South West
LOCAL HEALTH INTEGRATION NETWORK

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APPENDIX F

Readiness Assessments

October 31, 2006

Ontario

Wait Times Strategy

Access to specialized medical treatments in a medically recommended timeframe is a fundamental principle in an integrated health care model. Because of current inefficiencies and growing demand, increasing wait times have been a growing concern for both the federal and provincial governments. Increasing demand may come from a variety of sources such as an aging population that relies more on health care, or from advancements that allow doctors to diagnose more illnesses. Statistics Canada indicates that waiting for care remains the number one barrier for those having difficulties accessing care.[1]

Table 1 shows the wait time trends in the South West LHIN for selected priority programs related to the Ontario Wait Times Strategy. All wait times will have some monthly fluctuations – up and down – based on factors such as seasonal changes in volume, or surgeons focusing more on patients who have been waiting the longest.

Table 1: Wait Times for Selected Priority Programs, August 2005 to July 2006, South West LHIN

SOUTH WEST LHIN		Median Wait Time (Days)						90% completed within…(Days)					
Service	Procedure	Aug / Sep	Oct / Nov	Dec / Jan	Feb / Mar	Apr / May	Jun / Jul	Aug / Sep	Oct / Nov	Dec / Jan	Feb / Mar	Apr / May	Jun / Jul
Cancer	Cancer Surgery	29	22	28	34	33	35	92	77	82	97	99	105
Cardiac	Angiography	27	18	22	12	13	13	49	40	43	30	25	26
	Angioplasty	4	4	4	3	5	3	41	34	39	26	26	31
	Bypass Surgery	22	19	16	21	27	23	54	50	50	49	50	62
Cataract	Cataract Surgery	111	120	91	96	87	62	351	344	317	291	288	261
Joint Replacement	Hip Replacement	125	70	85	89	98	78	432	366	344	328	347	349
	Knee Replacement	238	181	186	154	128	107	481	509	439	421	387	390
Diagnostic Imaging	MRI Scan	14	34	36	26	29	36	156	154	137	142	191	183
	CT Scan	1	7	8	7	11	10	51	56	51	44	64	63

Source: Wait Times Database, Ministry of Health and Long-Term Care

The South West LHIN has seen significant decreases in its wait times, cataract surgery, hip replacement, and knee replacement. However, the LHIN has seen increases in cancer surgery, coronary bypass surgery, and diagnostic imaging since the Wait Times Strategy monitoring began in August 2005.

Furthermore, Table 2 shows that in comparison to Ontario, the South West LHIN is below the provincial average in cancer surgery, angioplasty and coronary bypass procedures. The provincial government recently announced a province wide increase of 525 cancer cases, 724 more hip and knee replacements as well as other additional procedures, which are hoped to reduce wait times for these procedures.

[1] Statistics Canada, *Access to health care services in Canada, January to June, 2005 Catalogue no. 82-575-XIE*

Table 2: Median Wait Time for Priority Services – South West LHIN and Ontario, June/July 2006

Local Health Integration Network	Median Time (in Days)								
	Cancer Surgery	Angiography	Angioplasty	Coronary Bypass	Cataract Surgery	Hip Replacement	Knee Replacement	MRI Scan	CT Scan
South West	35	13	3	23	62	78	107	36	10
Ontario	22	12	4	18	68	85	113	36	13

Source: Wait Times Database, Ministry of Health and Long-Term Care

Table 3 reflects the discharge disposition of patients in South West LHIN hospitals in 2004/05. In comparison to the Ontario average, South West LHIN hospitals are discharging a greater proportion of their patients with support services (e.g., home care).

Table 3: Discharge Disposition of Patients in South West LHIN hospitals in 2004/05

	Transferred to an acute inpatient facility (incl. Acute rehab., acute psych.)		Transferred to continuing care facility (nursing home,HFA, DVA homes)		Transferred to other type of facility (incl. Ambulatory care, palliative care, addiction treatment)		Discharged home with support services (home care)		Discharged home with no support services (home care)		Left against medical advice (with/without signout, awol)		Deceased		Grand Total
North															
Grey Bruce Health Services-Markdale Site	48	7.6%	42	6.7%	32	5.1%	61	9.7%	395	62.6%	2	0.3%	51	8.1%	631
Grey Bruce Health Services-Meaford Site	82	7.3%	84	7.5%	43	3.8%	60	5.4%	796	71.1%	7	0.6%	47	4.2%	1,119
Grey Bruce Health Services-Owen Sound	833	11.3%	258	3.5%	32	0.4%	831	11.3%	5,130	69.8%	55	0.7%	212	2.9%	7,351
Grey Bruce Health Services-Southampton	42	8.3%	38	7.5%	12	2.4%	88	17.4%	269	53.1%	5	1.0%	53	10.5%	507
Grey Bruce Health Services-Wiarton Site	89	12.1%	51	6.9%	1	0.1%	95	12.9%	441	59.8%	6	0.8%	54	7.3%	737
Hanover And District Hospital	103	9.4%	61	5.5%	28	2.5%	1	0.1%	845	76.7%	9	0.8%	54	4.9%	1,101
South Bruce Grey Health Centre-Chesley	40	8.3%	15	3.1%	1	0.2%	11	2.3%	391	81.1%	4	0.8%	20	4.1%	482
South Bruce Grey Health Centre-Durham	48	9.6%	11	2.2%			26	5.2%	382	76.4%	4	0.8%	29	5.8%	500
South Bruce Grey Health Centre-Walkerton	81	6.7%	58	4.8%			71	5.9%	930	77.1%	8	0.7%	59	4.9%	1,207
South Bruce Grey Health Ctr-Kincardine	129	12.6%	22	2.1%	2	0.2%	43	4.2%	775	75.7%	4	0.4%	49	4.8%	1,024
North Total	1,495		640		151		1,287		10,354		104		628		14,659
Central															
Alexandra Marine and General Hospital	117	7.0%	94	5.6%			97	5.8%	1,267	75.7%	25	1.5%	73	4.4%	1,673
Huron Perth Healthcare Alliance-Clinton Public Hospital	62	8.0%	36	4.6%			2	0.3%	641	82.7%	2	0.3%	32	4.1%	775
Huron Perth Healthcare Alliance-Seaforth Community Hospital	40	9.1%	84	19.1%			105	23.9%	188	42.7%			23	5.2%	440
Huron Perth Healthcare Alliance-St Marys Memorial Hospital	84	12.2%	94	13.7%			98	14.3%	372	54.1%	10	1.5%	29	4.2%	687
Huron Perth Healthcare Alliance-Stratford General Hospital	550	8.9%	456	7.4%			247	4.0%	4,768	77.4%	31	0.5%	107	1.7%	6,159
Listowel Memorial Hospital	130	12.4%	63	6.0%			69	6.6%	727	69.3%	2	0.2%	58	5.5%	1,049
South Huron Hospital	98	12.2%	47	5.8%			80	9.9%	526	65.3%	4	0.5%	50	6.2%	805
Wingham and District Hospital	132	10.0%	73	5.5%		0.0%	81	6.1%	988	74.7%	8	0.6%	40	3.0%	1,322
Central Total	1,081		874		-		698		8,489		74		372		11,588
South															
Alexandra Hospital	122	11.7%	64	6.1%			174	16.7%	601	57.7%	24	2.3%	56	5.4%	1,041
Four Counties Health Services Corp	115	19.4%	33	5.6%			112	18.9%	282	47.5%	6	1.0%	46	7.7%	594
London Health Sciences Centre	2,141	5.9%	1,310	3.6%	106	0.3%	4,380	12.0%	26,758	73.4%	295	0.8%	1,484	4.1%	36,474
St Thomas-Elgin General Hospital	350	5.9%	456	7.7%	1	0.0%	735	12.5%	4,064	68.9%	40	0.7%	254	4.3%	5,900
St.Joseph's Health Care (SJHC) ,London	363	3.5%	387	3.8%	16	0.2%	1,219	11.8%	8,098	78.7%	32	0.3%	177	1.7%	10,292
SJHC Regional Mental Health Care - London	25	2.2%	229	20.3%	24	2.1%	66	5.8%	732	64.8%	30	2.7%	23	2.0%	1,129
SJHC Regional Mental Health Care - St. Thomas	39	8.1%	6	1.2%	28	5.8%	42	8.7%	353	73.1%	13	2.7%	2	0.4%	483
Strathroy Middlesex General Hospital	122	4.4%	310	11.3%	9	0.3%	239	8.7%	1,932	70.1%	16	0.6%	127	4.6%	2,755
Tillsonburg District Memorial Hospital	126	6.8%	163	8.7%	3	0.2%	14	0.8%	1,451	77.8%	7	0.4%	102	5.5%	1,866
Woodstock General Hospital	223	4.4%	387	7.6%	65	1.3%	385	7.6%	3,733	73.5%	104	2.0%	184	3.6%	5,081
South Total	3,626		3,345		252		7,366		48,004		567		2,455		65,615
South West LHIN Total	6,334	6.8%	4,932	5.3%	403	0.4%	9,432	10.1%	67,835	72.8%	753	0.8%	3,495	3.8%	93,184
Ontario	65,886	6.6%	48,379	4.8%	7,536	0.8%	86,211	8.6%	746,343	74.4%	9,757	1.0%	38,943	3.9%	1,003,055

Source: Inpatient discharges data, MOHLTC, Provincial Health Planning Database

Information Management/Information Technology

Drivers for change in e-Health

The e-Health strategic plan, in its current form, focuses attention on its alignment with the four strategic integration initiatives as developed through the community engagement process of the South West LHIN. At the same time, steps have been taken to align the planning process with the e-Health renewal strategy developed by the e-Health office of the MOHLTC.

