South West Local Health Integration Network

Annual Business Plan 2010/2011

Ontario
Local Health Integration Network

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1.0 Context

1.1 Transmittal Letter from LHIN Board Chair

To: Ken Deane, Assistant Deputy Minister, Health System Accountability and Performance Division

Cc: Kathryn McCulloch, Director (A), LHIN Liaison Branch

Subject: South West Local Health Integration Network – Annual Business Plan

In keeping with the South West LHIN's obligations under the *Local Health System Integration Act* (LHSIA) 2006, the Memorandum of Understanding (MOU) between the Ministry of Health and Long-Term Care (MOHTLC) and the LHIN, and the Ministry-LHIN Accountability Agreement (MLAA), I am pleased to submit the South West LHIN's 2010/11 Annual Service Plan, Annual Business Plan component.

These are exciting times at the South West LHIN as we prepare to implement our recently-approved *Health System Design Blueprint – Vision 2022*. Developed in collaboration with all our stakeholders, including our health system partners and the public, our plan is to make sure people get the high-quality services they require when they need them.

Our vision puts patients and clients at the centre of the system, closing gaps between services and removing duplication. While we improve the way we approach care delivery, we will also strive to ensure Ontario taxpayers get the best value for every dollar spent as health care receives almost half of all provincial program dollars.

Our new 2010-13 Integrated Health Service Plan (IHSP) maps our goals for the first three years of the Blueprint, and the 2010/11 Annual Business Plan details priorities, actions plans, issues and risks for the fiscal year.

While we have made significant progress in improving access to quality care in the right place at the right time, we are continuing to build upon those successes. Our directions in the new IHSP will help us to continue improving our emergency department wait times and reduce our Alternate Level of Care rates. Our Aging at Home initiatives will continue to thrive through priorities such as increasing the availability of community care and supports for high-risk seniors. We also are planning a number of initiatives that include, but are not limited to improving hospital bed utilization, reducing emergency department demand and improving early identification, early intervention and access to mental health and addictions services.

I would like to highlight that our Board has approved a balanced operational budget for the coming three years. Our intent is to remain fiscally responsible during these uncertain economic times. However, this fiscal responsibility comes with some risk in terms of our ability to achieve the system change which we know is desired by both our Board and the Minister of Health and Long-Term Care and is at the core of our health system design blueprint.

In partnership with the Ministry and our health service providers within the South West LHIN, we look forward to continuing to facilitate system change that will improve the health of the residents of the South West LHIN and the Province of Ontario.

Sincerely,
John Van Bastelaar, Chair Board of Directors (Acting)
c: Michael Barrett, South West LHIN CEO
South West LHIN Board of Directors

1.2 Mandate and Strategic Directions of the South West LHIN

The South West LHIN shares the government's overall direction for health care: *"A health care system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren."* Our mission is to bring people and organizations together to build a health care system that balances quality, access and sustainability. The South West LHIN strives to achieve five system level goals:

- Healthier South West LHIN Community
- Equitable Access to Services
- Quality of Care and Service
- Integration of Health Care Delivery
- Sustainability of the South West Local Health System

In order to achieve the LHIN's vision, mission and system level goals, the South West LHIN recently completed a Blueprint[1] to guide the design of the health system to meet its needs and changing demands over the next 12 years. The Blueprint describes in detail what we want health service delivery to look like by 2022 and the Integrated Health Service Plan[2] (IHSP) 2010-2013 identifies the strategic directions and active steps we need to take in the next three years to begin to make it a reality.

1.3 Overview of the South West LHIN's Current and Forthcoming Programs and Activities

Since the development of the first IHSP (2007-2010), a number of initiatives have been implemented that provide early starts to some of the Blueprint implementation elements and IHSP 2010-2013 strategic directions. Our actions related to seniors and adults with complex needs have been leveraged through the provincial Aging at Home initiative, Alternate Level of Care/Emergency Room initiatives and quality improvement initiatives such as the FLO Collaborative. Through the roll-out of the Ontario Diabetes Strategy and eHealth Registry and our success with the implementation of the Partnerships for Health program, the South West LHIN has strengthened our position to be effective in improving diabetes care across the LHIN. In addition, our learnings from the experiences with diabetes will help us to evolve systems of care for other chronic conditions. Another initiative currently underway is the development and implementation of a Hospital Patient Flow Protocol in the South West LHIN. It will standardize patient access and flow procedures for hospitals and physicians across the LHIN to make patient referral and transfer more transparent, effective and efficient and understood by everyone.

The directions outlined in the Blueprint and IHSP will assist us in moving towards achieving the following objectives for our priority populations and programs in the local health system:

- Increased availability of community care and supports for high-risk seniors, including Alternate Level of Care patients waiting for long-term care home placement
- Enhanced service to clients with behavioral challenges in long-term care homes
- Improved hospital bed utilization by:
    - Avoiding admission to acute care beds through prevention activity, facilitated discharge from Emergency Department to alternative settings with supports and provision of acute care in an alternative setting

[1] Health System Design – Blueprint Vision 2022, South West Local Health Integration Network
[2] Integration Health Service Plan 2010-2013, South West Local Health Integration Network

    - Expediting discharge from acute care to subsequent care destinations whether at home, Long-Term Care home, Complex Continuing Care or Rehabilitation
- Reduced Emergency Department demand - reducing the number of non-urgent cases that present at the ER will allow emergency clinicians to focus on patients with emergent needs
- Early identification of and intervention for people living with mental illnesses and addictions
- Improved access to and enhanced capacity of mental health and addiction services
- Increased accessibility of Chronic Disease Prevention and Management team-based care close to home, particularly for those who traditionally face barriers to accessing care
- Strengthened capacity for self-management among those with or at risk of, developing chronic disease(s) and for self-management support among providers
- Improved ease of access to health education materials
- Enhanced technological supports to manage chronic disease(s)
- People move swiftly and appropriately to receive the care required during and following a visit to emergency departments
- Improved access to medicine, surgical and critical care services at the local, multi- and LHIN community levels

1.4 Assessment of Issues Facing the South West LHIN

Factors such as demographics, population density, health status and growth contribute to determining the health care needs of our population and will influence delivery of health care in the South West LHIN. Challenges include:

- The large geography of the LHIN and the rural nature of most South West LHIN communities continue to pose challenges for their residents in accessing health services
- The current unemployment rate may have an adverse effect on select populations, increasing the need for mental health and addiction services beyond the current capacity
- The high prevalence of chronic disease throughout the South West LHIN may contribute to increased hospitalizations if not managed appropriately
- The demands of an aging population have already had a significant impact on services and will continue to grow in the future

