APPENDIX A: Summary of IHSP Actions: Implementation Strategies

Health Equity
Work alongside health service providers to develop culturally competent Boards and organizations through Continuous Cultural Competency training (including ongoing Indigenous/Aboriginal cultural and linguistic competency training and Francophone cultural competency training) and board/staff development focused on increasing awareness about key equity issues.
Continue to engage with key stakeholders and health service providers in developing an approach to equity and an implementation plan that outlines foundational equity expectations such as: deploying tools, training requirements, staff expertise, prominence of equity considerations in organizational strategic and operational plans, development and monitoring of equity indicators and targets as part of quality improvement, collection of socio-demographic data/community profiles to advance equity, advancement of targeted equity initiatives, services and/or policies, and identification of best practices and resources.
Apply an equity lens to decision-making by developing guidelines to increase the application of the Health Equity Impact Assessment tool, [1] including when developing and accessing health programs and services and for all major financial decisions and integrations at the LHIN.
2016-17 Progress **Application of the Health Equity Impact Assessment (HEIA) Tool** • Diabetes Coordinated Access – HEIA reviewed by Southwest Ontario Aboriginal Health Access Centre (SOAHAC) • Health Links – established matrix to actively track progress toward HEIA mitigations in the South West • Francophone Health Link Strategy - translated Health Links info sheets for providers and clients/caregivers to French • Oxford and Elgin Hospice Palliative Care – HEIA completed • Huron Perth & London Middlesex Hospice Palliative Care – HEIA refreshed • Mental Health and Addiction Peer Support Strategy – HEIA completed • Bedded Rehabilitation Capacity Plan – HEIA completed • Stroke Phase 2 – HEIA completed **Cultural Competency Training** • Culturally Safe Care for Aboriginal populations – Initial phase focuses on building/ implementing educational training for health care providers at key touch-points; enabler to address culturally safe care; equitable access to care; Phase 1 Indigenous Cultural Safety (ICS) executed: 2,520 health providers trained since May 2014 **Advancement of Targeted Equity Initiatives** • Primary Health Care Capacity Planning: leveraging an equity lens focused on vulnerable populations to improve access to primary health care for individuals most impacted by the social determinants of health • Transitional and Life-Long Care Clinic Model – program extends services to physically disabled youth transitioning to adult services. Previously experienced significant loss of supports • Congregate Residential Living - cross-Ministry collaboration to identify communities with no access to 24/7 assisted living services for Medically Fragile Technologically Dependent population

- Rehabilitative Care Coordinated Access – this work has created system beds throughout the LHIN, which improves access to rehab/ccc as all partners have access to all beds

Integration & Collaboration

Work alongside Health service providers to pursue opportunities to transform the health system to integrate population and public health planning with other services to create stronger links to health promotion and disease prevention; to provide integrated, population-based care by strengthening end to end integration at a multi-community and local level across the South West LHIN

Work alongside health service providers to pursue opportunities for Integrated Funding Models. This will promote high quality person-centred care across the care continuum by bundling payment to encourage coordination of care, reduce variation of care pathways, increase efficiency, and improve outcomes.

Engage health service providers in capacity planning activities to improve and increase access to care and use resources more efficiently by and act on opportunities to integrating/aligning services and resources.

Continue to evaluate integration activities to ensure they are in the best interest of the public. Proposed integrations must demonstrate how they will positively impact on population health, experience of care and value for money.

Proactively work with health service provider governance through Board-to-Board engagement to intentionally identify and support integration activities related to service, administration and governance

Provide tools to assist health service providers to continually assess quality of health services, organizational health, human resources, finances and performance outcomes to identify and successfully advance integration and collaboration opportunities.

Work with health service providers to improve back office services, make the best use of public resources, and plan for future health system transformation.

2016-17 Progress

Capacity Enhancements

- Adult Day Program (ADP) Re-design – Adult Day Programs involved in system capacity review process
- Long-Term Care Home (LTCH) Redevelopment – continuous analysis and active engagement with LTC homes to optimize access to long-term care across the LHIN
- MH&A Services Standardization - Mental Health Crisis providers have collaborated in the development of recommendations to create standardized, consistent and equitable crisis services across the LHIN
- Long-Term Care Home Specialized Units - cross sector partners have collaborated to determine the individuals who would most benefit from a specialized unit, identify partner expectations care pathways to transition individuals in and out of the units
- Rehab Capacity Plan and Implementation: LHIN wide capacity plan being created that includes bedded and community providers to ensure the system of care is considered in decision making
- Critical Care: South West Local Critical Care Network collaborating on joint regional priorities across Level 1 and 2 ICUs in the Region

- Stroke Phase 1 and 2: wide spectrum of stakeholders engaged (clinicians, decision makers, data analysts, project and process improvement resources) to support evidence / data / populations based decision making regarding the design of new models of care to improve integration, coordination and transitions of care

Formal Integrations in the Best Interest of the Public

- Coordinated Access for Mental Health and Addictions (MH&A) Services - formal integration occurred in July 2016 between 4 MH&A providers and ConnexOntario to create "Reach Out" in Oxford, Elgin and London Middlesex
- MHA Peer Support Strategy - formal integrations have started to occur to move Peer Support programs into Lead MH&A organizations to enhance Peer Support at the sub-region level.
- Grey Bruce MH&A Integration & Collaboration Project - through collaboration, governance level partners are exploring integration opportunities

Quality Improvement & Innovation

Work with health service providers to develop a coordinated approach to engage people who receive services and determine experience of care measures.