In addition to these two elements, which are reflected in this document, there are other 'drivers for change' that are influencing the decisions of health service organizations, and these will need to be understood and taken into account when the e-Health building process moves into the implementation planning phase. As an example, Ontario's Wait Times Strategy, which is hospital focused, is being driven provincially and is a key priority. It is absorbing hospital resources, both human and financial and will impact on the capacity of hospitals to turn their attention to other e-Health initiatives. Ongoing service pressures on organizational budgets and the need to exercise constraint will also have an impact on the availability of staff and resources to implement e-Health initiatives. In addition to the LHIN integration priorities, there are other integration initiatives that are already active and 'in play'. For example, the Southwest region (covering both the South West and Erie St. Clair LHIN hospitals) is in the third year of a five-year comprehensive implementation of a regional, shared digital imaging network. There are existing clinical networks in the areas of stroke, cancer, geriatrics, paediatrics and perinatal services, to name a few, that would benefit from being able to use e-Health enabling technologies to facilitate their system development work.

It is therefore important as the e-Health implementation plan is mapped out, that current and future constraints on the system be identified and factored into the planning process. By doing so, there may be opportunities to leverage these developments and use them to facilitate the LHIN-based e-Health agenda or alternatively, a need to modify the implementation plan so it does not interfere or run counter to other developments.

One of the fundamental enablers to health care integration is the ability for information to be exchanged between and among providers and consumers across the health care continuum. To that end, the Ontario government has begun an e-Health renewal strategy for the province. The renewed vision for Ontario's e-Health system states that by 2015, Ontario's health system is the safest, highest quality, and most sustainable in Canada because people have the right information, at the right time, and in the right place. Ontarians are confident that by 2015:

- They have the information they need to make decisions about their health and health care;
- Providers and clinicians are freed to focus on timely and highest quality care; and
- Government and LHINs ensure an accountable, equitable, effective, and efficient health system.

Providers within the South West LHIN have already begun to initiate e-Health projects. The following are some examples of e-Health implementation occurring in the LHIN:

- **VideoCare** - (a program of the Ontario Telemedicine Network) based in the South West LHIN provides secure videoconferencing services to the hospitals and LHIN offices throughout the Erie St. Clair and South West LHINs and Ontario. Expansion to community services is planned. Transitioning to the Ontario Tele-Health Network (OTN) is now complete.
- **Smart Systems for Health Infrastructure** – is distributed throughout the South West LHIN within Hospitals, CCACs, Public Health Units and Family Health Teams.
- **Ontario Lab Information System** – as of March 2006 the first two provincial sites are live. One is Gamma-Dynacare, a province-wide community lab service that has five sites in London-Middlesex and one in Oxford County.
- **Ontario Drug Benefits Access in Hospital** – has been implemented throughout the South West LHIN. This project was complete in June 2006.
- **Wait Times Information Strategy and Enterprise Master Patient Index (WTIS/EMPI)** – a pilot EMPI implementation was completed in Grey Bruce Health Services in the spring of 2006. All 11 Grey Bruce hospitals along with London Health Sciences Centre and St. Joseph's Health Care, London will implement both EMPI and WTIS in the fall of 2006. Six other hospitals in the South West LHIN – Alexandra, St. Thomas-Elgin, Stratford General, Strathroy Middlesex General, Tillsonburg District Memorial and Woodstock General are planned for WTIS/EMPI deployment in summer 2007.
- **e-Children's Health Network (eCHN)** – is connected to the Children's Hospital of Western Ontario (CHWO). Grey Bruce will connect in early 2007.
- **Supply Chain** – eRequisitions and ePay are applications positioned to play an important role in supply chain efficiency for the Grey Bruce Hospitals.
- **Shared PACS and Diagnostic Imaging Repository (DI-r)** – is complete across eight hospital corporations in the Thames Valley Hospital Planning Partnership (TVHPP). Expansion to Huron-Perth will be complete in winter 2007. All 11 Grey Bruce Hospitals will share a single PACS by summer 2007. Planning for a regional DI-r is underway that will expand the TVHPP DI repository to all PACS enabled hospitals in the South West and Erie St. Clair LHINs.
- **Community Care Access Centre Connectivity** – is underway throughout the South West LHIN and across Ontario.
- **Shared Electronic Patient Record (EPR)** – several roll outs of ADT integration have been completed across the TVHPP hospitals with completion planned for 2007.
- **www.thehealthline.ca** – is a web portal of consumer and provider information about the health services available across the South West LHIN.

Readiness Assessment

In August 2005, the "Ontario Hospitals Connected for Care: 2005 Electronic Health Record Readiness Survey Report" was prepared for the South West LHIN. Nineteen hospital sites participated in the survey. The report reflects significant variation among hospitals in the South West LHIN on EHR readiness. Some organizations are fully capable in many areas, while others have made little or no progress.

Table 4 reflects the scores for the South West LHIN on the indicators contained in the report. For all indicators the South West LHIN is above the provincial average, suggesting that there is some momentum in this area. Almost all the South West LHIN hospitals report some EHR capability gap, suggesting that there are opportunities for improvement. Patient registration and, to a lesser degree, results reporting are the most developed e-Health areas for the South West LHIN hospitals.

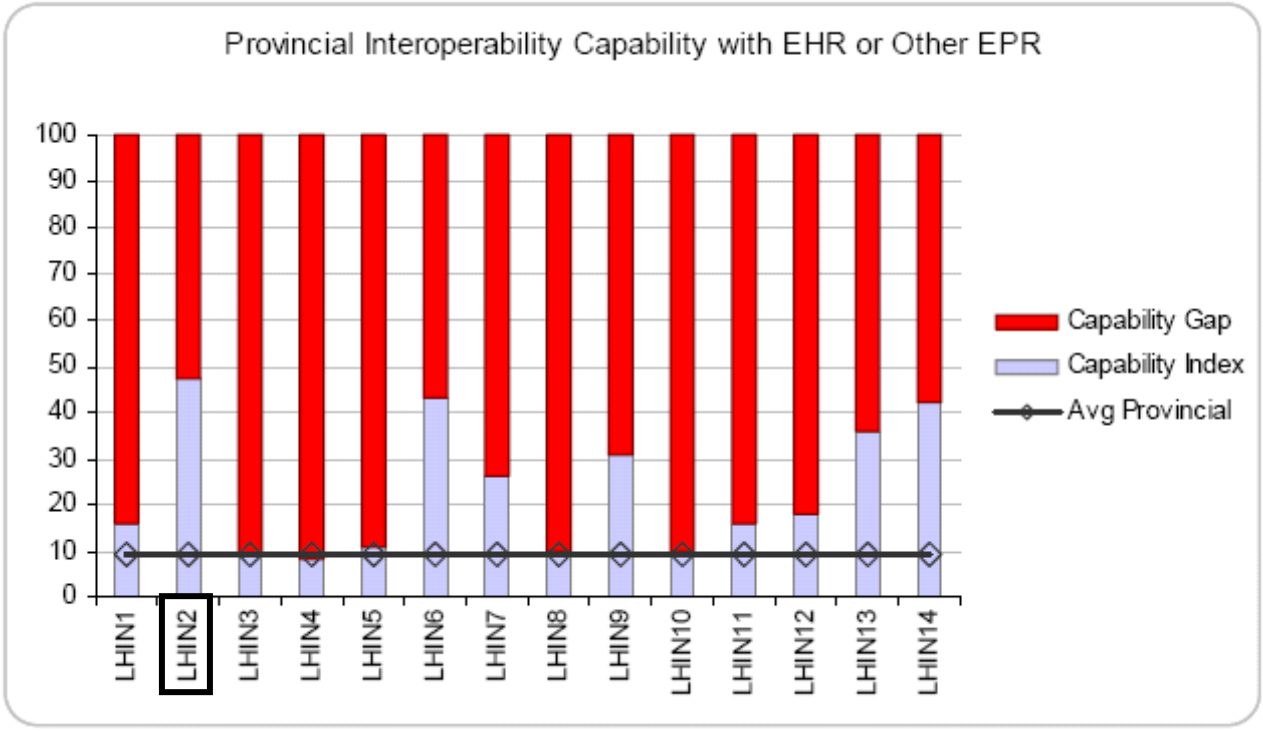
Table 4: Summary results from the EHR Readiness Survey for South West LHIN Hospitals

SECTION	INDICATOR	Hospital Scores		Number of SW LHIN hospitals with 100% gap	LHIN / Ontario Comparison		
		% of Hospitals with some portion of a capability gap	% of hospitals below the provincial average		LHIN standing compared to Ontario average	Ranking among the LHINs (1 = smallest gap)	Score
Key Electronic Patient Record (EPR) and Electronic Health Record (EHR)-enabling functional capabilities and use	Patient registration - capability	42%	5%	0	Above	3rd	95
	Patient registration - use	32%	11%	0	Above	4th	95
	Results reporting - capability	100%	16%	0	Above	4th	60
	Results reporting - use	100%	32%	0	Above	6th	48
	Order entry - capability	100%	16%	2	Above	4th	55
	Order entry - use	100%	32%	6	Above	6th	40
	Clinical documentation - capability	100%	26%	1	Above	5th	50
	Clinical documentation - use	100%	26%	4	Above	5th	40
	Information infrastructure - capability	100%	26%	2	Above	4th	55
	Information infrastructure - use	95%	32%	2	Above	5th	55
Level of regional/inter-organizational EHR readiness	Information sharing with other physicians	89%	37%	6	Above	5th	25
	Information sharing with other hospitals	100%	26%	5	Above	2nd	35
	Inter-organizational Enterprise MasterPatient Index - capability	100%	21%	0	Above	2nd	40
	Inter-organizational Enterprise MasterPatient Index - use	100%	26%	4	Above	2nd	30
	Interoperability with an EHR or other EPRs - capability	89%	5%	1	Above	1st	47
	Interoperability with an EHR or other EPRs - use	89%	70%	5	Above	1 - tied	35
	Regional governance	100%	21%	2	Above	4th	50
Level of EPR organizational and human capacity	Leadership and planning	74%	42%	1	Above	5th	52
	Skills complement	Top need SW LHIN: Network / Architect Support (23%) Top need Province: Application Support (53%)					
	Priorities	Order is similar to province, but upgrading infrastructure ranks much higher for SW LHIN (2nd) than Province (7th)					

Source: Ontario Hospitals Connected For Care: 2005 Electronic Health Record Readiness Survey Report

Figure 1 shows that the South West LHIN ranked highest among the LHINs on interoperability between organizations (e.g., sharing diagnostic and lab results between clinicians of different organizations), suggesting they are well positioned to implement the action plans described in this IHSP.

Figure 1: Interoperability Capability with Electronic Health Records or Other Electronic Patient Records, LHINs, Ontario



South West LHIN e-Health Steering Committee

A South West LHIN e-Health Steering Committee has been established with representative leadership from numerous clinical sectors and administrative areas across the LHIN with the vision – ***to Enable Measurably Better Information, Better Care, Better Health and Less Travel for All.*** E-Health is about achieving better health outcomes through the strategic and practical application of information technology. Connecting the Continuum of Care reduces duplication and ensures that information about the right client is available to the right provider anyplace, anytime. The South West LHIN will strive to exceed the government's Transformation Agenda while demonstrating value for dollars spent. The real value of an e-Health strategy lies in its ability to improve the flow of client information and ultimately client care at the local/network and regional LHIN levels. On the periphery but still critically important is the need to enhance research and academic capabilities while ensuring we focus on the "*back shop"* as we look to be more effective and efficient in our administrative roles.

Embracing this vision will enable the South West LHIN to reduce delays in diagnosis, enhance client choice, become more client-centred, demonstrate results and be effective in care delivery.

Terms of Reference for this group are included at the end of this appendix.

The South West LHIN e-Health Steering Committee will achieve its objectives by:

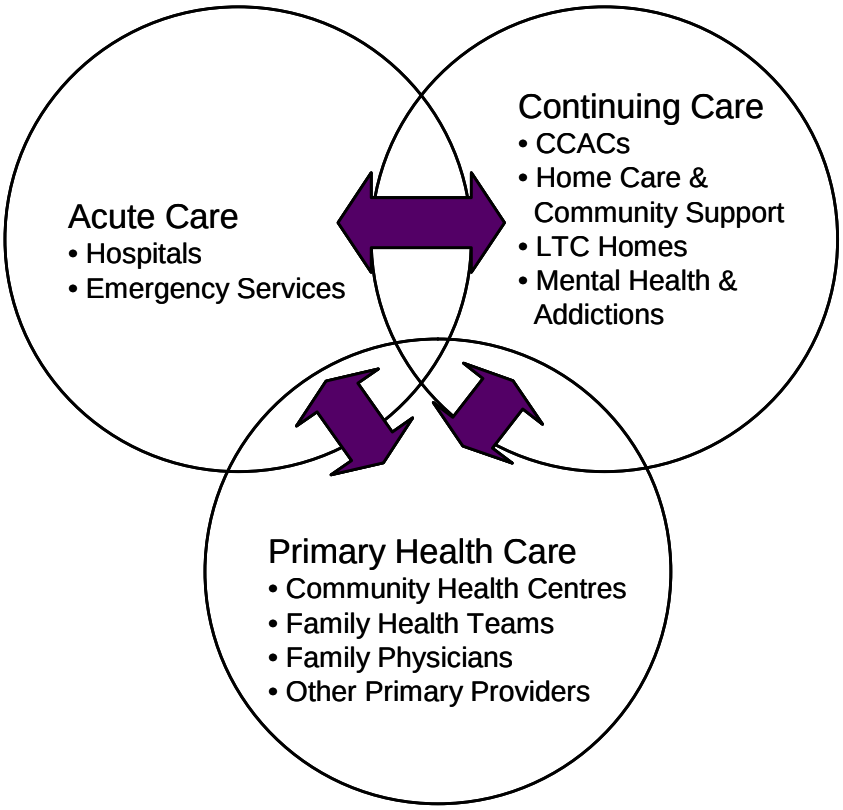
- Developing an Integrated e-Health Strategy
- Aligning the South West LHIN e-Health vision and strategic direction with the provincial and federal e-Health vision and direction
- Determining priorities for the South West LHIN's development and investment required to reach the vision
- Identifying key enabling technology and information sharing, decision-making considerations and criteria for use by hospitals and community agencies
- Building a communication plan and strategy
- Identifying key measurement criteria success factors, risks and appropriate mitigation strategies

The e-Health Steering Committee agreed on the following key health system integration issues that the e-Health strategic plan should address:

- Connection to the Ministry to ensure ongoing support with providing enablers (funding, resources)
- Connect providers and organizations that will collaborate to develop an integrated approach to chronic disease prevention and management
- Facilitate sharing of vital health care information among service providers
- Support real-time access to quality, utilization and access data to clients, providers and organizations
- Connect specialized programs to providers and clients for provider education, training, client education, health status assessment and monitoring and other applications
- Ensure LHIN-wide access to e-Health applications
- Link primary health care services with their primary communications, care and relationship partners (specialists, hospitals, CCACs etc.)
- Share client information among service providers that share clients with chronic diseases: 1 patient, 1 record across continuum of care
- Support collaboration among providers to support integrated delivery of care
- Support the provision of collaborative care and clinical best practices among LTC homes
- Connect primary health care providers and settings with related community care and support services to support the coordination of client care, referrals and follow-up and health care outcome monitoring and reporting
- Provide equitable access to services for people living in rural and remote areas

While determining a way to organize its thinking, the e-Health Steering Committee used the following diagram as a way to identify what is unique to each sector of service as well as what they have in common. While each sector has particular e-Health challenges, the focus of the Steering Committee was on identifying the elements that connected and integrated the sectors, both bilaterally and multi-laterally.

Figure 2: Sector Interaction



It is expected that the South West LHIN e-Health Strategy will be aligned with the evolving provincial renewal e-Health strategy by focusing on three components:

1. **Business Strategy** - to achieve better health system outcomes
2. **Information Strategy** - to achieve improved information for health care and system management
3. **Technology Strategy** - intra and inter-provider technology; standards; and alignment with regional and provincial e-Health technology

As a first step in development of these strategies the following were undertaken:

- Performed a scan of the environment to identify current e-Health initiatives at the regional, provincial and national levels;
- Facilitated broad stakeholder engagement, through sector specific workgroups;
- Carried out a high level assessment of present and future e-Health services and initiatives within the province and determine how these will likely affect Strategic Priorities; and
- Documented the guiding principles that will be used to make decisions and measure the effective development and delivery of e-Health in the South West LHIN.

Each of these steps is outlined in more detail below.

Environmental Scan – a simplified approach was used to conduct an initial scan of the current and future state from a number of perspectives. A graphical model was employed to depict a desired future state and current state along each of the following dimensions:

- Alignment of South West Priorities with MoHLTC e-Health Renewal Strategies – Figure 3
- Provincial e-Health Renewal Strategy – Figure 4
- Consumers – Figure 5
- Continuing Care e-Health Blueprint – Figure 6
- Acute Care – Figure 7

Figure 3: South West LHIN Priority Alignment with MOHLTC e-Health Renewal Strategy

e-Health Alignment with LHIN Integration Priorities					
	Strengthening and Improving Primary Health Care	Preventing and Managing Chronic Illness	Building Linkages Across the Continuum - All Seniors, and Adults with Complex Needs	Accessing the Right Services, in the Right Place, at the Right Time, by the Right Provider	Health Human Resources
Infrastructure - Technology Foundation	✓	✓	✓	✓	✓
Sustain the Investment	✓	✓	✓	✓	✓
Application Foundation	✓	✓	✓	✓	✓
Public Applications	✓	✓	✓		✓
Messaging Applications		✓	✓	✓	✓
Stakeholder Automation Applications	✓	✓	✓	✓	✓
Clinical Integration Applications	✓	✓	✓	✓	✓
Business Integration Applications				✓	✓
Information Management Applications	✓	✓	✓	✓	✓