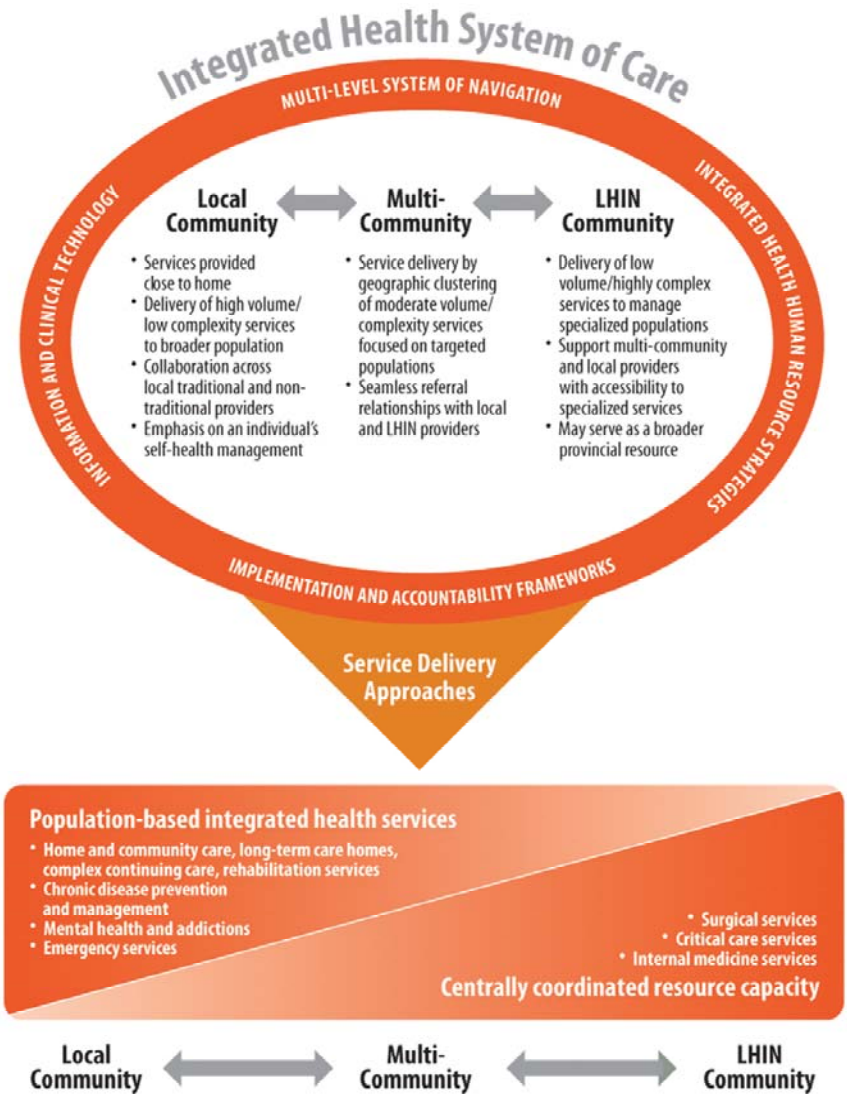
Other risks facing the local health system include:

- Given the resource constraints experienced across the South West LHIN and the magnitude of change required in the local health system, there is limited capacity to advance all initiatives at once. New initiatives must be selected strategically in order to ensure they are adequately resourced.
- Resource constraints, both health human resources (HHR) and funding, present challenges to meeting current and anticipated health service demand
- Boards and Senior Leadership of health service providers must be willing and have the capacity to transform service delivery
- Lack of certainty in out-year funding makes planning beyond 2010/11 difficult
- There is a potential for reduction in current services to meet balanced budget requirements
- Physician compensation and variation in physician referral patterns

If not addressed, these challenges will threaten the sustainability of our health care system in the future.

2.0 Core Content – Integrated Health Services Priorities

In order to address these current and emerging challenges, the Blueprint has developed a vision for the future health system, an Integrated Health System of Care. Building on the work of teams that had previously come together and through the input and participation of providers and the public, the future system seeks to address today's challenges, and adjust for tomorrow's needs.



This system emphasizes the message that all health programs and services are part of a single, unified health system of care. A unified system clearly communicates the roles and responsibilities of the various health service providers and non-health organizations, and also delineates the interdependencies between the various stakeholders to enable a shared approach to service delivery. In acknowledging unique characteristics among community, long-term care, acute services, and primary care services, the Integrated Health System of Care is to be implemented through two integrated service delivery approaches described in sections 2.1 and 2.2 below. It is important to note that these approaches are not mutually exclusive, but are truly integrated recognizing that as an individual at various points in their lifetime interacts with the system, their needs will vary and the system must be able to respond in a seamless and coordinated manner.

2.1 Population-based Integrated Health Services

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Population-based Integrated Health Services

IHSP Priority Description:

The **Population-based Integrated Health Services** approach exhibits the following characteristics:

- This approach calls for health service delivery tailored to the local needs of its catchment population and health service providers. It builds local communities to be able to support the health and wellness of its catchment population. This approach will focus on **total health management** including prevention, screening, identification, assessment, treatment, follow-up and the necessary support.
- There is an emphasis on individual's accountability in the management of one's own health.
- The majority of service coordination and intervention will be delivered through local **health and social service providers** and coordinated through local health resources**, integrated health services collaboratives**. These collaboratives will be achieved through various delivery models such as co-located, mobile, and/or virtual settings depending on the health and social needs of the community and health service provider base.
- Relies on **care coordination and inter-professional support at the local level**, including primary care, community, and public health professionals as part of the broader health care team.
- As individual needs become increasingly complex, **referral to specialist and sub-specialist care** at the Multi-Community and LHIN levels may be required and coordinated through the inter-professional team.

The 2010-2013 IHSP focuses specifically on three populations:

- Seniors and adults with complex needs
- People living with mental health and addiction challenges
- People living with or at risk of chronic disease(s)

Current Status:

Seniors, people living with chronic conditions, and those with mental health and addictions challenges, tend to access and use a substantial portion of our health care resources. But they don't always use these resources at the right time, in the right place and by the right provider which often leads to crisis intervention that could have been prevented if early identification, management and supports were in place. For Q4 2009/2010, 55% percent of all emergency room visits in the South West LHIN are for low acuity (CTAS IV & V) patients.

The reasons why these populations do not always access the right resources at the right time include:

- Inequitable distribution of health services across the LHIN pose access challenges for residents, particularly those in rural communities
- Current funding and operating models reinforce a provider-focused vs. person-centred

approach to health service delivery

- Lack of integration across sectors and health service providers inhibits the seamless transition of individuals and families across the continuum of care
- Capacity limitations make it difficult to meet the increased demand for health services
- Limited availability of health human resources make it difficult to meet the current and anticipated health service demand
- The health profile of the South West LHIN necessitates more appropriate, integrated screening and early identification of health risk factors and conditions
- Lack of integrated technology platforms across the LHIN inhibit seamless information-sharing among health service providers across sectors and geography

These issues must be addressed in order to improve the health system and ensure its sustainability in the future.

There are currently 45 projects[3] underway that enable local communities to support the health and wellness of their catchment populations.

Current performance results related to these projects include:

- The number of ER visits has increased in Q2 09/10 compared to Q1 09/10 for the South West LHIN in line with majority of the LHINs and as anticipated due to seasonal variations. The South West saw a decrease in ER visits in Q2 09/10 compared to Q2 08/09.
- For the ALC discharges in April 2010, the number of days between ALC designation and discharge (90th percentile) from an acute care facility decreased to 34 days from 58 days in March 2010.
- Longest time from ALC designation to discharge is seen for patients waiting for a LTC bed. Efforts are underway to reduce ALC days for these patients and we are starting to see an impact – ALC patients in acute care waiting for LTC decreased from 55% in May 2009 to 54% in May 2010.
- Between May 2009 and May 2010 the South West LHIN has seen a 9% percent decrease in total beds occupied by ALC patients
    - The percent of acute care beds occupied by ALC patients has remained at 10% in both May 2009 and May 2010
    - The percent of other inpatient care beds occupied by ALC patients has decreased from 16% in May 2009 to 14% in May 2010

[3] See Appendix A – Projects, Programs and Initiatives Related to Strategic Directions

PART 2: GOALS and ACTION PLANS

Goal(s):

Enhance capacity and integration of primary, specialized and community-based care, with a focus on the following populations:

- Seniors and adults with complex needs
- People living with mental health and addiction challenges
- People living with or at risk of chronic disease(s)

Consistency with Government Priorities:

These goals align with the following key government priorities:

- **Improve Access to Emergency Department Care** by reducing the avoidable use of emergency services altogether. Reducing the number of non-urgent cases in the ER would enable emergency clinicians to focus on patients with critical needs. The South West LHIN, through the Blueprint's Integrated Health System of Care, has identified ways to help people access appropriate health care services in places other than emergency rooms and to improve health care capacity in local communities.
- **Improve Access to Hospital Care** by reducing the amount of time that patients spend waiting for an alternate level of care. LHINs will continue to invest time and money to reduce the number of people who stay in hospital when they could be at home or in the community getting services better suited to their needs. The South West LHIN has a number of strategies in place that have helped people receive care in the right setting.
- **Improve Access to Diabetes Care** by supporting the roll out of the Ontario Diabetes Strategy.
- **Enhance Mental Health and Addictions Services** – The Ontario Government has announced plans to enhance Mental Health and Addictions services. The Minister's Advisory Group on Mental Health and Addictions is laying the foundation for a 10 year strategy to address this area. A number of actions will be implemented in the South West LHIN over the next three years to assist people to gain access to addiction and mental health service prevention, treatment and recovery programs.
- **Implement Ontario's eHealth Strategy** – In addition to being selected as one of the first three LHINs to implement the Ontario Diabetes Strategy in its first year, we are also one of two LHINs identified as an "early adopter" for the province's eHealth Strategy. The South West LHIN also has a number of additional information and clinical technology initiatives underway.

