

South West
LOCAL HEALTH INTEGRATION NETWORK

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Integration Priority & Action Plan:

Accessing the Right Services in the Right Place at the Right Time by the Right Provider

October 31, 2006



Accessing the Right Services in the Right Place at the Right Time by the Right Provider

Description

Ensuring that there are appropriate services to meet the health needs of our communities is a central role of the South West LHIN and critical to the success of integration. But to deliver “the right services in the right place, at the right time, and by the right provider” we must consider a full range of issues including distances traveled, demographics and culture, as well as a variety of socio-economic considerations particularly for marginalized populations. Any analysis needs to consider people of all ages and at all stages of the lifecycle, from neonatal care to end of life. Planning for the appropriate mix of services that should be available locally also involves a range of clinical factors in order to ensure that quality care can be delivered safely and effectively.

A particularly significant factor influencing equitable access to health care is the geographic diversity of the South West and the distances often traveled from rural and remote communities. Partners within the South West LHIN will need to identify innovative solutions to support equity of access for rural and urban communities, and address some of the underlying challenges associated with this including health human resources, technology and knowledge sharing across the network.

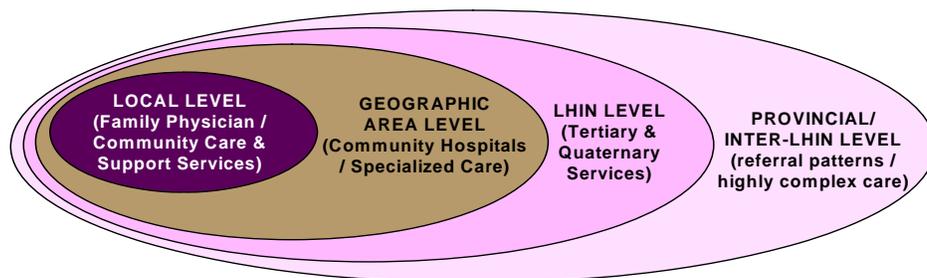
Accessing Services Across the South West LHIN

The geography of the South West LHIN includes a distinctive mix of urban and rural settings, each posing distinct opportunities and challenges for delivering health care services. Health needs in rural environments often differ from those of urban centres because of characteristics of the environment, occupations, demographics, and the populations.

When planning services for people in rural communities, we must consider such characteristics as demographics, critical mass, health status, transportation and traveling distances. There is often a narrower range of services available in rural communities, where providers often face unique cost pressures and health professionals typically “wear multiple hats” in their roles. Larger urban providers and academic health science centres play a critical role in delivering tertiary and quaternary care to consumers throughout the South West as well as neighboring LHINs. With resources in short supply, these providers often have to balance significant pressures to manage the interests of their local communities with that of the broader network and beyond.

As the diagram on the following page indicates, it is important for the LHIN and the providers to understand where to locate specific services in order to optimize access and ensure the quality and safety of services delivered. For consumers and providers, it is important to know what services are available and how to access them. The Core Services Report for small hospitals that is to be

released by the Joint Policy and Planning Committee will inform the development of services at each level.



Local Level: This area will focus on the basket of services that should be provided at the community level and will be predominantly primary health care programs and services.

Geographic Area Level: There are three geographic areas identified in the South West LHIN. The focus for this level will be on those specialized services that need to be available in appropriate numbers throughout a geographic area.

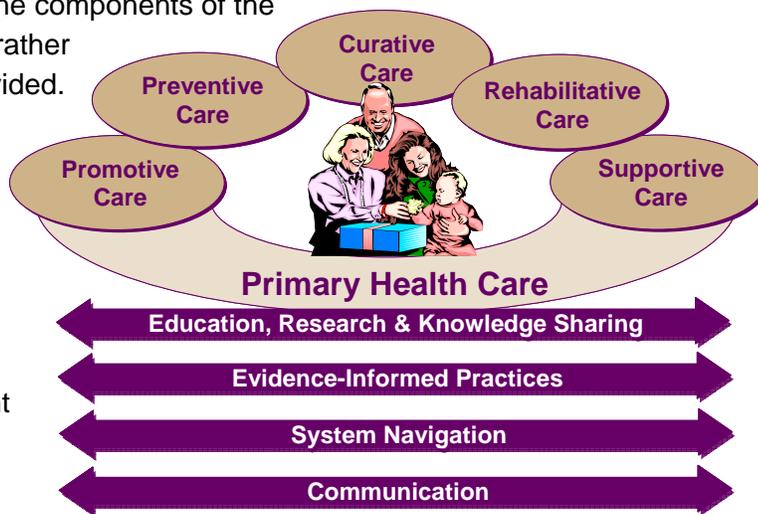
LHIN Level: At this level the focus is on the tertiary and quaternary services that are required in the South West LHIN, recognizing critical mass and the need for highly specialized expertise and equipment.

