Appendix A: Implementation of Initiatives

Program: Access to Care

The Access to Care project has been a significant undertaking by the South West LHIN since 2011/12. It has three streams of work that focus on improved transitions from hospital to home through the home first philosophy, and system redesign for Assisted Living, Supportive Home and Adult Day Programs as well as Complex Continuing Care and Rehabilitation services.

Improve Access to Family Health Care

Initiative/Action:

Ensure timely medication reconciliation and follow up appointment with physician or nurse practitioner post discharge from hospital in alignment with the Home First philosophy

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
20%	5%	30%	30%

Enhance Coordination and Transitions of Care

Initiative/Action:

Implement geographic "cluster care and virtual ward" models of care

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	40%	40%	10%

Improve Access to Family Health Care

Initiative/Action:

Using a Home First philosophy, screen for potential high needs patients who frequent the ER and hospital and who require complex discharge plans; enhance monitoring of eReferral, eNotification and eDischarge Summary, and coordinate care with other providers

Magnitude of Change: Low - Marathon

Duration of Initiative:12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
20%	20%	60%	

Enhance Coordination and Transitions of Care

Initiative/Action:

Continue to implement Access to Care project LHIN wide and align senior friendly hospital strategies to obtain project deliverables and outcomes

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	25%	25%	25%

Enhance Coordination and Transitions of Care

Initiative/Action:

Implement CCAC expanded role to coordinate access to Assisted Living, Supportive Housing, Adult Day Programs, Complex Continuing Care and Rehabilitation beds to obtain the right service at the right time by the right provider

Magnitude of Change: Low - Marathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
50%	25%	25%	

Drive Safety Through Evidence Based Practice

Initiative/Action:

Ensure timely medication reconciliation and follow up appointment with (physician or nurse practitioner, pharmacist or nurse) following discharge from hospital and coordinate care with other providers in alignment with home first philosophy

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
20%	5%	30%	30%

Increase the Value of our Healthcare System

Initiative/Action:

Implement redesign recommendations to improve access to Assisted Living, Supportive Housing, Adult

Day Programs, Complex Continuing Care and Rehabilitation beds to obtain the right service at the right time by the right provider

Magnitude of Change: High - Decathlon

Duration of Initiative: Greater than 2 Years

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	25%	25%	25%

Increase the Value of our Healthcare System

Initiative/Action:

Prioritize, develop and implement restorative care options across hospital, long-term care and community based care

Magnitude of Change: High - Decathlon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	30%	30%	30%

Enhance Coordination and Transitions of Care

Initiative/Action:

Support the implementation of the long-term ventilation regional initiative

Magnitude of Change: Low - Marathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
15%	35%	25%	25%

Program: Behavioural Supports Ontario

The South West LHIN began to focus efforts on creating a behavioural support system of care for older adults in 2010-11. Through the design and implementation of a cross-sectoral system of supports and services, advancements continue to be made to meet the needs of older adults with responsive behaviours due to mental health and addictions, dementia, or other neurological conditions and those at risk.

Enhance Coordination and Transitions of Care

Initiative/Action:

Continue to build a Behavioural Support System of Care by implementing coordinated prevention, care and educational strategies across primary care, seniors MH&A teams and specialist resources, Alzheimer Societies, Long Term Care homes, CCAC and other community based services

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
30%	30%	10%	10%

Program: Chronic Disease Prevention and Management (CDPM)

The initiatives within the CDPM portfolio support a quality improvement approach within primary care and broader system partners focused on improving chronic disease prevention and management across the system. This includes quality and e-health coaching, and learning collaboratives that support the implementation of best practices in managing chronic disease, supporting self-management, and maximizing the use of information systems to enhance patient flow and care.

Improve Access to Family Health Care

Initiative/Action:

Strengthen links to health promotion, disease prevention and self-management programs and services including those offered by public health units

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	10%	20%	10%

Improve Access to Family Health Care

Initiative/Action:

Increase adoption of Advanced Access through e-health training and quality improvement coaching; Provide Advanced Access training through e-health training and quality improvement coaching

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	10%	15%	15%

Improve Access to Family Health Care

Initiative/Action:

Build self-management system capacity by implementing chronic disease and MH&A self-management strategies including promotion and participation in self-management training, implementation of support techniques, and focus on priority populations (Francophone and Aboriginal)

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	5%	20%	10%

Enhance Coordination and Transitions of Care

Initiative/Action:

Build self-management system capacity by implementing chronic disease and MH&A self-management strategies including promotion and participation in self-management training, implementation of support techniques, and focus on priority populations (Francophone and Aboriginal)

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	5%	20%	10%

Enhance Coordination and Transitions of Care

Initiative/Action:

Promote “Living a Healthy Life with Chronic Conditions” workshop to people and their caregivers

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	25%	25%	25%

Enhance Coordination and Transitions of Care

Initiative/Action:

Through Partnering for Quality, implement chronic disease best practices between primary, specialist, and community based care including initiatives that align to the Integrated Vascular Blueprint for Ontario and C-change guidelines

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	5%	10%	5%

Enhance Coordination and Transitions of Care

Initiative/Action:

Integrate diabetes strategy into collaborative chronic disease planning and implementation, including the Aboriginal community

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	25%	25%	25%

Enhance Coordination and Transitions of Care

Initiative/Action:

Diabetes Foot Ulcer Strategy

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	20%	20%	30%

Program: Clinical Services Planning

This planning work aims to manage the scarce resources in the South West LHIN and balance the access challenges in our rural and northern communities while considering quality and safety. This work also aims to build a cultural shift towards further enhancing our culture of system integration while improving organizational performance.

Enhance Coordination and Transitions of Care

Initiative/Action:

Prioritize, develop and implement LHIN-wide hospital clinical services plans in alignment with Health System Funding Reform, Wait Time Strategies and other cost, quality improvement initiatives'

Magnitude of Change: Low - Marathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	30%	35%	30%

Increase the Value of our Healthcare System

Initiative/Action:

Support LHIN 1 and 2 perinatal capacity assessment and regional planning

Magnitude of Change: High - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	40%	60%	0%

Increase the Value of our Healthcare System

Initiative/Action:

Oxford Joint Services Planning

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
20%	20%	20%	20%

Increase the Value of our Healthcare System

Initiative/Action:

Surgical Wait List Management System

Magnitude of Change: High - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	40%	60%	0%

Increase the Value of our Healthcare System

Initiative/Action:

Orthopedic Planning

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	15%	45%	15%

Program: Connecting and Empowering People

The South West LHIN works with Aboriginal and Francophone communities to increase access to culturally appropriate/culturally safe health care and increase equity and quality of health services, while addressing each of the strategic directions within the IHSP3, as it relates to these unique populations. In addition, initiatives also focus on human resource best practices related to optimizing skillsets and collaborating across organizations and geography to increase capacity and efficiency of teams and services.

Improve Access to Family Health Care

Initiative/Action:

Optimize the skillsets of interdisciplinary team members to leverage team capacity and effectiveness

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	20%	30%	25%

Improve Access to Family Health Care

Initiative/Action:

Increase access to and integration of traditional healers and indigenous healing methods

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016

	0%	25%	25%	25%

Improve Access to Family Health Care

Initiative/Action:

Implement culturally appropriate care and services

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
20%	20%	20%	20%

Enhance Coordination and Transitions of Care

Initiative/Action:

Implement enhanced access to addiction services, including Aboriginal site access

Magnitude of Change: High - Decathlon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	10%	30%	60%

Enhance Coordination and Transitions of Care

Initiative/Action:

Improve the interfacing between the CCAC, hospitals and Aboriginal health service providers to better manage case management, discharge planning and patient care

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	25%	25%	25%

Enhance Coordination and Transitions of Care

Initiative/Action:

Develop a strategic primary care plan focused on the Aboriginal population

Magnitude of Change: High - Decathlon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016

	0%	**35%**	**35%**	**30%**

Enhance Coordination and Transitions of Care

Initiative/Action:

Promote self-management programs for people living with chronic conditions and their caregivers (e.g., "Living a Healthy Life with Chronic Conditions" workshops)

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	**2013-2014**	**2014-2015**	**2015-2016**
25%	**25%**	**25%**	**25%**

Enhance Coordination and Transitions of Care

Initiative/Action:

To encourage hiring of French-speaking behavioural support staffing resources in London/Middlesex

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	**2013-2014**	**2014-2015**	**2015-2016**
0%	**10%**	**25%**	**25%**

Enhance Coordination and Transitions of Care

Initiative/Action:

To work with the CCAC to develop a mechanism to identify and track the number of Francophone clients that they serve each year to understand opportunities for culturally sensitive CCAC services and other services that they coordinate access to including long term care homes, assisted living and adult day programs, complex continuing care and rehabilitation beds

Magnitude of Change: Low - Marathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	**2013-2014**	**2014-2015**	**2015-2016**
0%	**50%**	**25%**	**25%**

Enhance Coordination and Transitions of Care

Initiative/Action:

Work with thehealthline.ca to create navigation tools to support the Francophone population

Magnitude of Change: Low – Sprint

Duration of Initiative: Less than 12 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
15%	100%	0%	0%