Action Plans/Interventions:	**Planned Completion**		
	2010/11	**2011/12**	**2012/13**
Seniors and Adults with Complex Needs:			
Through Aging at Home (Year 3):			
• Develop and implement an integrated model of care for high-risk seniors	25%	75%	

• Develop and implement a coordinated system of care for seniors with behavioural issues	30%	60%	10%
• Enhance services and supports for Aboriginal seniors	60%	30%	10%
• Enhance capacity and coordination of transportation services	50%	50%	
• Create additional convalescent care beds in long-term care homes	75%	25%	
Define the role of and access to complex continuing care beds and rehabilitation services	30%	20%	25%
Monitor results of all Aging at Home initiatives	Ongoing	Ongoing	Ongoing
People Living with Mental Health and Addictions Challenges:			
Increase supportive housing for people with problematic substance use and concurrent disorders	33% (2009/10 = 33%)	33%	n/a
Implement a screening tool to screen universally for concurrent disorders	50%	10%	10%
Implement a training program to help people to develop personal wellness plans	25%	25%	25%
Improve access to community mental health and developmental services for persons with a dual diagnosis	30%	20%	20%
Work with partners to facilitate the movement of specialty hospital services (Tiers 2 and 3 divestment) **dependent upon capital planning projects approval*	10%	25%	20%*
Work with partners to enhance the availability of and access to children's mental health beds[4]	50%	n/a	n/a

[4] An action plan and process, utilizing existing resources, will be developed and communicated by 2010-11 with ongoing monitoring/evaluation and enhancements in subsequent years.

People Living with or at Risk of Chronic Disease(s):			
Implement Chronic Disease Prevention and Management strategies with an initial focus on the Ontario Diabetes Strategy (ODS) and extend to other chronic illnesses where relevant • ODS expansion implemented • ODS regional coordination implemented • ODS team expansion, if provided, implemented	 100% 75%	 100%	
Leverage success of the Partnerships for Health project and extend to other chronic illnesses where relevant – Work with MOHLTC to identify opportunities to promote Partnerships for Health • Teams using methodology with one other chronic disease population • Teams continuing to participate in quality improvement opportunities	 5% 10%	 5% 10%	 5% 10%
Implement enabling technologies with an initial focus on the provincial Diabetes Registry and include other enabling technologies where relevant. *Specifically, implement leader sites for Diabetes Registry. **dependent upon funding and targets set in coordination with eHealth Ontario*	100%*	TBD**	TBD**
Explore the applicability of the Diabetes Registry to manage data for other chronic diseases ****dependent upon progress of Diabetes Registry*	TBD***	TBD***	TBD***
Continue with, and expand, implementation of self- management strategy • Master Trainers and Peer Leaders trained • Client sessions delivered	 100% 33%	 33%	 33%
Implement peritoneal dialysis in long-term care homes to align with Ontario Renal Network	10%	10%	10%

Across all Three Priority Populations:			
Continue to work with Aboriginal and Francophone communities to improve availability of and access to services	20%	20%	20%

Expected Impacts of Key Action Items:

Operational metrics:

- Reduced rate of re-admission to hospital for seniors with behavioural issues as a result of mental illness and/or substance abuse
- Decreased proportion of active dementia cases admitted to hospital due to self-threat or threat to others
- Increased number of seniors impacted by the seniors-related initiatives
- Continued use of improved processes and efficiencies around application of the CDPM model
- South West LHIN participation in QIIP activities (re: Partnerships for Health)
- The CDPM Self-Management will achieve full base capacity by end of year 1 (2010/11). Base capacity includes:
    - 6 Stanford Chronic Disease Self-Management Program™ (CDSMP) Master Trainers
    - 64 Stanford CDSMP™ Peer Leaders
    - 915 x 3 = 2745 clients trained over three years
    - 180 providers trained in Motivational Interviewing and 3 Minute Empowerment™
    - 150 providers with ability to apply tools in the Self Management Toolkit
    - An evaluation strategy will be developed in year 2 (2011/12) to determine the impact of the strategy on the system with the goal of measuring patient: unplanned physician visits; emergency department visits; and hospital admissions for reasons related to their chronic conditions
- Increased number of clinicians and patients who have access to information via the Diabetes Registry which allows them to better manage their chronic disease
- A minimum of 1 LTC home in each geographic area that would be able to accommodate and support residents requiring peritoneal dialysis
- Number of Mental Health and Addictions agencies who have implemented use of GAIN CD Screener
- Minimum of 1 self-management Master Trainer for each geographic area in 2010/11 year to support enhanced training and expansion in subsequent years

Outcome metrics:

- Number of days from Alternative Level of Care designation to discharge (to appropriate destination) reduced to 35 days (Stocktake)
- Adjusted percent of people (aged 66+) with diabetes for more than a year who had a serious diabetes complication treated in the hospital no greater than 8.3% (South West LHIN)
- Hospital admission rates per 100,000 population for diabetes no greater than 83 (South West LHIN)

- Number of ER unscheduled visits by quarter per 1000 population no greater than 132 visits (Stocktake)
- Alternative Level of Care days no greater than 8.8% (MLPA)
- Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions reduced to 12.5% (MLPA)
- Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions reduced to 19% (MLPA)
- 90th Percentile Wait Time from Community Setting to Community Home Care Services (from Application to First Service) reduced to 35 days (MLPA)
- Readmission within 30 Days for Selected CMGs reduced to 14.2% (MLPA)

All LHINs are working with the Ministry and stakeholders to develop the best indicators for mental health and addictions.

What are the risks/barriers to successful implementation?

- Funding for most health care providers has not kept pace with inflation and many are finding it difficult to attract and retain qualified staff, which compromises service capacity and limits the role of some agencies to serve as the 'right provider at the right place at the right time'
- Lack of certainty in out-year funding makes planning beyond 2010/11 difficult
- There is a potential for reduction in current services to meet balanced budget requirements
- Given the resource constraints experienced across the South West LHIN and the magnitude of change required in the local health system, there is limited capacity to advance all initiatives at once. New initiatives must be selected strategically in order to ensure they are adequately resourced.
- Resource constraints, both health human resources (HHR) and funding, present challenges to meeting current and anticipated health service demand
- Boards and Senior Leadership of health service providers must be willing and have the capacity to transform service delivery
- Change and integration may provoke a negative reaction in some communities
- Physician compensation and variation in physician referral patterns

2.2 Centrally Coordinated Resource Capacity

PART 1: IDENTIFICATION OF INTEGRATED HEALTH SERVICES PRIORITY

Integrated Health Services Priority:

Centrally Coordinated Resource Capacity

IHSP Priority Description:

The **Centrally Coordinated Resource Capacity** service delivery approach exhibits the following characteristics:

- Approach focuses on optimizing the use of targeted resources to improve access and complement the management of health and wellness at the more local level.
- **LHIN-wide coordination of medicine, surgical and critical care inpatient and ambulatory services** to maximize our resident's access to services. Service delivery will be coordinated across local community, Multi-Community, and LHIN community providers.
- Local providers will play a key role in **primary and secondary identification, assessment, treatment, and follow-up services** for their local communities. Providers will also focus on changing their practices to include the individual and their families as part of the care team to emphasize the individual's accountability in the management of one's own health.
- Providers whose role will be to deliver services at the Multi-Community level will provide **specialist services** for a larger population.
- South West LHIN-wide providers will be responsible for delivering **highly specialized services for complex population segments.**
- It should also be noted that while in some cases tertiary hospitals will be expected to function as a LHIN-wide resource, it is also expected that they will also continue to function as the local care resource for the communities in which they currently operate today.
- Development of shared physician on-call system and structure.