Inter-LHIN or Provincial Level: Referral patterns will impact inter-LHIN service utilization, but understanding the appropriateness and need for this utilization will be paramount. For highly complex care – quaternary – there will be a need to understand the services and access mechanisms for those programs and services that may be available only at a provincial level.

Access to the Continuum of Care for All the Lifecycle Stages

The continuum of care diagram depicted here illustrates the range of services accessed by people throughout their lives – from cradle to grave. The components of the continuum focus on the types of care provided rather than on the setting within which the care is provided.

The continuum of care approach allows us to focus on individual populations such as mothers and babies, children and youth, adults or seniors to examine the services available as well as the unique challenges of delivering and accessing quality care. The continuum will focus on ensuring that the right provider is providing the right service at the right place to achieve a sustainable system.





Primary health care serves a dual function in the health care system:¹

- Direct provision of first-contact services (by providers such as family physicians, nurse practitioners, pharmacists, and telephone advice lines); and
- Coordination to ensure continuity and ease of movement across the system, so that care remains integrated when individuals require more specialized services (with specialists or in hospitals, for example).

Primary Health Care is positioned as the foundation for the continuum of care, which is comprised of five key components, including:

Promotive Care: “Health promotion is the process of enabling people to increase control over, and to improve, their health.”² The focus is on strengthening the skills and capabilities of individuals so that they can make decisions about the adoption of healthy choices and lifestyle. Access to education and information is necessary to achieving the participation of the individual and the community. In addition, there must be a focus on changing social, environmental and economic conditions to alleviate their impact on both public and individual health.³

Preventive Care: Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to stop its progress and reduce its consequences once established.⁴ Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to stop or slow existing disease and its effects through early detection and appropriate treatment, or to reduce the occurrence of relapses and the establishment of chronic conditions.

Disease prevention is sometimes used as a complementary term to health promotion. Although there is frequent overlap between the content and strategies, disease prevention is considered the action which usually originates from the health sector dealing with individuals and populations identified as exhibiting risk factors.

Curative Care: Curative care is episodic in nature and is comprised of medical or paramedical services aimed at relieving symptoms of illness or injury, reducing the severity of an illness or injury, or protecting against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function.⁵

¹ Health Care Renewal in Canada: Accelerating Change, Health Council of Canada, January 2005.

² Ottawa Charter for Health Promotion, World Health Organization, Geneva, 1986.

³ Ibid

⁴ Reference adapted from Glossary of Terms in Health for All series. World Health Organization, Geneva, 1984.

⁵ Organisation for Economic Co-operation and Development, Health Data, June 2006.



Rehabilitative Care: Rehabilitative care comprises services that emphasize improving the functional levels of individuals where the functional limitations are either due to a recent illness or injury or of a recurrent nature. Included are services delivered to persons where the onset of disease or impairment to be treated occurred further in the past or has not been subject to prior rehabilitation services. Rehabilitative care can be provided in the hospital, in the community or in a person's home and plays an important role in both prevention and reactivation after an illness or hospital stay.

Rehabilitative care comprises services where the emphasis lies on improving the functional levels of the persons served and where the functional limitations are either due to a recent event of illness or injury or of a recurrent nature (regression or progression).