Figure 4: Provincial e-Health Renewal Strategy – Desired Future State

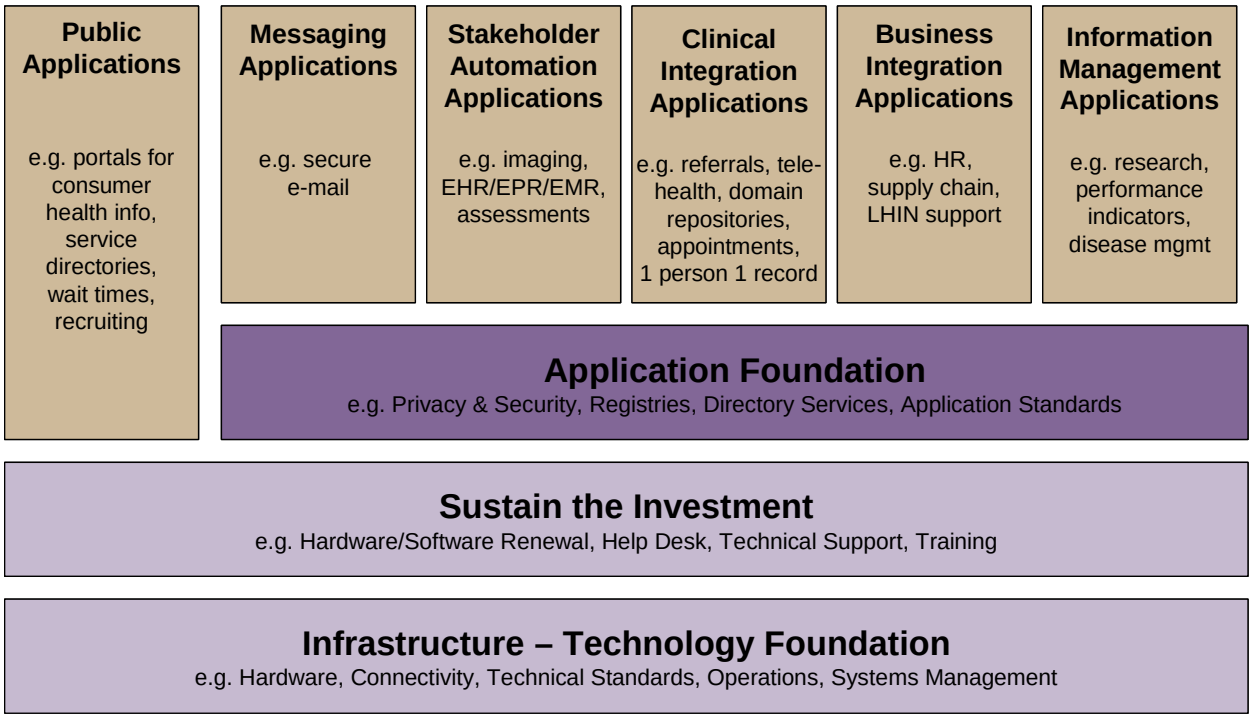


Figure 5: Consumer – Current State

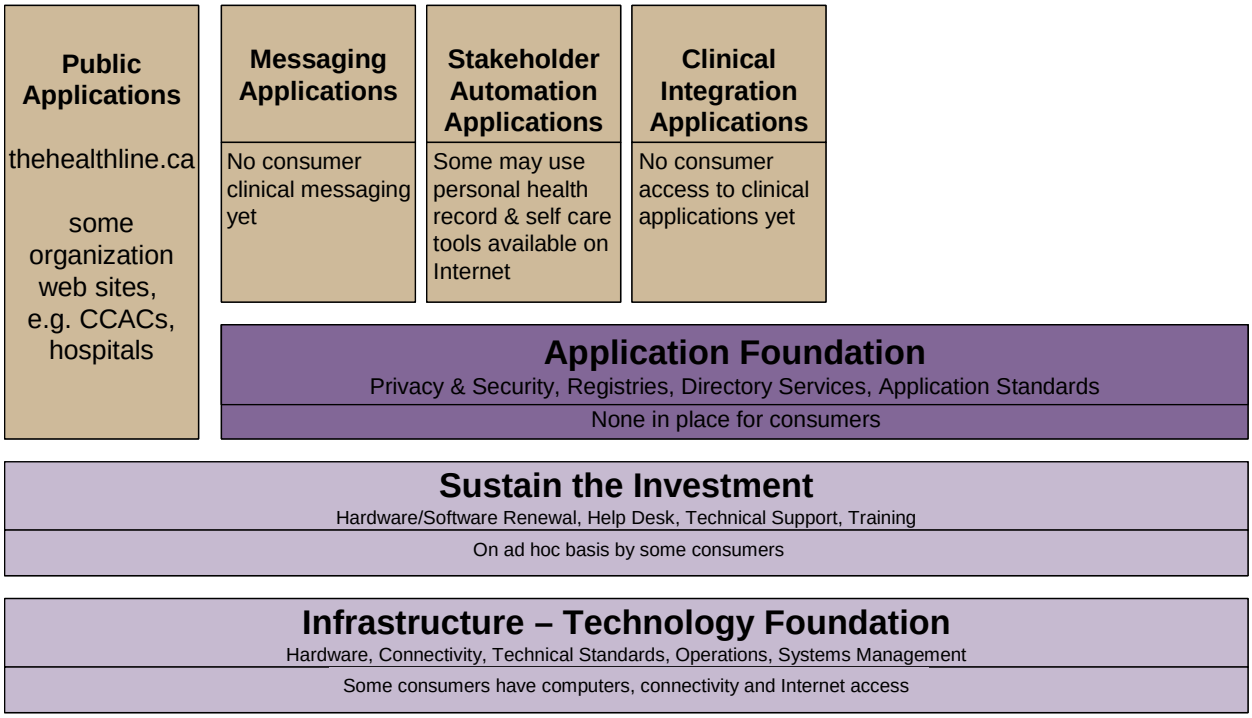


Figure 6: Continuing Care – Current State

Public Applications

thehealthline.ca

some organization web sites, e.g. CCACs,

Messaging Applications

CCACs implementing SSHA's secure ONE Mail; expansion planned

Stakeholder Automation Applications

CCACs use legacy & RAI-HC long-stay assessment tools; LTC (RAI) pilot in 3 SW sites. Future: Common intake assessment tool in all CCACs, common CMH assessment.

Clinical Integration Applications

Hosp-CCAC eReferral pilot outside SW. Future: CCAC-service provider eReferral, maybe CMH&A; Tele-homecare, mobility services

Business Integration Applications

Financial & statistical system in all CCACs, HRIS in 50%, HRIS to be completed. Future: Expand payroll & business systems in sector.

Information Management Applications

Common Data Sets in CMH; MIS in all CCACs & 80% of CMH&A. Future: MIS in Comm. Support Services, access tracking data from eReferral.

Application Foundation

Request/Clinical Care Data Set & 3 nomenclature standards approved by OHISC; SSHA has ONE Pages directory services for ONE Mail users. Provincial client registry not yet extended to continuing care, no provincial provider or location registries yet

Sustain the Investment

Hardware/Software Renewal, Help Desk, Technical Support, Training
Done locally and on shared application basis (CCACs)
Challenges finding/retaining the financial and human resources

Infrastructure – Technology Foundation

Hardware, Connectivity, Technical Standards, Operations, Systems Management
Done locally except CCAC applications hosted by SSHA
SSHA network connectivity minimal except for CCACs. Lack of local system management tools, disaster recovery capabilities.

Figure 7: Acute Care – Current State

Public Applications

thehealthline.ca

some hospital web sites

Messaging Applications

Some links e.g. notify MDs of ER visits, public health surveillance

Stakeholder Automation Applications

Many elements of hospital EPR triangle installed/in progress, many shared geographically.

Clinical Integration Applications

VideoCare, digital imaging repository, some clinical links (CCO, eCHN). eReferral pilots outside SW. No lab or drug repositories, little integration with private labs or other sectors.

Business Integration Applications

Some geographically shared HR, Finance, AP, Billing, some purchasing with CCAC. eRequisitioning & ePay being planned. No regionally integrated HR.

Information Management Applications

Wait Time IS in progress, some org. performance indicators. No data warehouse, integrated research, little disease management.

Application Foundation

Privacy & security mostly policy based. Most application vendors not yet PHIPA-compliant
Provincial client registry being phased in. No provincial provider or location registries yet
Application interfaces use HL7 v2 & v3. Need XDS (Cross-Enterprise Document Sharing) for integration

Sustain the Investment

Hardware/Software Renewal, Help Desk, Technical Support, Training
Done locally and/or (increasingly) on shared geographic or application basis
Challenges finding/retaining the financial and human resources

Infrastructure – Technology Foundation

Hardware, Connectivity, Technical Standards, Operations, Systems Management
Done locally and/or (increasingly) on shared geographic or application basis
Installed SSHA network capacity does not fully meet needs. Some lack of robust system management tools, disaster recovery capabilities.

Community Engagement - The South West LHIN e-Health Steering Committee has broadly defined its clinical sectors as Primary Care, Continuing Care and Acute Care. Although the Primary Care sector is not a direct mandate of the LHIN, it is considered a key component for overall success in the development of an e-Health strategy. A workgroup was established for each of the Primary Care and Continuing Care Sectors with the following initial observations:

Continuing Care Workgroup

1. Understand the challenges in aligning with the Provincial e-Health Renewal strategy

    - Requires a major investment - investments have not been equitable across sectors
    - Sufficient tools and retention of skilled resources are required - sector should focus on retaining skills but not site by site
    - There are privacy challenges
    - Too many gatekeepers and restrictions
    - Difficulty in demonstrating payback of past investments – plenty of data submitted but not being used
    - A 10 year lag behind the acute sector
    - MOHLTC data requirements are acute sector driven and not relevant to this sector
    - Agenda needs to be driven by the sectors and not the LHIN - sectors can't be bound by LHIN boundaries
    - Access to data for planning purposes is limited (e.g., current state surveys)
    - Multiple data repositories will be a quality challenge
    - ECR to promote standards driven data repository to publish sector data
    - Requires a consistent interpretation of indicators within and across sectors
    - Don't have to reinvent the wheel – look what other provinces have done with Regional Health Authorities
    - Use of a Provider registry for identity management is critically important
    - Several MOHLTC programs (e.g., Chronic Disease Management) are highly dependent on technology – and primary care will be a roadblock
    - Consider a shared services model for technical resources
    - Planning can (and should be) done across sectors – South West has done it on many occasions

2. Understand the challenges with adoption of the Continuing Care e-Health Blueprint

    - Determine if defined e-Health initiatives can be piloted in the South West LHIN
    - Accelerate those that most directly support the LHIN IHSP
    - Better communication needed in this sector (e.g., impact of Continuing Care projects on an organization's upgrade plans)
    - Could others leverage CCAC SSHA connections for faster ramp up (e.g., multi-tenant)
    - The Mental Health common data set is not yet what it needs to be

3. Understand the challenges with enabling the South West LHIN Integrated Health Service Plan

    - There are gaps in alignment between the Continuing Care Sector Blueprint and the MOHLTC e-Health renewal strategy

Provincial e-Health Strategy Assessment – the e-Health Steering Committee undertook a process to rank the Provincial e-Health Renewal Strategies based on the perceived importance in enabling the South West LHIN's key health system integration priorities. The outcome follows:

1. Portals

    - MyHealthyOntario – citizen/consumer portal and health record integration
    - E-HealthOntario – provincial health care providers portal including HSIU decision support capabilities
    - OntarioMD/PublicHealthOntario - sector portals for physicians, specialists and public health
    - Regional portals as foundation for LHIN based integration
    - Province-wide e-learning tools and services; online certifications and accreditation
    - Best practices and clinical guidelines
    - Communities for communications, collaboration and knowledge management

2. Stakeholder Automation

    - Physicians/Specialists Clinical/Practice Management Systems
    - Hospital Electronic Patient Record Systems
    - Public Health Electronic Client Record Systems
    - Community Care Electronic Client Records Systems
    - Integrated best practices & clinical guidelines
    - Administrative process automation tools

3. Technology Foundation

    - Personal/Mobile computing & productivity tools
    - Local Networking
    - Internetworking
    - Mobile Computing
    - Provincial and regional data centres, operations management and end-user support
    - Disaster Recovery
    - Province-wide security and privacy services with Regional integration;
    - e-Health User enrolment and Digital Identities
    - 2-factor authentication, encryption, digital signatures, non-repudiation
    - Provincial Electronic Mail Services

4. Electronic Health Records

    - Initial EHR via eCHN followed by Regional Electronic Health Records interconnected to create Provincial EHR
    - Expansion of DPV and longer-term Provincial repository containing All Drugs for All People

- Provincial Laboratory Information System
- Provincial Diagnostic Imaging Archive
- Provincial Immunizations Repository
- Electronic Referrals and other document centric business process integration

5. Telehealth

    - Telehealth as a provincial strategic priority to address access, health human resource management, and service delivery needs/demands
    - Expansion of existing Ontario Telehealth Network (OTN) to include additional acute/rehab facilities, specialties and inclusion of Long-Term Care and Community Care

6. Information Management

    - Operational Health System Information Utility (HSIU)
    - Integrated and authoritative data warehouse of all relevant demographic, clinical, resource and performance indicators
    - Decision support tools deployed through eHealthOntario portal

7. Access to Care Solutions

    - Expand Wait Times Strategy to include all surgical procedures; ER wait times and Paediatric wait times
    - Expand WTIS to include other parts of continuum of care (e.g., referral patterns)
    - Client Registry/Enterprise Master Person Index solution
    - Provider/Location/Service Registries
    - Provincial White/Yellow/Blue pages directories and Community 211 services

8. Population Health Solutions

    - Public Health Outbreak Management, Inspections and Immunizations
    - Surveillance tools for Chronic Disease Management

Decision Making Principles – the e-Health Steering Committee established these guiding principles:

- The systems will be developed with ongoing collaboration with the following participating organizations: Canada Health Infoway, Smart Systems for Health Agency, and the Ontario Ministry of Health and Long-Term Care
- To align, where possible, with provincial and national business and clinical workflow redesign, integration efforts and explanation to clients in understandable language
- Understand that process change is inevitable and must be clinically driven
- The regional approach will maximize the investments made and lessons learned by others
- The regional approach will work to respect the investments partners have already made in systems and will work to ensure interoperability in order to realize the vision
- The first option for investment will be to leverage and expand on current investments and shared services model
- The regional systems will include the shared investment in, and access to, the common technology architecture

Health Human Resources

With a growing population and an aging workforce, health human resources is becoming an increasingly important issue for the entire sector in Ontario and for all of Canada. In 2004, federal, provincial and territorial governments, in their "Ten-Year Plan to Strengthen Health Care," renewed their commitment under the 2003 Health Accord, and agreed to increase the supply of health professionals in Canada and to make their action plans public. The ability to provide access to high-quality, safe and effective patient-centred health services is dependent on having the right mix of health care providers with the right skills in the right place at the right time.[2]

The primary thrust of a health human resource strategy is to ensure that there is an appropriate supply and distribution of health care workers to meet the identified needs of the population, that patients can receive timely, quality care, and that workplaces remain healthy and safe for our health care providers. A health human resource strategy must work equally across all of these fronts in order to identify the workforce that is required, and to ensure that it is prepared appropriately, supported adequately and used effectively.

While health care agencies have made significant efforts to develop a range of strategies to address these supply shortages, many efforts are limited in their effectiveness because underlying challenges remain unaddressed. Some of these include:

- A decreasing volunteer pool
- Wage disparity across community and institutional partners
- Increasing diversity of needs among staff in terms of work/life balance
- Increasing public expectations about service delivery
- Lack of human resource strategies that address the broad spectrum of health care professionals
- Lack of a provincial health human resource data infrastructure to support planning

To achieve and maintain a sufficient supply of health care workers for their residents, the LHIN must take an active role in creating an environment that will attract and retain new primary care and specialized physicians, nurses and allied health professionals. Key actions that will contribute to achieving this objective include the following[3]:

- Create morale amongst health professionals that support the residents of the South West LHIN (e.g., encourage collaboration; aggressively promote through communications the work that is being done on integration; provide forums for group networking and idea exchange among health professionals (e.g., community family physicians);
- In partnership with the academic institutions, foster education and training opportunities such as: interdisciplinary teams; practices in rural and remote settings (e.g., student electives in rural primary care office practices), particularly for those professions that are in short supply;

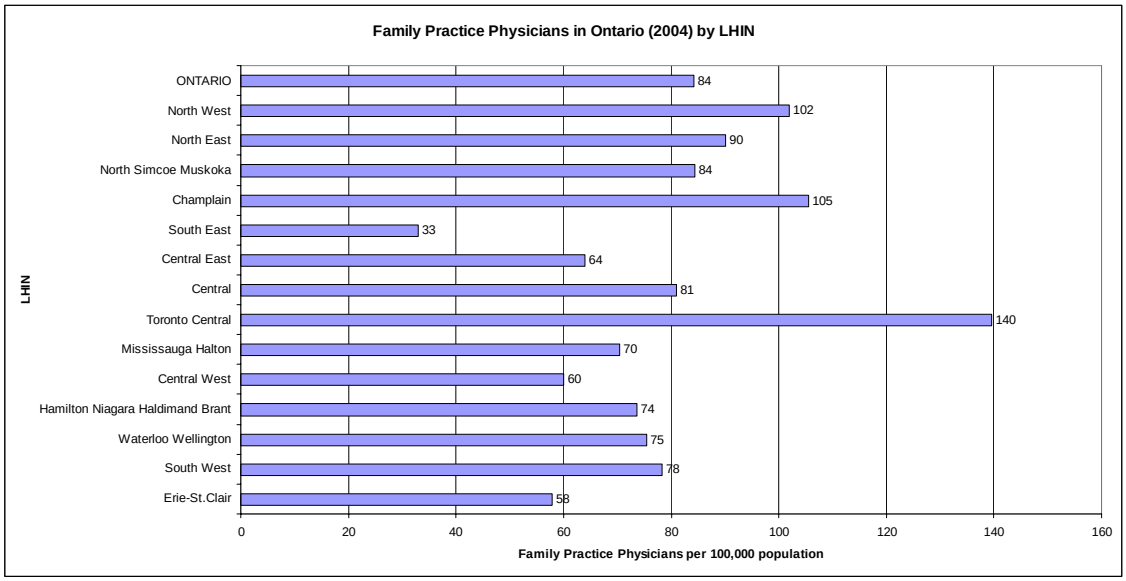
[2] Health Human Resources Action Plan - Status Report, Government of Canada, December 2005
[3] IHSP Strategic Advisory Group round table discussion – June 14, 2006

- Create an inventory of health professionals within the South West LHIN to understand and monitor current supply;
- Encourage regional succession/transition planning for aging health professionals nearing retirement;
- Evaluate the impact of managed competition on human resources within the community health care sector;
- Evaluate current practices with respect to casual and part-time positions;
- Foster opportunities to share allied professionals (e.g., social workers, nutritionists) across health care modalities (e.g., hospital, private clinic, LTC homes, Family Health Teams);
- Be an advocate for addressing the inequities (e.g., pay) of similar professions across different services; and
- Promote volunteerism in the health sector.

Physician Supply

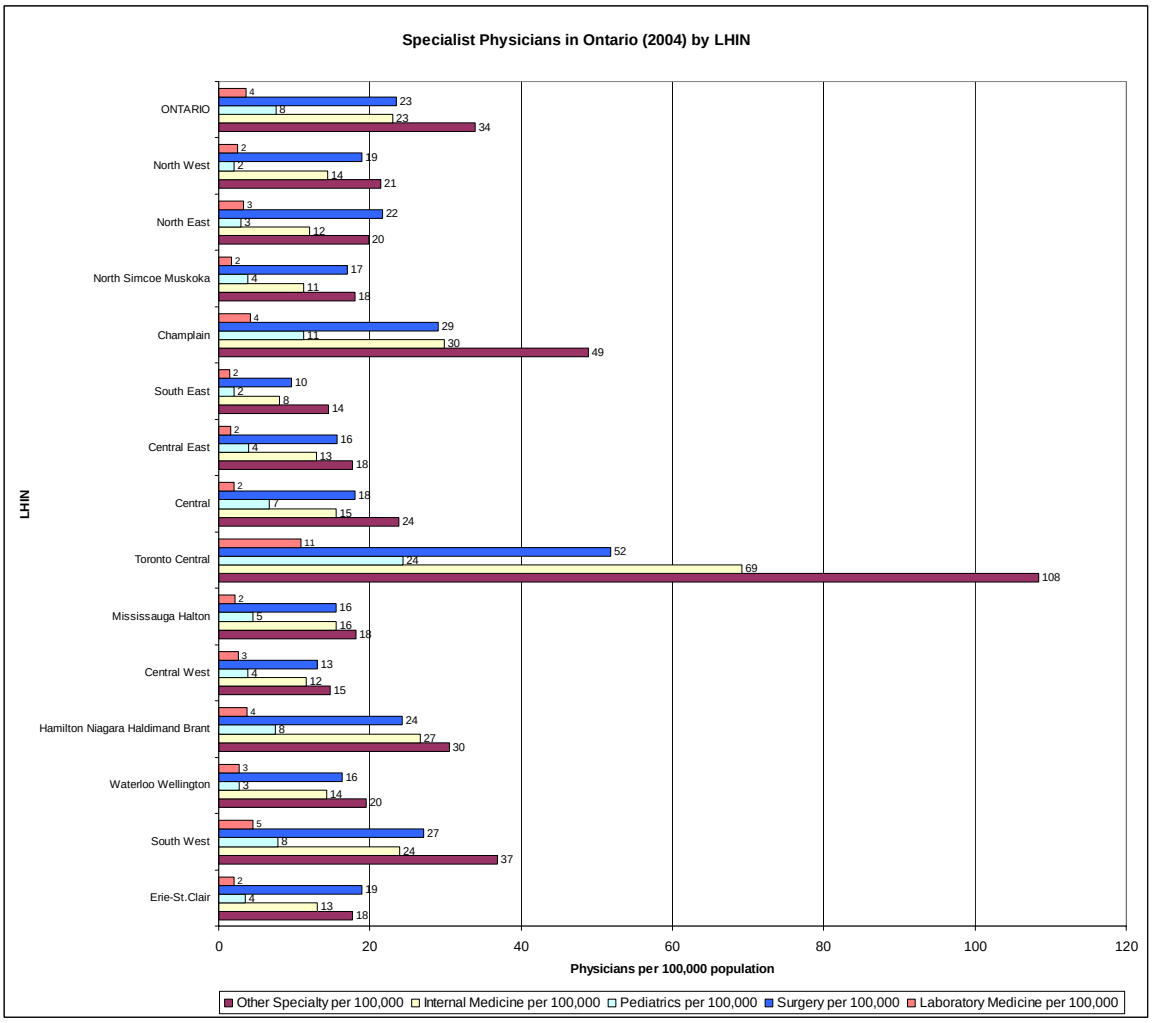
The current physician supply varies across LHINs. Figure 8 shows the number of family physicians per 100,000 population that provided care to South West LHIN residents in 2004 was 78; slightly below the provincial average of 84. Figure 9 reveals that within specialty areas, the South West LHIN is near the provincial average in all categories.