Enhance Coordination and Transitions of Care

Initiative/Action:

Implement culturally appropriate care and services

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	10%	20%	20%

Increase the Value of our Healthcare System

Initiative/Action:

Collaborate across organizations and geography to increase capacity and efficiency of teams and services

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	20%	20%	20%

Increase the Value of our Healthcare System

Initiative/Action:

In London-Middlesex, FLS-identified HSPs understand and comply with French Language Services requirements

Magnitude of Change: Low - Marathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	20%	25%	50%

Increase the Value of our Healthcare System

Initiative/Action:

In London-Middlesex, all HSPs to develop mechanism to identify and track the number of Francophone

clients that they serve each year to understand opportunities for culturally sensitive services

Magnitude of Change: Low - Marathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	10%	40%	50%

Increase the Value of our Healthcare System

Initiative/Action:

Implement the Aboriginal Mental Health and Addictions Strategy

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	25%	25%	25%

Increase the Value of our Healthcare System

Initiative/Action:

In London-Middlesex, Mental Health and Addiction agencies ensure French language service capacity for key service functions

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	25%	25%	25%

Increase the Value of our Healthcare System

Initiative/Action:

Increase the cultural competency of health service providers delivering care to Aboriginal populations

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	30%	20%	20%

Increase the Value of our Healthcare System

Initiative/Action:

Distribute the FLS toolkit to all HSPs and promote its use in London-Middlesex

Magnitude of Change: Low - Sprint

Duration of Initiative: Less than 12 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	100%	0%	0%

Increase the Value of our Healthcare System

Initiative/Action:

Implement culturally appropriate care and services

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
20%	20%	20%	20%

Increase the Value of our Healthcare System

Initiative/Action:

Identify the data requirements for furthering health planning and service delivery as it relates to the Aboriginal population

Magnitude of Change: Low - Sprint

Duration of Initiative: Less than 12 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	100%	0%	0%

Increase the Value of our Healthcare System

Initiative/Action:

Examine options for creating a comprehensive source of reliable health data for the Aboriginal population

Magnitude of Change: Low - Marathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	25%	25%	50%

Increase the Value of our Healthcare System

Initiative/Action:

Examine data collection and sharing agreement options for the LHIN as it relates to First Nations, Metis and Urban Aboriginal populations

Magnitude of Change: Low - Sprint

Duration of Initiative: Less than 12 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	100%	0%	0%

Program: Critical Care

Many of the Critical Care initiatives build on the work of previous years to enhance performance and quality improvement, leverage policy enhancements, and implement new tools to improve access and efficiencies in Critical Care.

Increase the Value of our Healthcare System

Initiative/Action:

Provincial Life or Limb Planning & Implementation

Magnitude of Change: Low - Sprint

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	50%	40%	0%

Increase the Value of our Healthcare System

Initiative/Action:

Provincial Hospital Resource System (PHRS) implementation and LHIN wide roll out of PHRS Repatriation Tool

Magnitude of Change: High - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	35%	60%	0%

Increase the Value of our Healthcare System

Initiative/Action:

Implement provincially driven performance and quality improvement approach in Critical Care and leverage policy enhancements to improve access and efficiencies in Critical Care

Magnitude of Change: Low - Sprint

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
20%	60%	20%	0%

Program: Diagnostic Imaging

The South West LHIN will implement provincially driven diagnostic imaging strategies.

Increase the Value of our Healthcare System

Initiative/Action:

Implement provincially driven diagnostic imaging appropriateness pilot and related strategies (DI Coordinated Access)

Magnitude of Change: High - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	80%	10%	0%

Program: Emergency Services

The South West LHIN continues to leverage the Pay 4 Results program with its participating site in an effort to improve wait times and the quality of Emergency care in the South West. The South West LHIN has launched a Knowledge Transfer initiative partnering with St. Thomas Elgin General Hospital to spread ED best practices in terms of reduced wait times and increased patient flow in the South West LHIN.

Increase the Value of our Healthcare System

Initiative/Action:

Leverage Pay 4 Results program to improve wait times and effectiveness in emergency care

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	25%	25%	25%

Increase the Value of our Healthcare System

Initiative/Action:

Spread ED best practices related to improvement in patient flow and reduced wait times within the South West LHIN

Magnitude of Change: Low - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	60%	30%	0%

Program: Health Links

Patients with the greatest health care needs make up five percent of Ontario's population but use services that account for approximately two-thirds of Ontario's health care dollars. Health Links will bring local health care providers together in strengthened partnerships in the community, closing the gaps that often occur when a patient moves from one provider to another, allowing for faster follow-up for patients being discharged from hospital, reducing the likelihood of readmission, and ensuring that people are at the centre of their care.