Supportive Care: Supportive care is an umbrella term that covers a wide range of services, provided by a wide range of individuals and organizations. These services include self-help and peer support, the provision of information and education, psychological support and therapy, pain and symptom control, social support, rehabilitation, complementary therapies, spiritual support, palliative care and bereavement care. Supportive care is the provision of the necessary services, as defined by those living with or affected by a long term disease or illness, to meet their physical, informational, emotional, psychological, social, spiritual, and practical needs during the pre-diagnostic, diagnostic, treatment and follow-up phases.⁶

The focus on supporting **individuals and their families** is central to the continuum of care concept and recognizes the important role that individuals and families play as health care partners. Self-care refers to the decisions and actions taken by people to maintain and improve their health⁷ (Health Canada, 1997). Supporting self-care includes supporting the person (conveying acceptance, listening, etc.), sharing knowledge, facilitating learning and personal development, helping the person build support networks and providing a supportive environment. An effective continuum of care will include strategies that support self-care and enable individuals and their families to take responsibility for and participate in making decisions about their health.

The following four supporting themes are key elements of an effective continuum of care:

- Education, Research and Knowledge Sharing;
- Evidence-Informed Practices;
- System Navigation; and
- Communication.

⁶ Adapted from Cancer Care Ontario, 1994

⁷ *Supporting Self-care: A Shared Initiative 1999-2002*, Published by the Canadian Nurses Association with support from Health Canada, March 2002

To achieve a truly integrated and seamless continuum of care that provides easy access and movement through the system, providers across the continuum must embrace a focus on lifelong education and continuous service delivery improvement. Results from research and ongoing evaluation will translate into evidence-informed practices that will require dissemination through knowledge sharing across all providers. The application of evidence-informed practice through knowledge transfer will result in behavioural change in service delivery that will have a direct impact on health outcomes. For individuals with complex health needs, the development of an enhanced care coordination role will enable better care management and system navigation. To achieve the significant benefits of this continuum of care enhanced communication among providers and consumers is needed to ensure a consistent level of care across the system and a seamless experience for the consumer.

Access for Marginalized Populations

A number of factors may influence consumers' ability to access health services, including language and culture, age, socio-economic factors such as poverty, ability to navigate the system, availability of transportation and social support services in the community. Some groups such as newcomers, immigrants, Aboriginal people, Francophone and other non-English speaking populations, those living with mental illness and/or addictions and seniors may have unique challenges for accessing health care regardless of the communities in which they live. In both larger urban centres and rural communities barriers to accessing services exist for marginalized populations.

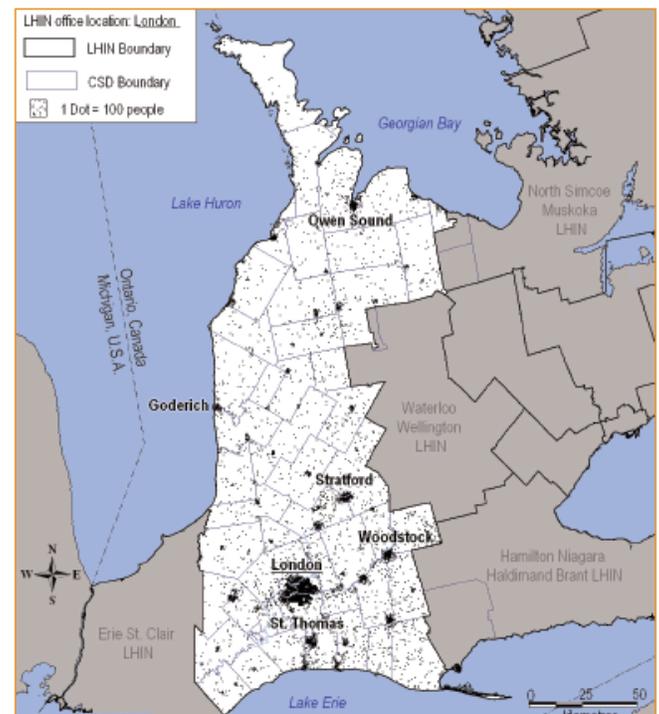
Wait Times and Critical Care Capacity

Several provincial initiatives are under way to improve coordination of service providers and reduce wait times for access to services. The South West LHIN is actively participating in these programs and will continue to work with local providers to ensure that lessons learned from these initiatives inform a broader range of services in the future.