Work alongside health service providers to implement best practices (e.g. Quality Based Procedures, Adult Day Program Redesign) and reduce variation within and among organizations to improve outcomes and value for money.

Work with health service providers to advance quality outcomes for identified priorities and initiatives.

Encourage health service providers to embed quality improvement within their organizations through processes such as accreditation and use tools such as the Quality Improvement Enabling Framework.

Continue to integrate and standardize improvement tools and templates into the LHIN's project management approach.

Continue to acknowledge and stimulate quality improvement efforts through the LHIN's annual quality symposium and awards.

Work alongside health service providers to leverage provincial quality improvement learning opportunities (e.g. IDEAS program--Improving and Driving Excellence across Sectors) by implementing an approach and roadmap to identify improvement projects.

Engage a Quality Improvement community of practice to continue to build a culture of continuous quality improvement and broadly share quality evidence.

Work alongside health service providers to consistently embed patient engagement approaches (e.g. Experience Based Design) to advance quality improvement.

Provide leadership in establishing shared quality improvement strategies through Quality Improvement Plans across and within sectors to advance key priorities.

2016-17 Progress

Engaging People Who Receive Services

- Special Needs Strategy – patient advocates involved in planning of proposals and presentations to Ministries; client and caregiver voices incorporated in design of model of care
- Tele-homecare Program – Experience Based Design being leveraged to identify why patients left the program early
- Francophone Health Link strategy – exploring use of Experience Based Design to improve access to services for Francophone population
- Home and Community Care implementation – client and caregiver voices incorporated in design of model of care
- Adult Day Program Redesign – leveraged Experience Based Design framework to address client perspectives of barriers to access
- Aboriginal Approach to Hospice Palliative Care and Coordinated Care Planning (Health Links) - working with Indigenous community to create innovative care coordination model and improvements
- Critical Care (CC): participation in Critical Care Services Ontario Patient Voices project to understand lived experiences of CC patients and families as well as local Patient experience work at each site shared regularly with South West CC Network for collaboration and sharing
- Stroke Phase 1 and 2: Robust patient engagement plans that will result in improved patient experience and outcomes

Quality Improvement Tools and Measures; Advancing Quality Outcomes

- Assisted Living (AL) Hubs – consistent use of quality improvement tools and measures across AL hub communities
- Oxford and Elgin Hospice Palliative Care Outreach – Driver diagram completed
- Planning for implementation of Emergency Medical Services (EMS) Protocols with Crisis Centre – leveraging existing protocols for London Police
- Reach Out – call center best practices leveraged to develop Reach Out
- Mental Health and Addictions Capacity Planning – development of clinical protocol to improve patient access and flow completed; implementation underway to test and evaluate clinical protocol
- Assess and Restore – partnered with London Middlesex EMS to include standardized risk assessment tools that assist EMS to connect at risk frail elderly to community resources when they do not require Emergency Department visit; piloting assess and restore care pathways
- Antimicrobial Stewardship Program: hospitals participating in the pilot project have implemented best practices from the Antimicrobial Stewardship Program (ASP) at London Health Sciences to ensure appropriate use of antimicrobial agents, improve patient outcomes, and reduce pharmaceutical costs.
- Patient Flow Strategies: Chief Nursing Executive Leadership Forum working to implement standardized best practices in ALC management and the spread of discharge summaries to Primary Care within 48 hours across the LHIN
- Stroke Phase 1 and 2: the initiative uses Quality Based Procedures (QBP) to guide system design and decision making; recommendations are supported by best practice
- Regional Medical Imaging: Initiative objectives include standardizing protocols across the region to ensure standardized views/scans completed

Leveraging Provincial Quality Improvement and Learning Opportunities

- Health Links – Grey Bruce and Huron Perth Health Links involved in IDEAS cohort 10
- Rehabilitation Capacity Plan and Implementation – using new provincially standardized definitions and eligibility criteria to ensure right care, right place, right resources
- Senior Friendly Hospital Strategy: working with organizations to improve/standardize care for Frail Elderly by focusing on delirium/functional decline across the LHIN

Quality Awards

- Home and Community Care implementation – received 2016 South West LHIN Quality Award

Transparency & