i>Stage: Stage 3</i></p>	<p>Central CHC opened at its current site in October 2010. Since that time, there has been an ongoing demand for expanded programs and services to meet client needs. To meet these needs and provide more adequate, safe and appropriate space for its clients, CCHC has undergone numerous small renovations and has found it necessary to provide many programs and services in offsite locations that are often inadequate in terms of size, suitability, and location. For example, Central CHC currently uses three renovated spaces plus a garage/storage unit for the mobile unit; uses donated space from several community organizations (churches, libraries, other charities); and has rented space where necessary. The lack of co-location of programs and services makes it difficult for Central CHC staff to function as an interdisciplinary team and impacts the client experience. There are also multiple health and safety concerns with the present site, such as accessibility, asbestos, inadequate heating and ventilation, and fire safety issues.</p> <p>A move to a permanent and larger site will allow for more efficient work among the interdisciplinary team, will support integration of health services with other LHIN-funded service agencies, and has the potential to allow for back office integration support through co-location with other LHIN-funded agencies.</p> <p>October 21, 2014 – South West LHIN Board endorsed Pre-Capital, Part A submission</p> <p>May 2016 – Ministry approval to move directly to Stage 3</p>	<p>Central CHC preparing Stage 3 submission</p>