Rationale

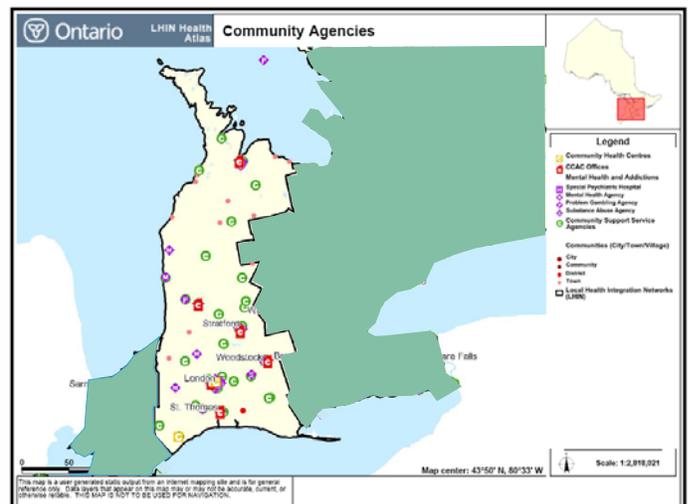
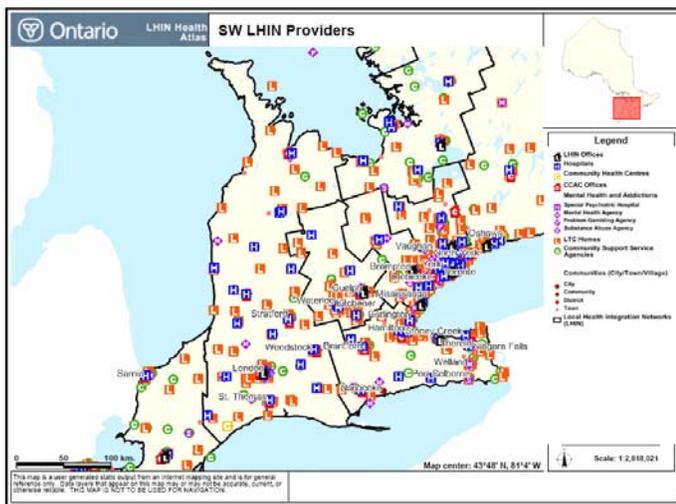
What Our Data Tells Us:

- The population density diagram clearly illustrates the significant urban population in the City of London, with many rural communities scattered throughout the South West LHIN boundaries. More than 280,000 or approximately 30% of



people in the South West live in rural communities. Consistent with other parts of the province, the urban areas of London-Middlesex are expected to see the majority of population growth in the coming years. Rural communities, particularly in the northwest communities, are expected to see moderate declines.

- Rural communities in the North have the highest percentage of residents over the age of 65, especially in communities along the shores of Georgian Bay and Lake Huron. Rural areas also have proportionally higher percentages of families living below the poverty line and lower rates of people who have graduated from high school. While the London area as a whole rates better on many indicators, closer examination of individual neighbourhoods shows significant disparities in socio-economic status.
- Many areas experience a significant amount of tourist activity during the summer when the Stratford Festival and resort/beach community activities are under way. Agricultural communities often also have a seasonal influx of workers during harvest times. Therefore, health planning will need to take into consideration the significant variability in the demand for health services that are placed by these seasonal populations throughout the year.
- The people of the South West LHIN have socio-demographic characteristics that pose possible barriers to access to health services. Demographically, the population of the LHIN has a significantly higher proportion of seniors when compared to the rest of Ontario. The South West LHIN also has a greater proportion of people than the provincial average with the following chronic conditions: arthritis/rheumatism, high-blood pressure, asthma, diabetes, heart disease, and chronic bronchitis. People with multiple conditions experience greater difficulties obtaining health services.
- Health service providers tend to be concentrated in the South and Central areas, many of them in and around the City of London. As the maps below illustrate, the north west of the LHIN has the lowest density of service providers:



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- In 2004/05, South West LHIN hospitals ranked third highest among the LHINs in Emergency Room (ER) visits which are made up of a significantly higher proportion of “non-urgent” visits. Of the 527,433 ER visits in 2004/05, 65% were classified as “less-urgent” or “non-urgent”, suggesting ERs are not being used for urgent and emergency care.
 - 9,858 patients that entered South West LHIN Emergency Rooms were triaged, but left without being seen.