Current Status:

The South West LHIN has begun to address some of these issues by building on the implementation efforts of our first IHSP and innovative partnerships and initiatives already in progress or ready to be launched. Specifically, there are currently 12 projects[5] underway that relate to this priority. Several Hips and Knees projects are underway to advance the development and dissemination of standardized best practices and standardized physician referral practices. There is currently an initiative underway to develop and implement a Hospital Patient Flow Protocol that will standardize patient access and flow procedures for hospitals and physicians across the LHIN.

Current performance results related to these projects include:

- From January to April 2010, 9 out of 10 ED patients in South West LHIN spent at most 6.4 hours at the Emergency Department. Provincially this number ranged from 8.6 to 9.3 for the same time period. The South West LHIN ranks 1st among the LHINs for this indicator.
- From January to April 2010, 9 out of 10 high acuity patients with complex conditions/requiring more time for diagnosis, treatment or hospital bed admission spent at most 9.8 hours from the time they registered to the time they left the ER. The provincial target is 8 hours.
- From January to April 2010, 9 out of 10 low acuity patients with minor or uncomplicated conditions requiring less time for diagnosis, treatment or observation spent at most 4.3 hours from the time they registered to the time their visit is complete. The provincial target is 4 hours.

Currently some hospitals in the South West LHIN are experiencing patient access challenges that stem from patients requiring an Alternate Level of Care (ALC), limited access to long-term care home beds outside of London, human resource shortages and episodic higher emergency department volumes. These issues may then contribute to overcrowding in some hospital emergency departments, long lengths of stay, service delays and cancellation of surgeries.

[5] See Appendix A – Projects, Programs and Initiatives Related to Strategic Directions, Integrated Health Service Plan, 2010-2013

PART 2: GOALS and ACTION PLANS

Goal(s):

Enhance access and sustainability of hospital-based treatment and care related to:

- Emergency services
- Medicine, Surgical and Critical Care services

Consistency with Government Priorities:

These goals align with the following key government priorities:

- **Improve Access to Emergency Department Care** by ensuring adequate health human resources
- **Improve Access to Hospital Care** through advancing the development and dissemination of standardized best practices, standardized referral, and a patient access and flow protocol
- **Implement Ontario's eHealth Strategy** – Develop a resource capacity management system

Action Plans/Interventions:	**Planned Completion**		
	2010/11	**2011/12**	**2012/13**
Emergency Services:			
Based on the recommendations of the Emergency Department Human Resources Study, engage key local and multi-community stakeholders to initiate a process to develop and implement strategies tailored to their communities' emergency services needs, with a focus on:			
• Emergency services recruitment and retention capability	10%	10%	10%
• Emergency services coverage with current resource pool	10%	10%	10%
• Emergency services health care personnel capacity	10%	10%	10%
Medicine, Surgical and Critical Care Services:			
Engage key local, multi-community and LHIN community stakeholders to develop an action plan for creating and implementing Centrally Coordinated Resource Capacity for medicine, surgical and critical care services, with a focus on:			
• A LHIN-wide resource capacity management system	10%	10%	10%

• A centralized coordinated referral system, evidence based care pathways and order sets, tools and quality guidelines	10%	10%	10%

Expected Impacts of Key Action Items:

Operational metrics:

Emergency Services:

- Maintained or improved access to emergency services throughout the South West LHIN

Medicine, Surgical and Critical Care Services:

- Enhanced access and sustainability of Hospital-based Treatment and Care
- LHIN-wide management of capacity allowing individuals to flow through the system equitably, minimize backlogs and optimize current resources
- Continued use of consistent best practices, tools, and quality guidelines to produce better outcomes

Outcome metrics:

- 90th percentile ER length of stay for admitted patients less than or equal to 25 hours (MLPA)
- 90th percentile ER length of stay for non-admitted complex patients less than or equal to 6.3 hours (MLPA)
- 90th percentile ER length of stay for non-admitted minor/uncomplicated patients less than or equal to 4 hours (MLPA)
- 90th percentile wait times for: (MLPA)
    - cancer surgery at 80 days
    - cardiac by-pass procedures maintain at or improve from 55 days
    - cataract surgery maintain at or improve from 85 days
    - hip replacement maintain at or improve from 151 days
    - knee replacement maintain at or improve from 166 days
    - diagnostic MRI scan maintain at or improve from 81 days
    - diagnostic CT scan at 28 days

What are the risks/barriers to successful implementation?

- Some hospitals continue to struggle to provide comprehensive emergency department coverage, resulting in long wait times and potential emergency department closure
- The demand for MRI service continues to increase and capacity to reduce wait times is ultimately limited to the number of machines available
- Significant risks to future operations and financial health include: hospital working capital deficits, the cost of non-urgent ambulance transfers, and hospital restructuring costs
- Lack of certainty in out-year funding makes planning beyond 2010/11 difficult
- There is a potential for reduction in current services to meet balanced budget requirements
- Given the resource constraints experienced across the South West LHIN and the magnitude of

change required in the local health system, there is limited capacity to advance all initiatives at once. New initiatives must be selected strategically in order to ensure they are adequately resourced.

- Resource constraints, both health human resources (HHR) and funding, present challenges to meeting current and anticipated health service demand.
- Boards and Senior Leadership of health service providers must be willing and have the capacity to transform service delivery
- Physician compensation and variation in physician referral patterns

2.3 Other Health System Capacity Building Initiatives

Community Health Centre Development

The Multi-Sector Service Accountability Agreement for 2009-11 is in place for the **Woodstock and Area Communities Health Centre (WACHC)** and **Central Community Health Centre (CCHC).** On April 30th, the WACHC officially opened its site for operations to begin provision of services to the community. The Executive Director of the CCHC has begun hiring staff and it is anticipated that renovations on its interim site will be completed in July with provision of service to begin shortly thereafter.

The South West LHIN continues to work with the **South East Grey Community Health Centre (SEGCHC)** Board and Grey Bruce Health Services towards the development of a Rural Health Centre in Markdale. A Rural Health Centre will combine the primary care components of the CHC, and potentially other primary care services, together with the acute care components of the hospital, into one facility. In the meantime, the SEGCHC Board continues its search for a suitable interim site and will establish a timetable for the development of interim services when an interim site is identified.

Residential Hospice Development

Work will continue to develop residential hospices for terminally ill people in Grey and Bruce Counties and the London area. Establishing two new residential hospices (or equivalent services) will improve access to primary health care and reduce demand for ED/ALC services by providing an enhanced range of services such as assistance with the activities of daily living.

Long-Term Care Home Renewal Strategy

In response to the MOHLTC's call for applications to rebuild B, C and upgraded D homes, the South West LHIN received and reviewed applications from 5 Long-Term Care Home operators. One operator withdrew their application. The LHIN recommended to the MOHLTC that the remaining four homes be redeveloped.