Figure 8. Family Practice Physicians, Ontario LHINs and Ontario, 2004



Source: Ontario Physician Human Resources Data Centre

Figure 9. Specialty Physicians, Ontario LHINs and Ontario, 2004



Source: Ontario Physician Human Resources Data Centre

As of 2004, there were 723 family physicians in the South West LHIN. This translates to approximately 1 physician per 1,278 people. Table 5 reflects the family practice physician supply for the geographic area communities in the South West LHIN.

Table 5: Family Practice Physician supply by geographic area, South West LHIN

Family Practice Physicians in the South West Local Health Integration Networks				
CSD Name	Family Medicine/ General Pract.	F.P./ Anesthesia	F.P./ Emergency Medicine	Family Practice Total
North				
Arran-Elderslie	6	0	0	6
Blue Mountains	4	0	0	4
Brockton	7	0	0	7
Chatsworth	1	0	0	1
Georgian Highlands	5	0	0	5
Grey Highlands	8	0	0	8
Hanover	10	0	2	12
Kincardine	10	0	0	10
Northern Bruce Peninsula	6	0	0	6
Owen Sound	33	0	7	40
Saugeen Shores	9	0	0	9
South Bruce	2	0	0	2
South Bruce Peninsula	4	0	0	4
West Grey	4	0	0	4
North Total	109	0	9	118
Central				
Ashfield-Colborne-Wawanosh	3	0	0	3
Bluewater	5	0	0	5
Goderich	11	0	0	11
Huron East	14	0	0	14
Huron-Kinloss	2	0	0	2
North Huron	7	0	0	7
North Perth	11	0	0	11
Perth East	4	0	0	4
South Huron	7	0	2	9
St. Marys	12	0	0	12
Stratford	21	0	2	23
West Perth	6	0	0	6
Central Total	103	0	4	107
South				
Aylmer	6	0	0	6
Bayham	1	0	0	1
Central Elgin	3	0	0	3
Dutton/Dunwich	2	0	0	2
East Zorra-Tavistock	5	0	0	5
Ingersoll	8	0	0	8
London	332	0	10	342
Lucan Biddulph	2	0	0	2
Middlesex Centre	4	0	1	5
Newbury	2	0	1	3
Norfolk	1	0	0	1
North Middlesex	2	0	0	2
Norwich	4	0	0	4
Southwest Middlesex	2	0	0	2
Southwold	1	0	0	1
St. Thomas	32	0	8	40
Strathroy-Caradoc	20	0	0	20
Thames Centre	3	0	0	3
Tillsonburg	15	0	0	15
West Elgin	3	0	0	3
Woodstock	24	0	5	29
Zorra	1	0	0	1
South Total	473	0	25	498
South West LHIN Totals	685	0	38	723

Source:
Active Physician Registry, December 31, 2004
Ontario Physician Human Resources Data Centre

Table 6 lists areas designated as underserviced, the number of GP/FP in the area, and the number of vacancies for the South West LHIN. These figures demonstrate a need for 22, 23, and 32 GP/FPs in the North, Central, and South areas respectively. The MOHLTC Underserviced Area Program also identified jurisdictions with needs for Specialists and Rehabilitation Professionals. No South West LHIN counties were identified in these studies.

Table 6: List of Areas Designated as Underserviced for General (GP) and Family Practitioner (FP), South West LHIN, Apr. – June 2006

	GP/FP Compliment	GP/FP Vacancies
North		
Saugeen Shores	12	2
South Bruce Pennisula	6	2
Hanover	17	4
Markdale* Includes former Townships of Artemesia, Egremont, Euphrasia, Glenelg, Holland, Osprey and Proton and the former Village of Flesherton	13	9
Owen Sound** Includes the Township of Georgian Bluffs	23	5
North Total	71	22
Central		
Clinton Includes the former Village of Bayfield and the former Townships of Colborne, Goderich**, Hullet, Stanley and Tuckersmith	9	1
Exeter (Municipality of South Huron)	8	1
Goderich	11	1
Huron East	7	2
Wingham/Listowel** Includes the Town of North Perth and the Town of North Huron	22	5
Zurich Includes the former Township of Hay	2	1
Perth East	8	6
Stratford** Includes the Township of South Perth	25	4
West Perth	7	2
Central Total	99	23
South		
Aylmer** Includes the Township of Malahide and the former Village of Belmont	9	3
Bayham**	1	1
St Thomas*	31	11
Newbury Includes the Municipality of West Elgin and the former Townships of Ekfrid, Euphemia, Glencoe, Mosa, Orford, Wardsville, Zone and the former Town of Bothwell	10	3
North Middlesex	5	3
Ingersoll	11	1
Tillsonburg GP/Anaesthesia	4	2
GP/Emergency	8	5
Norwich	5	3
Woodstock*	22	2
Norfolk County (shared with a neighboring LHIN, the numbers are for the entire county, South West LHIN only Includes 21% of Norfolk)	44	13
South Total	150	47
South West LHIN Total	320	92

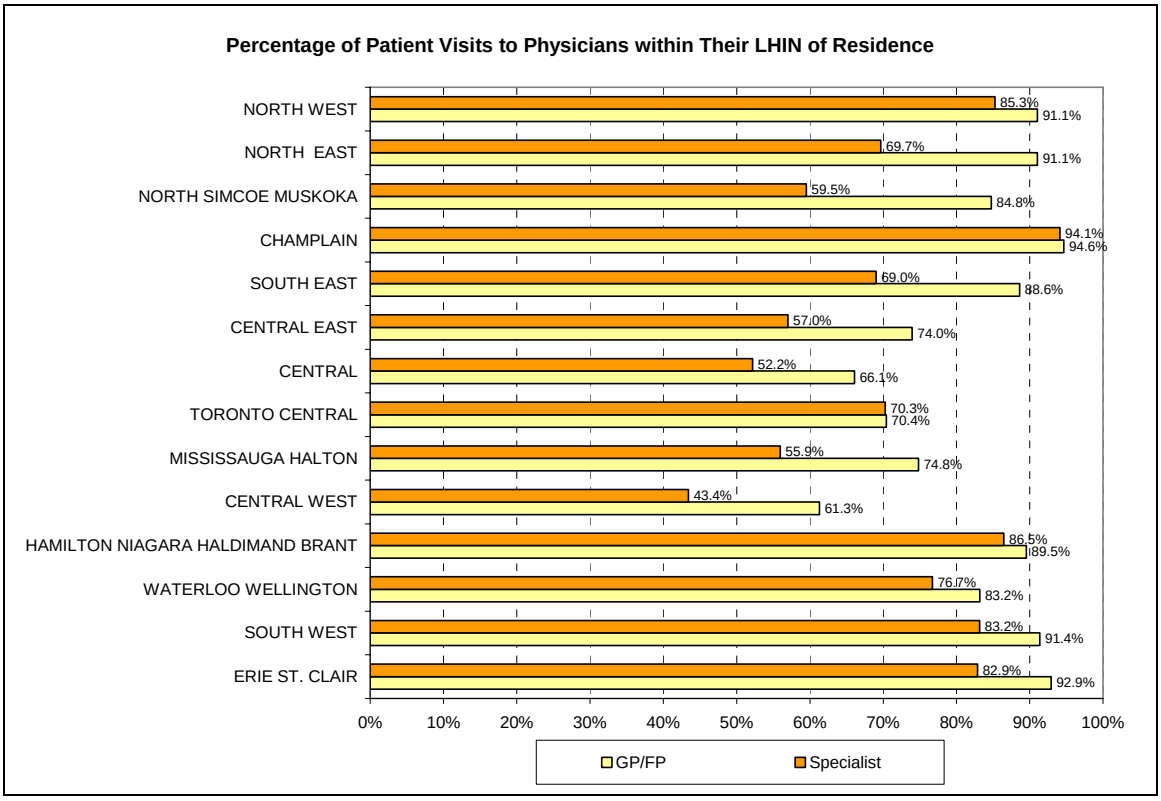
** Future Community Health Centres: Woodstock, Markdale, St. Thomas (existing CHC, West Elgin, & London). Note: London CHC is not designated as being in an underserviced area*

*** Future Family Health Team site: Owen Sound, Sauble Beach, Stratford, St. Mary's, Listowel, Seaforth, Goderich, East Elgin (Municipality of Bayham, Malahide and Town of Aylmer). Note: the only FHT that is not in a designated underserviced area is Victorian Order of Nurses/Salvation Army Centre for Hope FHT, City of London.*

Source: MOHLTC, Primary Health Care Team, Underserviced Area Program

South West LHIN residents do not often seek medical care outside of their local area. Figure 10 shows the percentage of patient visits to physicians within their LHIN of residence for 2003/04. For the South West, 91.4% of patients visited a primary care physician within their own LHIN. For specialists it drops to 83.2%. While data has been requested for 2004/05, it is not expected that the proportions will change significantly.