Community Engagement

What We Heard to Inform the Draft IHSP:

Issues of access to health services – particularly access for those living in rural communities – have figured prominently in all of the South West LHIN’s community engagement. Phase one input included:

- Of the top 10 priorities identified at the 2004/05 South West LHIN Community Workshop, three were directly related to rural health care issues: rural networks; rural services equal to urban services; and improved rural transportation.
- Providers attending the May 2006 Forum identified a range of innovative rural health projects already under way, including initiatives for integration across organizations, information management, shared resources, seniors’ health, recruitment, retention and training. Feedback highlighted:
 - The need for better transition planning, including short stay opportunities and discharge planning
 - The value of networks, as a source of expertise, and an opportunity to share resources and knowledge across the system
 - The need to focus on special populations, particularly seniors, those living with mental illness, children, youth and First Nations communities.
- Consultations with Ministry of Health and Long-Term Care Regional Office staff located in the South West LHIN focused on capacity issues, including bed shortages in London, long term care bed shortages across the system, and lack of access to tertiary care for those suffering from mental illness. Related to this were the availability of trained health professionals and the particular challenges of service delivery in rural areas.

What We Heard to Inform the Final IHSP:

The second phase of community engagement includes more than 65 sessions held to gain input from the public, providers, front line workers, as well as special communities such as Aboriginals and First Nations communities, the Francophone community, people suffering from mental illness, and the deaf. The majority of participants were supportive of the South West LHIN’s draft priorities, and many of the same themes emerged from the discussion. Some of the comments and suggestions made by the participants included:

- Preliminary consultations with Aboriginal and First Nations leaders suggested that there will be



opportunities to work together to improve the LHIN's understanding of access issues facing Aboriginal populations and to identify opportunities to increase capacity to deliver local services within these communities.

- Community engagement sessions with the public, as well as providers and front-line staff reinforced many of the themes seen in phase one of the South West LHIN's community engagement. Of particular concern were issues such as:
 - Access to primary care locally, and the recognition that primary care providers were the "gatekeepers" which enabled access to other health care services
 - The need for better access to information on health services available, both for the public, and for those who provide them with care
 - The need to better understand and improve services for children and youth, and to focus on education and health promotion with this age group as a means of illness prevention

Obstacles to Overcome: What We Heard

- **Transportation:** As with other priorities, transportation was identified as a central challenge for access, particularly for rural communities
- **Availability of services in rural communities:** In addition to transportation issues, participants familiar with rural service delivery identified a range of issues specific to these communities
- **Availability of human resources:** Participants saw far-reaching implications of human resource challenges, and suggested the need for change in the areas of education, training and recruitment
- **'Competition' among providers:** Participants suggested that there are a variety of areas where providers compete amongst each other
- **Education on what is available:** Participants cited challenges in educating both the public and providers on what services are available and how to access them

Strengths to Build On

- **What We Heard:** examples of successful initiatives in the South West included:
 - Huron Perth Non-emergency Transport Working Group
 - NSS Initiatives program; RPN program established locally
 - Grey Bruce Care Pathways program for Hips and Knees Network
 - CCAC information and referral database (needs to be expanded)
 - Cancer Care Ontario's regional care strategy
 - Ontario Breast Screening Program (Listowel) enables navigation, uses video-care and involves allied health professionals
 - Diabetic education programs at Huron Perth hospitals
- **South West Networks**
 - **South West End-of Life Network:** The organization sees alignment of approaches to support rural community providers with links to specialized hospice and palliative care resources.

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- **Regional Cancer Services Alliance:** Through its systemic therapy initiatives, the RCSA has a distributed system of cancer services throughout the region. Its current focus is on improving the quality of service through tele-education directed to both providers and patients.
 - **Southwestern Ontario Stroke Strategy:** BRAINSAVE, the tele-stroke project, is providing mentorship to district stroke centre physicians for the administration of tPA for hyper-acute stroke as well as consultation regarding patient transport to the tertiary care regional stroke centre. Professional education initiatives range from CME- accredited workshops to online courses and mentorship.
 - **Specialized Geriatric Services (SGS):** SGS has established easy access for referrals through a Centralized Intake service for the services offered across London and the region. This successful centralized Intake and Triage model could be replicated by other services wishing to provide integrated service delivery to clients.