New Long-Term Care Homes

One new Long-Term Care Home opened in the South West LHIN in the fourth quarter of 2009-2010. The Village of Glendale Crossing opened in February 2010 in London and includes 192 beds and a secure unit. A second new Long-Term Care Home, peopleCare Oak Crossing, opened in the first quarter of 2010/11 and has 160 beds and a secure unit.

2.4 Accountability and Performance Activities

Accountability between LHINs and MOHLTC

Strengthened accountability and performance are key components to a changing healthcare system and will help to guide system partners in aligning the local health care system to system level goals and the strategic directions outlined in the Blueprint and Integrated Health Service Plan. These accountabilities and performance obligations and responsibilities are set in the 2010-2013 MLPA. Obligations are articulated in the following areas:

1. Local Health System Management
2. Funding and Allocations
3. Local Health System Performance
4. Integrated Reporting

The following table lists the *draft* MLPA targets for 2010-2011:

Indicator	LHIN target for 2010/2011
Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions	12.5%
Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions	19%
90th Percentile Wait Time from Community Setting to Community Home Care Services (from Application to First Service)	35 days
Readmission within 30 Days for Selected CMGs	14.2%
90th percentile wait times for Cancer Surgery	84 days
90th percentile wait times for Cardiac By-Pass Procedures	Maintain or improve baseline
90th percentile wait times for Cataract Surgery	Maintain or improve baseline
90th percentile wait times for Hip Replacement Surgery	Maintain or improve baseline
90th percentile wait times for Knee Replacement Surgery	Maintain or improve baseline
90th percentile wait times for Diagnostic MRI Scan	81 days
90th percentile wait times for Diagnostic CT Scan	28 days
90th percentile ER length of stay for admitted patients	25 hours
90th percentile ER length of stay for non-admitted complex patients	6.3 hours
90th percentile ER length of stay for non-admitted minor/uncomplicated patients	4 hours
Percentage of ALC Days	8.8%

Accountability between LHINs and HSPs

In order to align funding accountabilities and performance obligations within the health care system, LHINs are required by LHSIA to enter into a Service Accountability Agreement (SAA) with each HSP. LHINs have been following an implementation schedule in order to manage the process and meet the legislated requirements. Currently, LHINs have SAAs with hospitals and multi-sector agencies (including the Community Care Access Centre, Community Support Services, Community Mental Health and Addictions Services, and Community Health Centres). LHINs are in the process of putting SAAs in place with the Long-Term Care Home sector.

The SAA 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.

Two SAA renewal planning processes will be conducted in 2010/11. The Multi-Sector SAA (M-SAA) and the Hospital Sector SAA (H-SAA) must be renewed for April 1, 2011. Simultaneously developing agreements for both sectors presents an opportunity to align the agreements between community HSPs and hospitals, and to the IHSP/Blueprint.

Local Health System Performance

Improved performance is a key element of the overall plan to ensure the health system is delivering timely, quality and accessible care to the public. A good performance management system is objective, focused, balanced, and integrated into planning and management.

Performance management toward improvement is a key component of the South West LHIN's implementation model and management of existing operations. A number of steering committees comprised of HSPs will provide strategic leadership and oversight to monitor the results achieved to advance the system level goals and strategic directions outlined in the Blueprint and IHSP. Performance indicators, as outlined in sections 2.1 and 2.2, are set to help measure the impact of change strategies at the local, geographic, LHIN and provincial levels. Alignment of performance indicators between the different levels is a key component to ensuring the performance management system is focused on and has an impact in achieving the South West LHIN's system level goals and directions.

Allocation of Funding to Support Service Accountability Agreements

The majority of funding transferred to health service providers support services is pledged to support service accountability agreements. In the 2009/10 fiscal year this base level of funding totaled $1.9 billion.

Service accountability agreements are drafted to match overall funding targets for each major sector: hospitals, long term care homes, and community health service providers. For 2010/11, the base funding breakdown is:

Sector[6]	# HSPs	Funding (000s)
Hospitals	20	$1,472,911
Long Term Care Homes	75	$254,610

[6] The numbers above are from 2010/11 MLPA as of June 30, 2010.

Community Care Access Centre	1	$161,533
Community health service providers:		
Community Mental Health	28	$46,355
Community Health Centres	4	$12,486
Community Support Services	62	$46,306
Addictions Programs	10	$7,274
Total		$2,001,475

This year, staff will continue to work to build the information streams and performance measures needed to advance the IHSP and maximize system performance.

3.0 LHIN Staffing and Operations

3.1 LHIN Operations Spending Plan

Template B: LHIN Operations Spending Plan					
LHIN Operations Sub-Category ($)	**2008/09 Actuals**	**2009/10 Allocation**	**2010/11 Planned Expenses**	**2011/12 Planned Expenses**	**2012/13 Planned Expenses**
Salaries and Wages	2,314,272	2,670,000	2,901,510	3,005,500	3,080,000
Employee Benefits					
HOOPP	208,061	267,000	292,500	313,500	325,000
Other Benefits	327,878	347,100	303,100	319,500	335,000
Total Employee Benefits	***535,939***	***614,100***	***595,600***	***633,000***	***660,000***
Transportation and Communication					
Staff Travel	62,109	89,219	85,000	80,000	80,000
Governance Travel	35,424	38,000	45,000	45,000	45,000
Communications	67,900	190,000	94,000	85,000	85,000
Other Benefits	2,999	1,400	15,000	10,000	10,000
Total Transportation and Communication	***168,432***	***318,619***	***239,000***	***220,000***	***220,000***
Services					
Accommodation	152,169	170,000	147,210	205,000	205,000
Advertising	53,631	104,000	55,000	30,000	30,000
Banking	2	-	-	-	-
Community Engagement		-	-	-	-
Consulting Fees	907,022	300,000	170,730	84,719	4,219
Equipment Rentals	12,560	35,000	18,000	20,000	20,000
Governance Per Diems	114,111	150,000	162,180	160,000	160,000
Insurance	2,433	2,500	17,790	18,000	18,000
LSSO Shared Costs	300,000	330,000	360,000	360,000	360,000
LHINC Shared Costs		50,000	50,000	50,000	50,000
Other Meeting Expenses	28,888	99,000	74,099	75,000	60,000
Other Governance Costs	76,248	16,000	30,600	31,000	30,000
Printing & Translation	(13,486)	40,000	40,000	40,000	40,000
Staff Development	51,791	30,000	68,500	45,000	40,000
Other Services	110,128	25,000	-	-	
Total Services	***1,795,497***	***1,351,500***	***1,194,109***	***1,118,719***	***1,017,219***
Supplies and Equipment					
IT Equipment	19,010	20,000	20,000	10,000	10,000
Office Supplies & Purchased Equipment	105,061	103,000	127,000	90,000	90,000
Total Supplies and Equipment	***124,071***	***123,000***	***147,000***	***100,000***	***100,000***
LHIN Operations: Total Planned Expense	4,938,211	5,077,219	5,077,219	5,077,219	5,077,219
Annual Funding Target			5,077,219	5,077,219	5,077,219
Variance			-	-	-

Operational Budget

Please note that the Board has submitted an operational budget which is balanced for all out-years, even though costs continue to escalate and our funding allocation remains unchanged in each of these years. I trust that the submission of a balanced budget signals our Board's intention to remain fiscally responsible during these uncertain economic times. However, fiscal responsibility does come with risk in terms of our ability to achieve the system change which is desired by both our Board and the Minister of Health and Long-Term Care.

In this context of rising costs, reductions will be required in certain budget lines to achieve a balanced budget. In the first two years, these reductions would impact consultant costs, governance, staff travel, equipment and supplies. In the third year, reductions in our staffing levels will be required in order to achieve a balanced position.