Improve Access to Family Health Care

Initiative/Action:

Through Partnering for Quality, implement Integrated Services Collaboratives across the South West LHIN by Leveraging BestPATH and Health Links implementation opportunities

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	20%	20%	20%

Improve Access to Family Health Care

Initiative/Action:

Using a Home First philosophy, screen for potential high needs patients who frequent the ER and hospital and who require complex discharge plans; enhance monitoring of eReferral, eNotification and eDischarge Summary, and coordinate care with other providers

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	10%	30%	20%

Improve Access to Family Health Care

Initiative/Action:

Participate in implementation of geographic "cluster care and virtual ward" models of care

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	20%	20%	30%

Enhance Coordination and Transitions of Care

Initiative/Action:

Identify and monitor the population of people who are at risk of using a significant portion of health care resources but are not currently part of the 1-5% with the greatest unmet needs

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	5%	10%	10%

Enhance Coordination and Transitions of Care

Initiative/Action:

Identify and implement health and social service strategies to support the evolving populations of people living with the greatest unmet health care needs (e.g., frail seniors, people requiring end of life care, 1%, 5% of the population utilizing a significant proportion of the health care resources)

Magnitude of Change: Low - Marathon **Duration of Initiative:** Beyond 36 Months	**Percent Completion:** **2012-13 5%** | **2013-2014 20%** | **2014-2015 20%** | **2015-2016 20%**

Program: Long Term Care Home Redevelopment

A number of older Long Term Care Homes are expected to be rebuilt when the Ministry announces Phase 2 of the redevelopment process. During this next phase, the South West LHIN will work to ensure equitable access to these beds throughout the LHIN.

Increase the Value of our Healthcare System

Initiative/Action:

Influence and manage the distribution of Long-Term Care Home beds as older homes redevelop

Magnitude of Change: High - Decathlon **Duration of Initiative:** Beyond 36 Months	**Percent Completion:** **2012-13 10%** | **2013-2014 5%** | **2014-2015 20%** | **2015-2016 20%**

Program: Mental Health and Addictions

All initiatives are aimed at moving the locus of care from hospital to community through reducing reliance on hospital-based care and enhancing capacity in the community. Enhancing community capacity is expected through various initiatives that look to coordinate and integrate existing capacity as well as measure and evaluate the impact of new resources.

Improve Access to Family Health Care

Initiative/Action:

Develop best shared care models that leverage support for clients among family physicians, NPs, psychiatrists, allied health and community services

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	25%	25%	25%

Improve Access to Family Health Care

Initiative/Action:

Facilitate access to Mental Health & Addiction (MH&A) Case Management services to ensure access to community based supports to reduce ED repeat and/or avoidable visits

Magnitude of Change: High - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	45%	55%	0%

Improve Access to Family Health Care

Initiative/Action:

Facilitate access to enhanced MH&A Crisis services by providing immediate intervention to clients and families in crisis to reduce ED repeat visits

Magnitude of Change: High - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	45%	50%	0%

Improve Access to Family Health Care

Initiative/Action:

WOTCH-SEARCH-CMHA Merger

Magnitude of Change: High - Decathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
25%	25%	50%	0%

Improve Access to Family Health Care

Initiative/Action:

Monitor the outcomes and explore the expansion of the Grey-Bruce Telemedicine primary care model

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	20%	20%	20%

Enhance Coordination and Transitions of Care

Initiative/Action:

Improve coordination, quality and access to care for Mental Health & Addiction (MH&A) clients by implementing a Coordinated Access to care model and strategies aimed at providing immediate intervention through Crisis and homelessness case management, access to community based supports and reduced wait lists

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
10%	15%	25%	50%

Enhance Coordination and Transitions of Care

Initiative/Action:

Participate in, support and promote anti-stigma initiatives aimed at prevention, self-management and accessing appropriate levels of care (e.g., United Way London-Middlesex campaign, Mental Health Commission of Canada Anti-Stigma)

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
55%	15%	15%	15%

Enhance Coordination and Transitions of Care

Initiative/Action:

Collaborate with care partners to maximize the flow of patient information among circle of care partners including but not limited to Mental Health and Addiction providers, CCAC, Family Health Care, CSS, Hospitals and LTC Homes

Magnitude of Change: High - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
50%	25%	25%	0%

Enhance Coordination and Transitions of Care

Initiative/Action:

Implement Methadone Maintenance Treatment workers and access to community services for pregnant and parenting women with addictions

Magnitude of Change: Low - Sprint

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	70%	25%	0%

Enhance Coordination and Transitions of Care

Initiative/Action:

Improve quality of care through enhanced Mental Health & Addiction Telemedicine support, providing urgent access to community based supports in urban and rural settings to reduce ED repeat and/or avoidable visits

Magnitude of Change: High - Decathlon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
15%	45%	15%	25%

Enhance Coordination and Transitions of Care

Initiative/Action:

Explore the use of valid data fields to define common and standardized outcome measures

Magnitude of Change: High - Decathlon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
55	45%	25%	25%

Increase the Value of our Healthcare System

Initiative/Action:

Continue to support movement of long stay clients from RMHC to community settings through effective use of community enhancements, partnerships, coordinated discharge planning, etc.

Magnitude of Change: High - Decathlon

Percent Completion:

Duration of Initiative: 25 to 36 Months	**2012-13 25%** | **2013-2014 25%** | **2014-2015 25%** | **2015-2016 25%**

Increase the Value of our Healthcare System

Initiative/Action:

Explore back office integration opportunities

Magnitude of Change: High - Decathlon **Duration of Initiative:** 25 to 36 Months	**Percent Completion:** **2012-13 0%** | **2013-2014 10%** | **2014-2015 25%** | **2015-2016 25%**

Increase the Value of our Healthcare System

Initiative/Action:

Implement Mental Health and Addictions community capacity recommendations

Magnitude of Change: High - Decathlon **Duration of Initiative:** 25 to 36 Months	**Percent Completion:** **2012-13 25%** | **2013-2014 0%** | **2014-2015 25%** | **2015-2016 50%**

Program: Palliative Care

The South West LHIN is working in partnership with the South West LHIN Hospice Palliative Care (HPC) Network to implement provincial directions for HPC to better support people with life-limiting illnesses and their families. The HPC work crosses sectors and involves collaboration at the regional, multi community and local (primary care) levels with the patient and family at the centre.

Enhance Coordination and Transitions of Care

Initiative/Action:

Develop and implement an integrated cross continuum/ sector palliative care program for the South West LHIN

Magnitude of Change: High - Decathlon **Duration of Initiative:** 25 to 36 Months	**Percent Completion:** **2012-13 0%** | **2013-2014 30%** | **2014-2015 45%** | **2015-2016 25%**

Program: Quality and Value

The South West LHIN will continue to build a culture of continuous quality improvement by leveraging the South West LHIN Quality Improvement Engagement Framework and performance monitoring to improve health services.

Improve Access to Family Health Care

Initiative/Action:

Partnering for Quality

Magnitude of Change: Low - Marathon **Duration of Initiative:** Beyond 36 Months	**Percent Completion:** **2012-13 25%** | **2013-2014 15%** | **2014-2015 15%** | **2015-2016 15%**

Quality and Value

Initiative/Action:

Build capacity for Quality Improvement across the South West LHIN

Magnitude of Change: Low - Marathon **Duration of Initiative:** beyond 36 Months	**Percent Completion:** **2012-13 0%** | **2013-2014 20%** | **2014-2015 40%** | **2015-2016 30%**

Quality and Value

Initiative/Action:

Develop and implement a strategy to support organizations in improving on key performance and quality related issues

Magnitude of Change: High - Decathlon	**Percent Completion:**

Duration of Initiative: Beyond 36 Months	**2012-13** **10%**	**2013-2014** **20%**	**2014-2015** **50%**	**2015-2016** **20%**

Program: Safety

The South West LHIN will enhance its focus on safety related initiatives.

Drive Safety Through Evidence-based Practice

Initiative/Action:

Participate in the implementation of the South West Regional Wound Care Program sustainability plan

Magnitude of Change: High - Decathlon **Duration of Initiative:** Beyond 36 Months	**Percent Completion:**			
	2012-13 **20%**	**2013-2014** **20%**	**2014-2015** **20%**	**2015-2016** **20%**

Drive Safety Through Evidence-based Practice

Initiative/Action:

In partnership with Public Health, implement the Falls Prevention Strategy by utilizing evidence-based tools/protocols/ training to screen, identify, manage and/or refer individuals to appropriate services

Magnitude of Change: Low - Marathon **Duration of Initiative:** 25 to 36 Months	**Percent Completion:**			
	2012-13 **5%**	**2013-2014** **25%**	**2014-2015** **25%**	**2015-2016** **25%**

Drive Safety Through Evidence-based Practice

Initiative/Action:

Implement a cross sector infection prevention strategy that utilizes evidence-based tools/protocols/training to manage risk factors for infections and ensure effective transfer of information during transitions of care

Magnitude of Change: High - Relay **Duration of Initiative:** 12 to 24 Months	**Percent Completion:**			
	2012-13	**2013-2014**	**2014-2015**	**2015-2016**

	0%	0%	50%	50%

Program: Technology to Connect and Communicate

Many advancements have been made and will continue to be made to strengthen the electronic exchange of patient/client/resident information, expand the use of technology to enhance "hands on" care, and implement decision support and navigation tools.

Technology to Connect and Communicate

Initiative/Action:

cSWO - Ontario Lab Information System (OLIS)

Magnitude of Change: Low - Marathon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
50%	20%	30%	0%

Technology to Connect and Communicate

Initiative/Action:

cSWO - Diagnostic Imaging Repository

Magnitude of Change: Low - Sprint

Duration of Initiative: Less than 12 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
95%	5%	0%	0%

Technology to Connect and Communicate

Initiative/Action:

Resource Matching and Referral solutions

Magnitude of Change: High - Decathlon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
50%	20%	20%	10%

Technology to Connect and Communicate

Initiative/Action:

eReferral/eNotification/eDischarge Summary/eConsultation solutions

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
15%	70%	0%	0%

Technology to Connect and Communicate

Initiative/Action:

cSWO - SPIRE/HRM

Magnitude of Change: High - Relay

Duration of Initiative: 12 to 24 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
80%	10%	10%	0%

Technology to Connect and Communicate

Initiative/Action:

cSWO - Clinical Connect

Magnitude of Change: High - Decathlon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	30%	30%	25%

Technology to Connect and Communicate

Initiative/Action:

Regional Integrated Decision Support (RIDS) System

Magnitude of Change: High - Relay

Duration of Initiative: Less than 12 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
5%	95%	0%	0%

Technology to Connect and Communicate

Initiative/Action:

cSWO - Integrated Assessment Record (IAR)

Magnitude of Change: High - Decathlon

Duration of Initiative: 25 to 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
50%	25%	25%	0%

Program: Transportation Best Practices

Lack of affordable and accessible transportation present significant challenges for many people to access necessary health services. Efforts will be made to identify opportunities to leverage current affordable and accessible transportation resources.

Increase the Value of our Healthcare System

Initiative/Action:

Spread transportation best practices to optimize access to and efficiency of current transportation resources

Magnitude of Change: Low - Marathon

Duration of Initiative: Beyond 36 Months

Percent Completion:

2012-13	2013-2014	2014-2015	2015-2016
0%	0%	10%	20%

APPENDIX B – Integration Activities

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
Mental Health Tier 2 Divestment: St. Joseph's Health Care (SJHC), London	The phased divestment of beds and services from SJHC London to Grand River Hospital (WWLHIN), Windsor Regional Hospital (ESC LHIN), SJHC Hamilton (HNHB LHIN) and St. Thomas Elgin General Hospital (SW LHIN) and an overall reduction of 70 longer-term mental health in-patient beds.	Health Service Provider Initiated Service Integration	• Compliance to and completion of HSRC directives • The divestment of both beds and services will provide access to mental-health services closer to home for patients and families in the SW,WW, HNHB and ESC LHINs • There will be better access to specialized programs • There will be a continued emphasis on providing outreach and consultation to the region particularly for highly specialized needs. • Patients repatriating to WW, ESC and HNHB LHINs will transition with the beds to their home LHIN. • Access to beds improved • Achievement of transition from an institutional care model to one that is based on the recovery philosophy	2009 – 2014/15
Joint Services Plan for Oxford County Hospitals	With the opening of the new Woodstock General Hospital in November 2011, capacity was added to Oxford County and area. In order to ensure that this the additional capacity is utilized efficiently and effectively, the South West LHIN requested that the 3 hospitals in Oxford County (Woodstock General Hospital, Tillsonburg & District Memorial Hospital, and Alexandra Hospital in Ingersoll) work collaboratively to develop a framework for a Joint Services Plan. The Plan has been staged into 2 phases.	South West LHIN Facilitated Service Integration	Phase 1: • Development of a service delivery model with specific goals, deliverables, timelines and governance structure in regards to the Oxford Hospitals three identified priorities: Surgical Program, Alternate Level of Care and Pharmacy Phase 2: • Development of clinical and non-clinical services inventory for the 3 Oxford hospitals. • Prioritization of clinical and non-clinical services for the development of more detailed planning of a service delivery model with goals, deliverables, timelines and governance structure. Also included will be continuous evaluation and implementation plans for Urgent and Non-Urgent transportation and Governance Structure Option	Phase One – Priority Projects Plan: Implementation to begin in fiscal 2013/14 Phase Two – Joint Services Plan: Implementation to begin in fiscal 2014/15

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	• Consolidation of adult outpatient physiotherapy from 4 sites to 2 sites (Seaforth and Clinton sites). • Increase in the number of beds at the Clinton and St. Marys sites. This realignment of beds will lead to an increase in acute medicine beds and the potential to increase surgical inpatient capacity (with appropriate funding) at the Stratford site. • Relocation of the HPHA Rehab beds to the Seaforth site and a redistribution of beds from medicine, Complex Continuing Care and Rehab.	2010 – 2013/14
Integration of Hospice Services – London Middlesex	Hospice of London (HoL) and St. Joseph's Health Care Society (Society) integrated in order to develop a new entity owned by the Society and utilizing the resources of HoL. This new organization will bring additional professional hospice care to the citizens of London and Middlesex County through the enhancement of current services as well as the development of a residential hospice.	Health Service Provider Initiated Governance Integration	• Establishment of a residential hospice in London • More effective system integration, planning and delivery of palliative services as the partnership will include the new residential hospice, South West CCAC, St Joseph's Health Care, London, London Health Sciences Centre and the primary care sector	Planning for the residential hospice began in late 2011/12 and will continue into 2012/13 and 2013/14. The new residential hospice is expected to open for residents in January 2014.
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	This initiative will improve outcomes for patients and families, and for the health system as a whole. It will: • 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.	2011/12 – 2013/14

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
Health Links	Health Links will foster collaboration by bringing together all health care providers in a community to better and more quickly coordinate local health care services for people who need them the most. The implementation of Health Links will provide a vehicle for framing future integrations among/within sectors.	Could include Governance, Service and Administrative (back office) Integrations	• 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. • Health Links will build on existing delivery organizations and their current partnerships and leverage current capacity and best practices. Successful Health Links will have representation from across health care sectors. • Health Links will partner with all service providers in their community/geography to ensure consistent, person-focused care as people move through the transitions of the continuum of care • Health Links will leverage existing infrastructures to increase access to collaborative care through efficient use and sharing of resources between providers. • Enhance the health system experience for patients with the greatest health care needs. • Reduce the average cost of delivering health services to patients without compromising the quality of care.	2012/13 - TBD
Mental Health Services Integration: WOTCH/SEARCH and CMHA integrated service delivery	In alignment with the South West LHIN Community Capacity and Implementation Project Final Report (received November 2011), Canadian Mental Health Association (CMHA) London-Middlesex, Search and WOTCH have agreed to pursue a model for service integration. The LHIN is providing resources, guidance and direction to advance the initiative and ensure the process aligns with its vision and direction.	South West LHIN guided; integration/ coordination of service delivery	Benefits of improved integration strategies include: • Improved access to services • Improved coordination of care, sharing of information and easier referrals • Faster service for those needing service • Better managed wait-lists and a "no wrong door approach" • Reduced overlap of service and using staff more effectively For the organizations, the benefits include ability to share information, consolidation of overlapping services and the sharing of best practices and knowledge among providers.	2012/13 – 2013/14

APPENDIX C – Capital Projects

County	Capital Project *Hospital Capital Projects*	Background/Description	Current Status
Bruce	**Grey Bruce Health Services (GBHS), Southampton Site – Emergency Department and Laboratory Capital Redevelopment Project** *Stage: Stage 1*	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. 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 *local* 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. August 2011 – Received MOHLTC support and will be subject to Legislative appropriation and all applicable approvals of the ministry Sep 26, 2012 – South West LHIN Board endorsed Stage 1	Ministry received Stage 1 Part B December 20, 2012 and is reviewing
Bruce	**South Bruce Grey Health Centre (SBGHC), Kincardine Site – Emergency Department and Ambulatory Care Capital Redevelopment Project** *Stage: Stage 1*	The two-phased redevelopment involves a single storey, two phased addition and demolition approach that would connect existing hospital to the existing Medical clinic. In Phase One, programs considered 'high priority' for replacement would be built first – Emergency, Ambulatory Care, Pharmacy, Education and Diagnostics Imaging Departments -- as well as a new Plant and Building Services Department. In Phase Two, replacement of the remainder of the departments would occur, culminating in the construction of a new Inpatient wing and conclude with the demolition of all remaining building assets of the existing hospital. March 5, 2013 letter sent to the Health Capital Investment Branch (HCIB) indicating that since our board had endorsed the original Phase 1 Stage 1 Part A submission and the rescaled submission received on September 27, 2012 is essentially the same submission with decreased square footage. For this reason we feel that this does not need to go back to our board for consideration.	Ministry is currently reviewing Stage 1 Part A with an expected completion date of April 2013