Overview of Action Planning

An evidence-informed approach is needed to understand the appropriate mix of services that should be available locally, at the geographic area level, and at the LHIN level. Planning must take a longer-term perspective and will need to draw on expertise from across the health care system to ensure an approach that maximizes access, quality care and safety for consumers and their families.

Much work has already been done in the South West to improve access to services and enable more effective and efficient management across organizations. Action planning will build on these initiatives, and look for opportunities to strengthen and expand existing networks and initiatives where appropriate. Existing initiatives also offer a valuable opportunity to identify and test best practice strategies for integration, which can then be implemented more broadly.

In addition, participation in provincial priority initiatives will allow the South West LHIN to pilot innovations such as common care pathways and cross-sectoral partnerships, and incorporate valuable lessons for implementation of other such integration initiatives.

To improve access to the right services, in the right place, at the right time, and by the right provider, the South West LHIN has developed three inter-related action plans:

- 1) Improve the understanding of the availability of and access to health services for **children and youth** (pre-natal to 19 years old) to identify opportunities to enhance support provided to families through better information and coordination across care providers and partners. Support this action through improved collaborative education and training opportunities for child health providers across sectors.

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- 2) Define and strengthen the delivery of equitable, timely and appropriate services and improve service coordination with a focus on implementing innovative approaches to support rural community providers with links to specialized resources.
 - 3) **Quick Start:** Develop and promote local solutions for provincial priorities and incorporate lessons learned from these initiatives to inform other South West LHIN access and integration activities:
 - A. Promote the work of the Hips & Knees Quality, Utilization & Access Steering Committee to ensure an integrated approach to hip and knee total joint replacements across the LHIN.
 - B. Build on the work of the provincial Critical Care Strategy Group to build critical care capacity and improve accessibility, quality and efficiency of services.

Performance Outcomes and Measures

These outcomes and indicators are preliminary and will be discussed and refined by the Priority Action Team. The indicators *italicized* are not represented in the Ontario Local Health System Scorecard and should be viewed as developmental until further work is complete and a determination of their ability to measure is made.

Short Term Outcomes (1 to 3 Years)	Medium Term Outcomes (4 to 5 Years)	Long Term Outcomes (6+ Years)
<ul style="list-style-type: none"> ○ Increased consumer and family awareness and understanding of the core basket of services (including children and youth services) at each level (i.e., local; geographic area; LHIN; inter-LHIN/ Provincial) ○ Increased provider awareness of evidence-informed practices for children and youth services ○ Increased provider awareness of access protocols for children and youth services 	<ul style="list-style-type: none"> ○ Increased linkages across the different levels of care (i.e., local; geographic area; LHIN; inter-LHIN/ Provincial); ○ Identification of critical mass criteria for key services based on best practices ○ Increased knowledge and application of evidence-informed practices for children and youth services by providers ○ Reduced wait times for provincial priority services ○ Improved access to quality children and youth services 	<ul style="list-style-type: none"> ○ Consistent application of evidence-informed practices for delivery of children and youth services by all providers ○ Fully integrated service delivery across the continuum for priority programs and services



Short Term Performance Indicators	Medium Term Performance Indicators	Long Term Performance Indicators
<ul style="list-style-type: none"> ○ Perceptions of the availability and quality of health care services ○ <i>Awareness indicator for Consumers</i> ○ <i>Awareness indicator for Providers</i> 	<ul style="list-style-type: none"> ○ Wait times for provincial priority services ○ Inflow/outflow at the each level ○ Wait times for selected children and youth services ○ Percentage of cases being treated according to CPGs ○ <i>Knowledge indicator</i> 	<ul style="list-style-type: none"> ○ Percentage of the population reporting unmet health care needs ○ <i>Access indicator through consumer satisfaction survey</i> ○ <i>Integrated service delivery indicator</i>



Action Plan #1

Objectives

Improve the understanding of the availability of and access to health services for *children and youth* (pre-natal to 18 years old) to identify opportunities to enhance support provided to families through better information and coordination across care providers and partners. Support this action through improved collaborative education and training opportunities for child health providers across sectors.