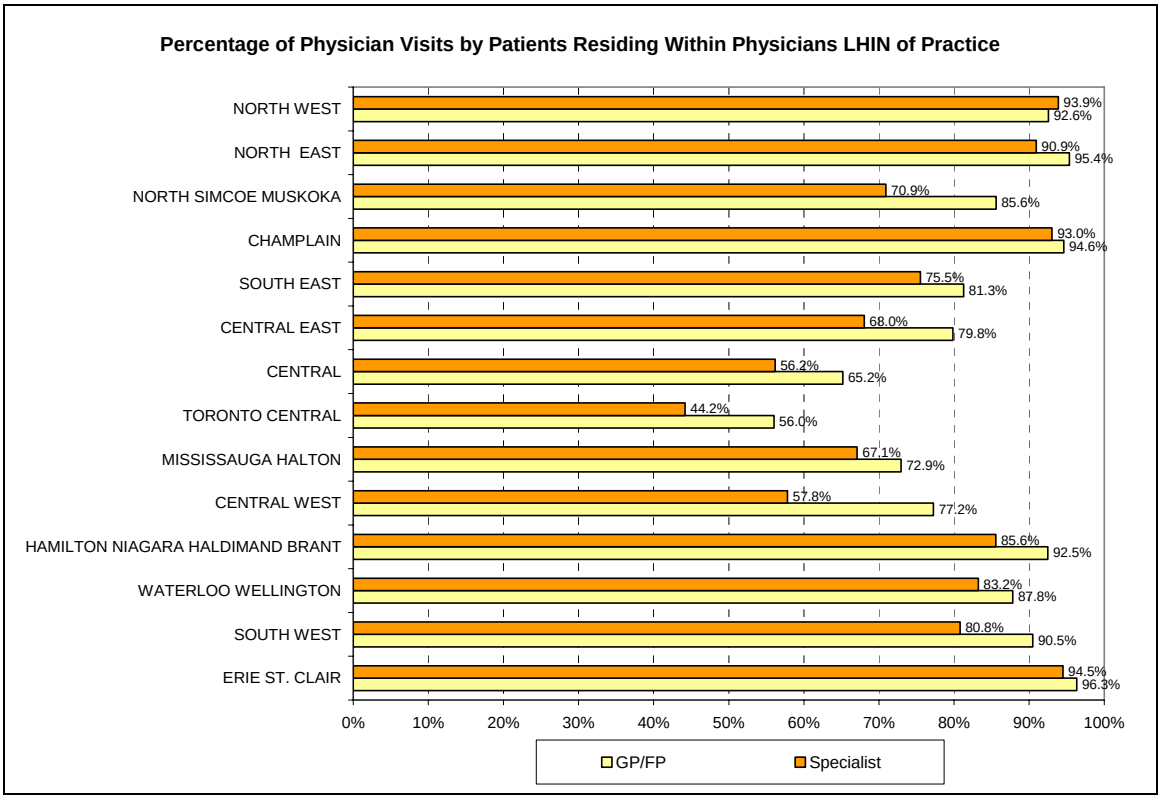
Figure 10: % of Patient Visits to Physicians within their LHIN of Residence, 2003/04



Source: Provincial Health Planning Database -MOHLTC

A similar pattern emerges when looking from the physician perspective. Figure 11 reflects the proportion of physician visits by patients residing within the physician's LHIN of practice. For the South West LHIN, 90.5% of the patients visiting a primary care physician came from within the physician's LHIN and for specialists it drops to 80.8%.

Figure 11: % of Physician Visits by Patients Residing within Physicians LHIN of Practice, 2003/04



Source: Provincial Health Planning Database -MOHLTC

Nursing Supply

Nursing is a critical health resource for all types of care throughout the health care continuum. The following section profiles the nursing population for the South West LHIN.

The South West LHIN includes 9.7% of the total nursing supply in Ontario. Table 7 reveals that the per capita nursing is approximately 12.0 per 1,000 population, higher than the provincial average of 9.1 and 5th among the LHINs.

Table 7: Number and per capita nursing supply, South West LHIN and Ontario

Nurses Employed by Practice Sector	Total Nurses		% of Total	
	South West LHIN	Ontario	South West LHIN	Ontario
Hospital	6,855	67,913	61.8%	59.5%
Community	1,862	19,328	16.8%	16.9%
Long-Term Care	1,632	16,126	14.7%	14.1%
Other	453	6,645	4.1%	5.8%
Not Stated	298	4,118	2.7%	3.6%
Grand Total	11,100	114,130	100.0%	100.0%

Source: Ontario College of Nurses - Data Query Tool (2005)

The following table reflects the nursing population by work status. The South West LHIN is higher than the provincial average for full-time, part-time and casual nursing per 1,000 population. Moreover, the LHIN has a significantly larger casual nursing pool, having the 2nd highest number of casual nurses in the province.

Table 8: Nurses (all types) by Work Status, South West LHIN and Ontario

Nurses Employed by Work Status	Full-Time		Part-Time		Casual	
	South West LHIN	Ontario	South West LHIN	Ontario	South West LHIN	Ontario
# Nurses	6,155	67,264	3,649	36,683	1,296	10,183
% of Total Nurses in Ontario	9.2	100	9.95	100	12.73	100
Total Resident Population	927,287	12,551,311	927,287	12,551,311	927,287	12,551,311
Nursing Per Capita	6.6	5.4	3.9	2.9	1.4	0.8
LHIN Ranking (1 = highest)	***5***		***4***		***2***	

Source: Ontario College of Nurses - Data Query Tool (2005)

Table 9 shows the number and proportion of the nursing population by the location of their employment. The distribution of the South West LHIN nursing staff among the various places of employment is similar to that of the province overall.

Table 9: Nurses (all types) by Place of Employment, South West LHIN and Ontario

Nurses Employed by Place of Employment	Total Nurses		% of Total	
	South West LHIN	Ontario	South West LHIN	Ontario
Acute Care Hospital	5,554	56,362	50.0%	49.4%
Long-Term Care Facility	1,382	13,643	12.5%	12.0%
Complex Continuing Care/Rehabilitation Hospital	551	5,659	5.0%	5.0%
Nursing/Staffing Agency	464	4,730	4.2%	4.1%
Addiction & Mental Health Centre/Psychiatric Hospital	662	4,271	6.0%	3.7%
Not Specified	298	4,118	2.7%	3.6%
Public Health Unit/Department	322	3,695	2.9%	3.2%
Physician's Office/Familty Practice Unit	351	3,471	3.2%	3.0%
Community Care Access Centre	297	2,878	2.7%	2.5%
Other Community	263	2,330	2.4%	2.0%
Retirement Home	216	2,095	1.9%	1.8%
Schools/Colleges/Universities	138	1,957	1.2%	1.7%
Other Hospital	88	1,621	0.8%	1.4%
Other	107	1,593	1.0%	1.4%
Community Health Centre/CHO	91	1,538	0.8%	1.3%
Government/Association	64	1,210	0.6%	1.1%
Self-Employed/Independent Practice	67	958	0.6%	0.8%
Industry	77	927	0.7%	0.8%
Community Mental Health Program	69	563	0.6%	0.5%
Other Long-Term Care Facility	34	388	0.3%	0.3%
Hospice	5	123	0.0%	0.1%
Grand Total	11,100	114,130	100.0%	100.0%

Source: Ontario College of Nurses - Data Query Tool (2005)

Table 10 reflects the various disciplines of focus for the nursing population in the South West LHIN and Ontario. The proportion of nurses involved in direct nursing, research, education and administration is similar to that of the province overall. The distribution of nursing staff in the South West LHIN for the dimension of work is similar to that of the province overall. At 89.3%, the South West LHIN has the highest proportion of nurses performing direct practice in the province.

Table 10: Nurses (all types) by Dimension of Practice, South West LHIN and Ontario

Nurses Employed by Dimension of Practice	Total Nurses		% of Total	
	South West LHIN	Ontario	South West LHIN	Ontario
Direct Practice	99,915	9,913	87.5%	89.3%
Administration	7,106	646	6.2%	5.8%
Not Specified	3,614	296	3.2%	2.7%
Education	2,868	183	2.5%	1.6%
Research	627	62	0.5%	0.6%
Grand Total	114,130	11,100	100.0%	100.0%

Source: Ontario College of Nurses - Data Query Tool (2005)

Table 11 reflects the age distribution for nurses employed in the South West LHIN and Ontario. The LHIN's nursing population has a similar distribution to the province overall. However, there is a relatively larger proportion of nurses aged 50-59 (35.8%) compared to Ontario (30.4%).

Table 11: Nurses (all types) by Age Group, South West LHIN and Ontario

Nurses Employed by Age Group	Total Nurses		% of Total	
	South West LHIN	Ontario	South West LHIN	Ontario
18 - 24	177	1,988	1.6%	1.7%
25 - 29	658	7,794	5.9%	6.8%
30 - 34	905	11,454	8.2%	10.0%
35 - 39	1,194	13,719	10.8%	12.0%
40 - 44	1,790	17,597	16.1%	15.4%
45 - 49	1,722	17,477	15.5%	15.3%
50 - 54	2,337	19,983	21.1%	17.5%
55 - 59	1,635	14,762	14.7%	12.9%
60 - 64	552	7,247	5.0%	6.3%
65+	129	2,103	1.2%	1.8%
Not Specified	1	6	0.0%	0.0%
Grand Total	11,100	114,130	100.0%	100.0%

Source: Ontario College of Nurses - Data Query Tool (2005)

Allied Health Professionals Supply

While the importance of the contribution of allied health professionals cannot be emphasized enough, there is limited information available on the supply of these health care providers in the South West LHIN and Ontario.

Table 12 lists the per capita number of selected allied health professionals for each LHIN in Ontario. Note that this is not a comprehensive list and is based on data currently available by LHIN boundary. The supply of allied health professionals in the South West LHIN is higher than the provincial average and ranked 4th or 5th highest among the LHINs, with one exception. The supply of midwives (1.48) is below the provincial average of 4.46 and ranked 9th highest among the LHINs.

Table 12: Selected Allied Health Professionals per 100,000 population, LHINs and Ontario

Local Health Integration Network	Health Professional				
	Pharmacists	Occupational Therapists	Dietitians	Physiotherapists	Midwives
Erie St. Clair	67.18	21.21	13.07	36.74	4.46
South West	**121.43**	**87.73**	**40.26**	**127.58**	**1.48**
Waterloo Wellington	34.60	18.47	11.50	32.83	0.00
Hamilton Niagara Haldimand and Brant	220.02	135.16	60.41	201.22	1.88
Central West	63.74	18.77	14.16	40.01	5.13
Mississauga Halton	333.74	108.21	71.31	202.73	16.17
Toronto Central	150.76	82.82	51.98	131.14	2.59
Central	170.35	107.62	35.97	121.14	1.50
Central East	67.75	22.07	12.03	45.61	1.18
South East	42.55	22.37	14.59	37.78	1.50
Champlain	75.53	41.53	25.08	86.64	0.00
North Simcoe Muskoka	22.25	12.18	6.40	20.67	1.75
North East	23.45	10.56	7.17	16.47	0.94
North West	11.38	5.90	4.13	8.61	1.15
Ontario	**82.47**	**38.00**	**24.36**	**63.49**	**4.46**
SW LHIN Ranking	***5***	***4***	***4***	***4***	***9***

Sources: Pilot Allied Health Human Resources Database, MOHLTC; Ontario Midwifery Program Liability Insurance database, College of Midwives of Ontario Registrant database; Draft Projections (2005 Base), 2006-2016, for Local Health Integration Networks, Ministry of Finance

The Ontario government has made some recent investments to address the shortage of health workers in the province, by creating the "HealthForceOntario Strategy". The strategy has three components:

1. Creating four new roles in areas of high need:
    - Physician Assistant
    - Nurse Endoscopist
    - Surgical First Assist
    - Clinical Specialist Radiation Therapist.

2. Developing Ontario's workforce by setting up a one-stop centre for internationally educated health professionals to obtain the information they need to work in Ontario; and

3. Better equipping Ontario to compete for scarce health care professionals, in Canada and throughout the world, by establishing a marketing and recruitment centre, including a comprehensive job portal.

Other initiatives already underway in Ontario to improve access to health care professionals include:

- A 23 per cent increase in medical school enrolment
- The creation of 150 Family Health Teams
- More than doubling the number of training and assessment positions for international medical graduates
- Developing a comprehensive nursing strategy
- Opening a new school of pharmacy in Waterloo
- Reinforcing the new fully inter-professional curriculum at the Michener Institute in Toronto.

South West Local Health Integration Network
e-Health Steering Committee

Terms of Reference

1. E-health 'Vision – Better Information > Better Care > Better Health

E-Health is about achieving better health outcomes through the practical application of information technology. By connecting the continuum of health care organizations, clients can be assured that information about the right person/client is available at the right time, to the right provider, at any place. It is a cornerstone of the LHIN's ability to meet the governments Transformation Agenda and an essential step towards improving the quality of care for South West Ontario. The South West LHIN realizes that the real value of an e-Health strategy lies in its ability to improve the flow of client information and ultimately client care at the local/network and regional LHIN levels.

E-health is an enabling strategy that contributes to health system transformation and integration.

The South West LHIN has developed a set of **decision-making principles** to guide its system transformation agenda. These eight principles will be used to help ensure that e-health strategies developed by the e-Health Steering Committee will support and enable the LHIN's integration agenda.

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

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

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

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

System sustainability – focuses on contributing to the future sustainability of our health system

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

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

Achievable – strategies can be implemented to ensure achievement of intended goals

Embracing the **Better Information > Better Care > Better Health** vision will enable health care organizations to effectively leverage technology and share information, to become more client-patient focussed, results-driven, integrated, efficient and effective in care delivery.

The e-Health Steering Committee will also focus on “back shop” opportunities to be more effective and realize administrative efficiencies.

The e-health strategic priorities and action plans will be driven by the broader system integration priorities of the South West LHIN. The South West LHIN has identified four draft strategic priority areas. These are as follows:

- **Equitable Access to Services** – focus on supporting rural community providers with links to specialized resources.
  Quick Start: hip and knee total joint replacement; critical care strategy
- **Continuum of Care** – focus on seniors and adults with complex needs. Focus on rehabilitation across the continuum and access to Long Term Care
- **Strengthening & Improving Primary Care** – focus on improving communication and linkages among primary health care providers & physicians. Focus on access to comprehensive primary care with emphasis on early intervention & wellness for people with mental health & addictions conditions
- **Chronic Disease Prevention & Management** – develop a comprehensive chronic disease prevention and management program across the South West LHIN.
  Quick Start: focus on diabetes, including people with mental health co-conditions.

2. Objectives

The expected outcome of connecting the continuum of care of the e-Health Strategy is to have a seamless information system in the region/LHIN. The South West Local Health Integration Network’s e-Health Steering Committee will strive to achieve the following objectives, which support that outcome using technology as an enabler to:

a. Client Care

- Increase client access to information about available services
- Increase the secure sharing of information among providers who are participating in a client’s care, across the continuum
- Improve quality and safety of care through enhanced information at point of care delivery

b. Overall

- Promote accountability through providing accurate and timely information
- Promote sustainability through improved decision-making enabled by access to appropriate management information

c. Technology

- Establish secure and robust technology infrastructure to deliver technology solutions and at the same time maintaining security, privacy and confidentiality of clinical information

3. Outcomes

The South West LHIN's e-Health Steering Committee will achieve its objectives by:

a. Developing an Integrated e-Health Strategy

b. Aligning the South West Local Health Integration Network's e-Health vision and strategic direction with the provincial and federal e-Health vision and direction

c. Determining priorities for the South West Local Health Integration Network's development and investment required to reach its future state

d. Identifying key enabling technology and decision-making criteria used by hospitals, physicians and community partners to support impact on the key priority areas

e. Building a communication plan and strategy.

f. Identifying key measurement criteria success factors, risks and appropriate mitigation strategies.

4. Guiding Principles for e-health strategy development

Principles to guide the development of the e-health strategy in the South West LHIN include:

- Use e-health to support and enable improvements in client outcomes
- Use e-health to have a positive impact on the flow of client information
- Use e-health to support South West LHIN integration priorities
- Align e-health goals and strategies with MOHLTC and Canada Health Infoway strategies
- Leverage existing investments and applications, especially shared services solutions
- Use e-health to realize cost efficiencies
- Develop strategies that leverage of funding opportunities
- Develop strategies that leverage opportunities to use existing staff to implement e-health strategies
- Develop strategies that leverage opportunities to realize positive e-health outcomes as quickly as possible
- Develop strategies that have a high probability of successful implementation
- Develop strategies that are relatively easy to implement
- Ensure document reflects the people that use the system

The regional systems will include the shared investment in, and access to, the common technology architecture.

5. Membership

a. Members of the e-Health Steering Committee include those currently using technology to transform care delivery and leverage resources in the South West LHIN. These members and member organizations include:

   a. Chief Executive Officer of the South West Local Health Integration Network – **Chair**

   b. Integrated Vice-President and Chief Information Officer of the London hospitals **– Co-Chair**

   c. Community Care Access Centre representative

   d. Long Term Care Home representative

e. Community Support Services representative
f. Community Mental Health and Addictions representative
g. Community Health Centre representative
h. Mental Health Facilities representative
i. Lawson Health Research Institute representative
j. Clinical Education – UWO representative
k. Canada Health Infoway representative
l. Smart Systems for Health Agency representative
m. Director of Health Planning of the South West Local Health Integration Network
n. Grey Bruce Health Network representative
o. Huron Perth Network representative
p. Thames Valley Hospital Planning Partnership representative
q. Regional Shared Service representative
r. Family Physician representative[4] (currently vacant)

b. Non-members may also be invited to participate in the meeting depending on the items before the committee and at the call of the Chair.

6. Working Groups

The committee may from time to time establish ad hoc working groups for particular purpose, on a task and finish basis, to take forward particular issue or develop solutions, and report back to the committee and provide terms of reference and guidelines relevant to these purposes.

7. Confidentiality

Members are expected to be open and candid in discussing items before the committee. For this reason it is important to maintain confidentiality. Committee members are committed respecting the privacy of committee participants and agree not to disclose information or views expressed by individuals during meetings. Records of decision will respect the principle of non-attribution. Deliberations should remain confidential until there is general agreement and consensus to make them public.

[4] The need for a family physician representative was brought forward at the July 12th meeting of the Steering Committee.

8. Meeting

The committee will meet bi-monthly and/or at the call of the Chair. In the initial period meetings will be bi-weekly. To reduce travel, videoconferencing will be used, as appropriate. A quorum will be 50% of membership plus one member. The committee will make decisions by consensus of the members.

9. Communication

Regular communications about the progress of work being undertaken by the committee is a priority and will be part of the regular work of the committee. Records of decision, process updates and other joint communications tools will be regularly developed and approved by committee members for communicating with interested stakeholders. Material will be made available to people outside the committee upon approval of the committee Chair.

10. Reporting

The committee will report to the Board of Trustees of the South West LHIN through the Chair.

The South West LHIN office will provide office support for this committee. Functional support responsibilities and project management have been assigned to the Integrated Vice-President and CIO of the London hospitals on behalf of the South West LHIN.

11. Resources

Financial resources for the initial Planning Phase will be provided by the e-Health Office of the MOHLTC.