Huron	**Wingham and District Hospital (WDH) – Emergency/ Ambulatory Care Renovation Project** *Stage: Pre-Capital*	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. September 26, 2012 – South West LHIN Board endorsed Pre-Capital submission January 24, 2013 Listowel and District Hospital presented 4 Self- Funded projects to the HCIB and South West LHIN. It was decided that these 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 our board. March 12, 2013 South West LHIN reviewed the Self-Funded projects and 2009 Master Plan letter sent to HCIB indicating that there were no changes to programs or services and that the Self-Funded projects were consistent with the 2009 Master Plan. For these reasons it is felt that this does not need to go back to our board for consideration.	Ministry is currently reviewing the Pre-Capital Submission
Oxford	**Tillsonburg District Memorial Hospital (TDMH) Redevelopment** *Stage: Stage 1*	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." January 26, 2011 – South West LHIN Board endorsed pre-capital submission September 2012 – submission put on hold pending the completion of Joint Services Planning underway in Oxford County	Submission on hold pending completion of Joint Services Planning underway in Oxford County
Middlesex	**LHSC/SJHC Post Milestone 2 Redevelopment** *Stage: Stage 1*	The LHSC and SJHC submissions address the need for facility redevelopment to accommodate current programs, not substantial expansion or changes to programs or services. The proposed redevelopment will allow LHSC and SJHC to address the needs of programs and services that were not considered as part of the Health System Restructuring Commission recommendations. April 27, 2011 – South West LHIN Board endorsed pre-capital submission	South West LHIN provided preliminary feedback regarding Stage 1 Part A submission. No timelines set by MOH for their review.
Elgin	**St. Thomas-Elgin General Hospital (STEGH) – Emergency, Ambulatory and Mental Health Redevelopment Project** *Stage 2*	**The redevelopment project includes the Demolition of the Snell Building and the Acute Mental Health Bridging Plan projects.** STEGH has been asked to continue work with the South West LHIN and St. Joseph's Health Care (SJHC), London on the development of the Bridging Plan to accommodate 15 acute mental health beds at STEGH in alignment with the SJHC, South Western Ontario Long-Term Mental Health Program Transfer Plan. July 22, 2009 – South West LHIN Board endorsed Phase 1 (Programs and Services component) August 7, 2012 – STEGH received MOH approval to proceed to Stage 2 planning for Emergency, Ambulatory and Mental Health Redevelopment Project (per rescoped submission) August 10, 2012 – STEGH received MOH approval to ward contract for Acute Mental Health Bridging Plan Phase 1 Components Decanting and Snell Building Demolition Project.	Bridging Plan being implemented March 19, 2013. South West LHIN, LHIN Liaison Branch (LLB), Health Capital Investment Branch (HCIB) and St. Joseph's Health Centre (SJHC) currently discussing funding options.

Grey	**Grey Bruce Health Services & South East Grey Community Health Centre (SEGCHC) – Markdale Site** *Combined Stage 1 & 2 submissions*	A new 72,000 square foot Rural Health Centre (RHC) located in Markdale, Ontario on a green field site is under joint planning by GBHS, the SEGCHC and the South West LHIN. This joint planning followed the completion of functional and master planning for a hospital re-build project which was submitted to the Capital Branch in October 2007 in response to a Planning and Design grant approved in May 2006. The RHC concept combines primary care and acute care services into one facility, providing a "one-stop shop" for the health care needs of a rural Ontario Community within a regional framework. The integrated facility includes primary care, emergency department, ambulatory surgical services and procedures, 12 inpatient beds and rehabilitation services, lab and diagnostic imaging services. The RHC will be located on the same site as Grey Gables, the long term care facility for the area	Ministry reviewing data submitted on ED Utilization
Middlesex	**London Health Sciences Centre, South Street Hospital – Decommissioning and Demolition Capital Project: Phases A & B** *Stage 2*	Decommissioning and demolition (phases A and B) of South Street Hospital. August 2011 – Received MOHLTC support and will be subject to Legislative appropriation and all applicable approvals of the ministry	Phase A demolition to commence March 2013, Phase B proposed to begin September 2014
	Community Capital Projects		
Huron	**South Huron Hospital Association (SHHA) – South Huron Medical Centre** *Pre-Capital*	The SHHA submission addresses the need to build a "Purpose-Built" Medical Centre in Exeter Ontario on the site of the current dated medical centre. From a fiscal perspective it does not make sense to invest in renovating the current facility as it will still not meet the needs in terms of space for the necessary support services such as CCAC, Occupational Therapy, Physio Therapy and assessment space for consulting.	South West LHIN reviewed Pre-Capital submission. Awaiting response regarding questions from SHHA