Description

For many families caring for an ill child, it can be difficult to know what children's and youth's services are available and how to access them. Whether an illness is mild or acute, children and youth have unique needs that are often not fully met by a system geared to adults. Families and primary care professionals need a better understanding of services at the community, secondary and tertiary levels, and providers must improve their understanding of the needs of children and youth to identify and address service gaps.

Children and youth in hospitals are being treated for increasingly complex health issues, while the number of children and youth being treated in community settings is increasing. This change in service delivery has meant that paediatric health providers now work in smaller, community-based organizations, and hospital providers are dealing with sicker children and youth. These changes have resulted in decreased access to education about evidenced-based treatment and best practices for community providers. Also, community hospitals lack a "critical mass" to offer educational programs.

Deliverables – Years One to Three

Year 1 Deliverables:

- Establish a cross-sectoral Priority Action Team to provide leadership for:
 - Creating a detailed environmental scan and analysis of current services provided, including an inventory of service availability (including usage) from pre-natal to 18 years of age
 - Through data analysis, gaining an understanding of the level of equity and timeliness of access to services and compare to the perception of these factors held by consumers and providers
 - Engaging providers, key partners, consumers and the public in order to understand the needs of children and youth and their families, as well as possible barriers to accessing services
 - Completing analysis and making recommendations on:
 - Gaps or unmet needs for children and youth
 - Strategies to improve coordination of care (primary, secondary, tertiary)
 - Strategies to improve dissemination of information on available services to consumers



and their families as well as providers

- Engaging the South West Ontario Perinatal Program (SWOPP) and the Western Ontario Regional Paediatric Network (WORPN) to provide leadership for:
 - Engagement of child health providers in hospital and community settings to understand their educational/training needs
 - Identification of educational/training opportunities available and/or currently being provided
 - Identify gaps and barriers that have limited exposure to educational/training events
 - Develop a Child Health Knowledge Exchange to identify consistent, collaborative education and training events for child health professionals
- Supporting implementation of strategies to ensure appropriate education and training opportunities are available to all child health providers across the South West LHIN

Year 2 Deliverables:

- Support implementation of strategies to improve coordination and disseminate information on services for children and youth
- Work with providers to define strategies to address gaps or unmet needs for children and youth services
- Work with WORPN and child health providers to identify sustainable mechanisms that will support educational and training programs

Year 3 Deliverables:

- Continue to support implementation and knowledge sharing

Performance Outcomes and Measures

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary performance scorecard included for this priority and the work of the Right Services, Right Place, Right Time, and Right Provider Expert Panel held on October 3, 2006.



Action Plan #2

Objectives

Define and strengthen the delivery of equitable, timely and appropriate services and improve service coordination with a focus on implementing innovative approaches to support rural community providers with links to specialized resources.

Description

Coordination and efficiencies across the South West cannot be achieved without collaboration among provider partners and enabling systems to manage information and share knowledge. Consumers and providers alike need know what services are available and how to access them — locally, within a geographic area, LHIN-wide and across LHINs.

Strong linkages already exist between rural hospitals, specialized services and tertiary care centres. However relationships with community partners are often less developed. Fostering these linkages and innovating to break down barriers will enable services to be delivered closer to home for consumers and their families and reduce the pressure on the larger urban providers to deliver services that would be better situated in the community. To achieve its goals the South West LHIN will need a longer term outlook and a roadmap to build consensus on objectives, define a detailed plan and identify performance targets for access improvements.

Deliverables – Years One to Three

Year 1 Deliverables:

- Establish a cross-sectoral Priority Action Team to provide leadership for:
 - A detailed environmental scan and analysis of current services provided, including:
 - A system-wide inventory of service availability and usage
 - Analysis of movement of people across care settings (e.g. from hospitals to long term care)
 - Engagement of providers, consumers and the public in order to understand:
 - Appropriate roles of providers for health service delivery in each geographic area that recognize the diverse needs of the local communities (e.g. role of hospitals in providing primary care)
 - Barriers to accessing services and how they can be addressed
 - Quantification of the acute episode continuum from community hospital to tertiary care to community hospital to home to understand the cost structures associated with transfer from one organization to the next to home
 - Analysis of the in-flow and out-flow across the geographic areas of the LHIN and across neighbouring LHINs