As stated previously, all of these reductions will limit our ability to achieve the system change which we are trying to achieve. For example, significant reductions in staff travel will limit our ability to actively engage, and build ongoing relationships with our providers across a geography that takes 6 hours to drive from end to end. Reductions in consultant costs will limit our ability to tap into expertise which we may not have within our own limited staff complement. And finally, a reduction in staff in 2012/13 will create fundamental challenges in sustaining existing responsibilities and deliverables, and building new ones.

3.2 LHIN Staffing Plan

Template C: LHIN Staffing Plan (Full-Time Equivalents)					South West
Position Title	**2008/09 Actuals as of March 31**	**2009/10 Forecast**	**2010/11 Plan**	**2011/12 Plan**	**2012/13 Plan**
CEO	1	1	1	1	1
Senior Director	2	2	2	2	2
Director Communication		1	1	1	1
Corporate Coordinator/EA	2	2	2	2	2
AA	2	2	2	2	2
Receptionist	1	1	1	1	1
Business/Program Assistant	3	3	3	3	3
Communication Specialist	2	3	3	3	3
Manager Corporate Services	1	1	1	1	1
Office Coordinator	1	1	1	1	1
Planning & Integration Specialist	2	2	2	2	2
Decisions Support Specialist	1	1	1	1	1
Project Manager		1	1	1	1
Team Lead Information Management	1	1	1	1	1
Team Lead Planning & Integration	1	1	1	1	1
Planning & Integration Lead	2	3	3	3	3
Hips & Knees Project Lead contract		1	1		
Team Lead Finance	1	1	1	1	1
Financial Analyst	2	3	3	3	3
Lead Perf/Cont		1	1	1	1
Perf/Cont/Alloc Cons	1	1	1	1	1
Total	**26**	**33**	**34**	**33**	**33**
	(1)				(2)

NOTE: (1) There were unfilled positions at the end of 2009
(2) The planning forecast will require us to reduce 1.75 FTE in 2012/13, the positions will not be decided on until that period

4.0 Communications Plan

Integral to the successful implementation of the integrated health services priorities outlined in the Annual Business Plan and detailed in the Blueprint and IHSP will be the approach to communications and stakeholder engagement. Through these activities, we must ensure that the strategic directions are accurately conveyed and clearly understood by all key stakeholders and that a collective commitment to achieve the vision outlined in the Blueprint and IHSP is reached on the part of all provider organizations, direct service providers and communities.

The communications/engagement strategy will be delivered through three stages:

Stage 1: Launch and Planning for Implementation

This stage took place from the release of the IHSP on November 30, 2009 until March 30, 2010. Objectives were to create an understanding among stakeholders of:

- The LHIN's **vision for an Integrated Health System of Care** to 2022 as identified in the Blueprint
- The IHSP **strategic directions and key enablers** to be worked on over the next three years
- The IHSP and Blueprint vision that all health programs and services are part of a **single, unified health system of care** with clearly defined roles and responsibilities that delineate the interdependencies of providers enabling a shared approach to service delivery
- The implication that this is the start of a **collaborative change process** led by providers that will be supported by the South West LHIN

Stage 2: Implementation Communications

This stage will cover the activities from April 1, 2010 though the end of the 2010/11 fiscal year. Objectives are to facilitate:

- Provider understanding of the **Integrated Health System of Care** service delivery approaches
- Provider engagement related to **implementation** of the Blueprint and IHSP strategic directions
- Provider recognition and acceptance of **shared accountability** to engage with their system partners and communities to deliver services
- The LHIN's role in supporting **provider-led collaboration and planning**
- An understanding of the potential **implications of proposed system changes** on local communities

Stage 3: On-going Implementation Communications

This stage will cover activities beyond the 2010/11 fiscal year. Objectives are to:

- Facilitate **stakeholder support and engagement** in implementing activities, and advance the notion that providers are to take responsibility for the system as a whole, not only for their individual organization
- Share lessons learned, **success stories** and other scenarios of where changes have worked
- Enable a culture of **continuous quality improvement**

A number of advisory groups will provide oversight, guidance and advice as we proceed with the development and implementation of projects and initiatives related to our strategic directions. These groups include:

- Health System Leadership Council
- eHealth Steering Committee

- Health Professionals Advisory Committee[7]
- Aboriginal Health Committee
- Southwest Addiction and Mental Health Coalition
- Francophone Community Representatives
- Grey Bruce Integrated Health Coalition
- Huron Perth Providers Council
- Geographic tables across the South:
  - Oxford Health Systems Integration Task Force
  - Middlesex Providers Council
  - London Health Providers Alliance
  - Elgin Health Systems Planning Group

[7] Currently suspended pending initiation of Health System Leadership Council

Project/ Program/ Initiative Name	Project/ Program/ Intitiative Description
Enhance the Capacity and Integration of Primary, Specialized and Community-based Care	
Seniors & Adults with Complex Needs	
Assisted Living Elgin - West Lorne, St Thomas (2 sites)	To provide 24-hour, seven day per week availability of personal support services including bathing, toileting, dressing, medication assistance, homemaking services such as light housekeeping, shopping, meal preparation, social programs, and care management in apartment buildings in St.Thomas and West Elgin.
Assisted Living Tillsonburg (ALCOM)	To provide a new model of supportive housing for people in their current home instead of needing to move to a supportive housing building. 24-hour, seven day per week availability of personal support services including bathing, toileting, dressing, medication assistance, homemaking services such as light housekeeping, shopping, meal preparation, social programs, and care management in Tillsonburg.
Capacity Building of Community Support Services	Establishes consistent standardized policy and procedures and enhances recruitment and retention of volunteers for services heavily reliant on volunteers to provide the service. Encourages the volunteerism of diverse community members to better respond to the needs of community members.
Caregiver Support Circle (Formally Caregiver Connects)	Provide information, counselling support, and relief services required by caregivers.
Community Stroke Rehab	To provide a team of rehabilitation specialist to assist individuals who have had a stroke to make further gains in their recovery after leaving the hospital so that they can continue to live independently.
Dorchester Adult Day Program	Increase the opportunity for more seniors to participate in a day away program to maintain their health and the health of their caregivers.
Elgin Adult Day	Increase the opportunity for more seniors to participate in a day away program to maintain their health and the health of their caregivers.
First Link (Elgin, Grey Bruce, Huron, London Middlesex, Oxford, Perth)	Connects people with their local Alzheimer Society for learning opportunities, counselling support and linkage to community services appropriate to them at different stages of the disease
Flo Collaborative & Flo expansion	Enhance processes to improve flow through a unit
Geriatric Emergency Management (GEM)	Assess patients in ERs to determine if their needs can be met with support outside of the hospital and connect them with the appropriate service
Grey Bruce Falls Prevention and Intervention Program	To provide a falls prevention program that screens seniors who are at risk of falling, that provides awareness and education, and provides exercise services to those at risk in their homes through the assistance of their personal support worker.
Grey Bruce Transportation Coordination	Through the hiring of a transportation coordinator, improved coordination will be established through a variety of methods such as an updated inventory of resources, best practices and innovative solutions like centralized management and dispatch of existing vehicles.
Home and Community Support Adult Day Services	Increase opportunity for more seniors to participate in a day away program to maintain their health and the health of their caregivers.
Home at Last (5): Oxford (2 sites), Grey Bruce, Huron Perth, Middlesex and Elgin	Offers seniors transportation and assistance to safely settle back home following a stay in hospital
Home Help / Homemaking Services - North, Central	Expand Home help services in Grey Bruce and Huron Perth such as housecleaning and odd jobs to maintain the homes that seniors currently live in.
Integrated Case Management Model Owen Sound	Assess patients in ERs to determine if their needs can be met with support outside of the hospital and connect them with the appropriate service
Interim Long-Term Care beds - Oxford	Allow ALC patients to leave the hospital while they wait for a permanent long-term care home bed
Long Term Care Home Rural Pilot Project	Rural outreach services including Wellness for Seniors, Meals on Wheels, Rural Transportation, and Supportive Housing.

Project/ Program/ Initiative Name	Project/ Program/ Intitiative Description
Nurse Led LTC Home Outreach	Provide individualized resident care planning support and education to LTC Homes to enhance the quality of the resident care and enable homes to address non or less urgent needs of residents at the home rather than having residents visit the ED or be hospitalized
Quality and Process Improvement Program	The South West LHIN will advance its quality & process improvement strategy and continue its focus on improvement work across the continuum of care, enhancing its resources in this area to ultimately improve people's health care experiences, the health of particular populations and the value we receive for the money that we spend. As outlined in the proposed Excellent Care for All Act, the aim is to "foster a culture of continuous quality & process improvement where the needs of the patients come first".
Rural Transportation Coordination (Huron Perth)	To create a single, coordinated place to call for accessible coordinated transportation in Huron and Perth Counties. Common trip scheduling of transportation vehicles will lead to leveraging the capacity of transportation resources to meet increased demand.
Safe at Home	A program that assists frail seniors through visits from a nurse practitioner and additional nursing and personal support visits to review medications and how the caregiver is coping, and to provide the medical and personal assistance to keep them safe and living independently in their home.
Services and Supports for Aboriginal Seniors	Increase opportunities for cultural safety across the system, ensure effective culturally appropriate service delivery and augment services and supports for seniors in the aboriginal community
Share the Care	Provides a defined process and tools to assist an informal care group to help look after a seriously or chronically ill person
SMART and In-Home Volunteer Exercise	Provides physical activity and wellness education related to health issues and nutrition for seniors across Grey and Bruce Counties in community settings and in senior's homes.
Supportive Housing Bluewater	In an apartment building across from Bluewater Rest Home, 24 –hour, seven day per week availability of personal support services including bathing, toileting, dressing, medication assistance, homemaking services such as light housekeeping, shopping, meal preparation, social programs, and care management.
Supportive Housing Grey Bruce (and Security Check)	In selected apartment buildings in Grey and Bruce Counties, 24 –hour, seven day per week availability of personal support services including bathing, toileting, dressing, medication assistance, homemaking services such as light housekeeping, shopping, meal preparation, social programs, and care management.
Supportive Housing London	To provide 24-hour, seven day per week availability of personal support services including bathing, toileting, dressing, medication assistance, homemaking services such as light housekeeping, shopping, meal preparation, social programs, and care management.
Supportive Housing Middlesex	To provide additional supportive housing for seniors in selected apartment buildings in Strathroy, 24-hour, seven day per week availability of personal support services including bathing, toileting, dressing, medication assistance, homemaking services such as light housekeeping, shopping, meal preparation, social programs, and care management. Mental Health services provided by Crest Centre to a portion of population.
System of Care for High Risk Seniors who live in their own homes	This project aims to define a framework for a system of care for high risk seniors currently living in the community and implement and evaluate the framework in London before spreading to the entire LHIN. Following an acute care episode, individuals living at home and defined as high risk will receive appropriate levels of care initially in the home setting through a London pilot. The framework developed will include a variety of care settings including home, assisted living, transitional care, complex continuing care, rehabilitative care or long-term care.

Project/ Program/ Initiative Name	Project/ Program/ Intitiative Description
System of Care for Seniors with Behavioural Issues	3 Geriatric Mental Health Response Teams (north, central and south) will be integrated within geographically designated Geriatric Cooperatives (all providers of geriatric services) and will build upon the local capacity necessary to address challenging behaviours where people reside
Transitional Care Unit Parkwood Hospital	Provide step down unit for patients needing slow stream recovery following an acute episode who meet admission criteria for the unit
Wellness for Seniors	Collaborative effort to provide and standardize physical activity and wellness education such as health issues and nutrition for seniors across Huron and Perth Counties in community settings.
Wrap Around for Immigrants and the Francophone Community	The aim of this program is to create individualized supports for culturally diverse seniors through professionals and community members from those communities based on the unique needs of the senior.
People Living with Mental Health & Addictions Challenges	
ED Wait Times- QI Forum- Mental Health & Addictions Grey Bruce	A forum was held March 31, 2010 to focus on understanding the current state of a continuum of care for people with mental health and addictions with respect to emergency department use. This forum will help develop a quality improvement approach to improve services in emergency departments for people with mental health and addiction issues. Mental health and addictions have been identified as one of the priorities for developing appropriate community alternatives. This project will provide an opportunity to move the system forward in collaborative efforts and innovative programming.
Dual Diagnosis Framework	To provide a joint framework for the planning, coordination, delivery of community mental health and developmental services and supports that will promote better access to both sectors for persons 18 years and older with a dual diagnosis, both developmental disability and mental health needs
Mental Health, Supportive Housing for People with Problematic Substance Use 2009/2010	In 2006 the MOHLTC announced a budget commitment of $36 million for 1,000 units provincially for supportive housing and transitional housing for people with problematic substance use or concurrent disorders, recognizing that stable housing for people with problematic substance use is central to attaining treatment goals (housing must be part of any comprehensive treatment program).
Mental Health, Supportive Housing for People with Problematic Substance Use 2010/2011	In 2006 the MOHLTC announced a budget commitment of $36 million for 1,000 units provincially for supportive housing and transitional housing for people with problematic substance use or concurrent disorders, recognizing that stable housing for people with problematic substance use is central to attaining treatment goals (housing must be part of any comprehensive treatment program).
Mental Health, Supportive Housing for People with Problematic Substance Use 2011/2012	In 2006 the MOHLTC announced a budget commitment of $36 million for 1,000 units provincially for supportive housing and transitional housing for people with problematic substance use or concurrent disorders, recognizing that stable housing for people with problematic substance use is central to attaining treatment goals (housing must be part of any comprehensive treatment program).
Tier 2 Divestment	In order to implement Health Services Restructuring Commission directions (1997) and subsequent Ministry of Health and Long Term Care (MoHLTC) directions, Tier II divestment is the transfer of psychiatric beds and resources (between 2010-1014) from St. Joseph's Health Care London to communities in Windsor, Hamilton, Kitchener-Waterloo, and St. Thomas . Tier II divestment is a complex undertaking involving both program transfers and capital projects, involving four LHINs, five hospitals and different branches on the Ministry of Health and Long-Term Care. Each hospital is at a different stage of development in both their program transfer and capital projects.
People Living with or At Risk of Chronic Disease(s)	