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- Analysis and recommendations on:
 - Gaps or unmet needs in the community and strategies to improve coordination of secondary and tertiary care
 - Developing an “inventory” of available services as an educational tool for both the public and providers
 - Supporting the development of an effective bed management strategy across providers and innovative approaches to return people to their communities sooner
 - Opportunities to achieve service improvements through the use of enabling technologies

Year 2 Deliverables:

- Define appropriate mix of services to be located at the local level, in the geographic area, and LHIN-wide
- Develop a detailed implementation plan to achieve recommendations of the Priority Action Team

Year 3 Deliverables:

- Implement detailed plans to enhance equitable and timely access to services

Performance Outcomes and Measures

The Priority Action Team will develop specific outcomes and indicators for this Action Plan building on the preliminary performance scorecard included for this priority and the work of the Right Services, Right Place, Right Time, and Right Provider Expert Panel held on October 3, 2006.



Action Plan #3 – Quick Start Plan

Objective

Quick Start: Develop and promote local solutions for Provincial Priorities and incorporate lessons learned from these initiatives to inform other South West LHIN access and integration activities:

- A. Promote the work of the Hips & Knees Quality, Utilization & Access Steering Committee to ensure an integrated approach to hip and knee total joint replacements across the LHIN.**
- B. Build on the work of the provincial Critical Care Strategy Group to build critical care capacity and improve accessibility, quality and efficiency of services.**

Description

The government of Ontario has a number of initiatives aimed at improving the delivery of health care, enabling coordination across the health system, and enhancing accountability of providers for health outcomes. Central to these initiatives is the Wait Time Strategy, which will hold providers accountable to reduce wait times with a focus on five key areas: cardiac procedures, cancer treatments, hip and knee and cataract surgery, MRIs and CT scans. Within the South West, organizations engaged in the Wait Time Strategy have begun to make significant advancements that are resulting in reduced wait times and system improvements. The LHIN is working with these providers to support local solutions that will reduce wait times, as well as other strategies to improve the quality of and access to care. Two targeted initiatives will provide the South West LHIN with valuable learning that can then be expanded to other areas:

- A. South West LHIN has formed a Steering Committee that is working collaboratively and on behalf of the South West to share local approaches and identify, prioritize and support the implementation of strategies to increase access and decrease wait times for hip and knee total joint replacements.
- B. Critical care is a pivotal service that has the potential to “make or break” other hospital services. If critical care is not available, surgeries can be delayed or cancelled, and wait times for surgeries increased. The Ontario government is implementing a province-wide Critical Care Strategy aimed at improving access, improving quality, and creating better linkages across the system. A local Critical Care Strategy Group has been established in the South West to support this initiative by developing a profile of local issues, facilitating planning and enabling intra-hospital cooperation.



Deliverables – Years one to three

Year 1 Deliverables:

A. Wait Time Strategy

- Work with the Steering Committee to conduct analysis and define a detailed implementation plan, including:
 - Creating a pre-surgical scope of services that are comprehensive and include prevention, early identification and optimization to prevent and/or delay surgical intervention
 - Developing mechanisms needed to ensure effective patient flow along the care continuum including the development of a common care pathway that spans the pre-operative to post-operative stages of care
 - Streamlining the pre-surgical assessment and triage process
 - Optimizing surgical capacity for total joint replacement procedures to improve volumes and create consistent patient flow
 - Creating a common care pathway for rehabilitation services and facilitating linking back (closing the loop) to primary health care services for hip and knee patients.
 - Confirming an organizational structure and processes required to support successful implementation
 - Identifying clear measures and targets for wait time management
 - Establishing processes for collecting and utilizing data to support wait time management
 - Supporting the successful implementation of the plan and establishment of the common care pathway

B. Critical Care Strategy

- Support the work of the local Critical Care Group to complete the assessment of current capacity and develop multi-hospital service delivery plans for critical care.
- Support the creations of a LHIN-wide “surge plan” based on coordinated hospital level plans.

Year 2 Deliverables:

- Identify opportunities to leverage lessons learned from hip and knee strategy implementation to respond to locally-defined and provincially-defined wait time priorities
- Continue to support the planning and implementation of the critical care strategy, both locally and at the provincial level.

Year 3 Deliverables:

- Extend implementation of wait time strategies to other areas in accordance with local and provincial priorities.