Project/ Program/ Initiative Name	Project/ Program/ Intitiative Description
Comprehensive South West LHIN Diabetes services coordination plan	This project focuses on the coordination of diabetes in the south west to define a strategy to best coordinate diabetes delivery in all health settings (CHCs, FHTs, hospital-based DECs) and across the continuum of care (primary, secondary, tertiary) in partnership with the newly established Ministry of Health Regional Coordination Centre for diabetes
Partnerships for Health - Year 3 Sustainability Plan	Partnerships for Health is a chronic disease management demonstration project focused on improved outcomes for patients living with diabetes that partners primary care physicians with CCAC case managers, strengthening the capacity of the health care team to coordinate care and facilitate navigation to community based resources in order to support improved patient outcomes. Currently in its third and final year, the focus is on developing a sustainability plan for the initiative.
Continue with, and expand, implementation of self-management strategy	This strategy targets both the person with the chronic disease, including their caregivers, and clinicians /other healthcare professionals. By implementing Stanford University's Chronic Disease Self Management™ training and other disease specific programs licensed by Stanford University, this strategy will arm people with chronic diseases with skills and resources to help them to better manage their disease, while improving their health and reducing hospital and health care system burden. By providing ongoing training for professionals in using the tools in the Self Management Toolkit developed and launched by the South West LHIN, Motivational Interviewing and 3 Minute Empowerment™, clinicians will be supported to develop the skills and behaviours that will help them support their patients in their self management efforts, thereby improving the quality and efficiency of office visits.
Thames Valley / South Diabetes Education Improvement Project	Improve partnerships between DECs in the south geographic area of the LHIN. In partnership with the ODS and RCC, ensure and facilitate the implementation of common standards of care in the DECs in the Thames Valley area
South West LHIN Diabetes High Risk 18 month pilot population. Building Bridges across the Diabetes Care Continuum	This pilot project aims to build bridges between Aboriginal and non-Aboriginal communities in order to •Remove barriers that prevent people in Aboriginal communities in Grey Bruce from accessing diabetes supports and resources •Leverage existing resources and build capacity for people providing these services to deliver care in a culturally relevant and sensitive way
Enhancing Access to Team Based Primary Care - FHT readiness assessment	Preparing readiness assessment in preparation for Wave 5 call for Family Health Team applications. The implementation of new Family Health Teams will improve access to comprehensive family health care for all Ontarians. The new Family Health Teams, part of the government's Family Health Care for All Strategy, will support other ministry initiatives including: reducing the number of unattached patients and improving chronic disease prevention and management with a focus on diabetes to support the Ontario Diabetes Strategy, and integrated cancer screening.
Enhance Access and Sustainability of Hospital-based Treatment and Care	
Emergency Services	
Improving Quality and Outcomes in Emergency Departments	Identifying the principles and requirements for a high quality, accessible and sustainable emergency system of care in the South West LHIN. Engaging key stakeholders to develop and initiate a process to implement the Emergency Department Health Human Resources Study strategies, specific to needs at the local, multi-community and LHIN-wide levels
Pay 4 Results / ED Process Improvement Program	Reduce wait times, increase efficiency and flow through of ERs at P4R hospitals (UH, Vic, STEGH, & GBHS) and potential spread to other hospitals in the LHIN
Medicine, Surgical and Critical Care Services	

Project/ Program/ Initiative Name	Project/ Program/ Intitiative Description
Hips and Knees Project - Referral Guideline and Common Referral Form, Common Hospital Order Sets and Education Tools	Develop and implement guidelines for primary care physicians to use when determining when to refer to an orthopaedic surgeon for a hip or knee replacement consult. Develop and implement common in-hospital order sets to promote common care based on evidence. Develop and implement common and hospital specific education tools for the patient's journey of care.
Supply Chain Integration Model	The South West LHIN integrated Supply Chain Management (iSCM) Model will: strengthen supply chain leading practices; improve efficiencies and operations to generate cost savings through economies of scale; standardize products, services, suppliers, processes, forms, policies and procedures; achieve further innovation through automation and advanced technology; improve performance measurement, and create opportunity to leverage expertise and synergies. This iSCM Model will bring the remaining health care organizations (hospital first) in the South West LHIN into the region-wide strategy.
LHIN-wide wound care management initiative	Development of: an integrated wound care framework; an integrated education framework; and a sustainable structure for the selection of wound supplies and products
Patient Access & Flow Project - SW LHIN	To develop and implement standardized, SW-LHIN wide rules of interaction and communication between hospitals and physicians that will improve the patient referral and transfer process to it is more transparent, understood by everyone, more effective and more efficient. One central number to call for transfer and repatriation.
Multi-Community Area Planning: Oxford County	Develop area clinical services plans for Oxford in conjunction with Woodstock General Hospital's redevelopment project.
Build on Patient Access and Flow	Expand the existing networks and relationships formed through Patient Access & Flow to further work in effective referral and repatriation
Complex Continuing Care Planning - Centralized Access for complex continuing care beds	Phase 1 is a current state analysis of the complex continuing care beds, creating admission and discharge criteria, gain an understanding of current admission and discharge criteria, gain an understanding of current access rules, and establish an optimal future model. Phase 2 would be the implementation of the new admission and discharge criteria and application of a consistent model for the access to these beds across the South West LHIN.
Diagnostic Imaging Committee	
Build a system of interprofessional care for patients requiring long-term mechanical ventilation	To build a responsive system of interprofessional care and education (IPC/E), with clearly defined roles/processes, that extends outside of the walls of the intensive care units to effectively and safely transition longterm ventilation patients back to their communities, and ensure continuing care.
Critical Care Capacity Management Planning	In collaboration with HSPs development of actions plans that will: improve patient access to safe and timely critical care services, enable alternate human resource strategies, equipment and technology to cover surges in capacity in ICU beds or when patient care is compromised. Including improving access to critical care services through the development of partnerships and standardized referral practices.
Hip Fractures	Increase access to hip fracture care in the South West LHIN to meet the provincial target of surgery within 48 hours of admission.
Cancer Surgery	Increase access to cancer surgery in the South West LHIN to meet target.
Key Enablers	
Information & Clinical Technology	
Alternate Level of Care Resource Matching & Referral (Phase 2)	Implement a multi-LHIN eReferral system which matches ALC patients to appropriate resources (Phase 2 of a 4 Phase approach)
LHINs 1, 2, 3, 4 Diagnostic Image Repository (DI-r)	Provides access to diagnostic images from any hospital in LHINs 1, 2, 3 and 4 allowing for region-wide consultation
Ontario Lab Information System (OLIS)	Grey Bruce Health Services has served as a provincial pilot site for OLIS, which is an early step in moving the health system away from paper-based records to more accessible, electronic files. OLIS has been built to electronically store test results from Ontario's medical laboratories, making them quickly available to authorized health care practitioners province-wide.

Project/ Program/ Initiative Name	Project/ Program/ Intitiative Description
Southwest Physician Office Interface to Regional EMR System	Implement an interface to EMRs used by 100 providers receiving reports from LHSC.
Southwest Physician Office Interface to Regional EMR System (Phase 2)	Implement an interface to EMRs used by an additional 100 providers receiving reports from LHSC and other TVHPP hospitals.
Southwest Physician Office Interface to Regional EMR System (Phase 3)	Implement an interface to EMRs used by 50+ physicians receiving reports from hospitals in the HPHA.
Southwest Physician Office Interface to Regional EMR System (Phase 4)	Implement an interface to EMRs used by 200 physicians receiving reports from GBHS & LHSC/SJHC hospitals with a specific focus on the transfer medication lists.
Ontario Diabetes Registry	Rollout and Support the Ontario Diabetes Registry.
North-South Hospital Connectivity Project	Implement a viewer connecting Cerner systems used by hospitals in GBHS & TVHPP
ESC-SW Clinical Viewer	Implement a viewer connecting at least one hospital in the ESC and SW LHINs
Ontario LHINs Privacy Project	Develop a PHIPA compliant Privacy Governance methodology and inventory of privacy & security tools and resources
HPHA TeleHomeCare Project	Implement an in-home videoconference system for patients using Mental Health services
SW LHIN Programs and Services Inventory	The Program and Service Inventory project is the first step in moving toward the vision of an online data repository with secure query and report capabilities. This project will produce a Microsoft Access database containing information on South West LHIN Health Service Providers. The information will then be accessed using standard Microsoft Access functionality.
Health Human Resources	
Huron Perth Health Human Resources Project	Gather data on occupational structure of all settings across the healthcare sector in Huron Perth Counties. Identify occupations in demand. Provide insights into emerging occupations and skill sets. Provide opportunities to new developing partnerships within the healthcare community and build on advantages of currently existing collaborations.
Shared Benefits Initiative	Leveraging the power of group purchasing to achieve savings in the provision of employee benefits for participating hospitals in the South West LHIN.
Implementation & Accountability Frameworks	
Service Accountability Agreements	L-SAAs (Long-term care) - July 2010; H-SAAs (Hospitals) and M-SAAs (multi-sectoral) end of 2010/11 fiscal year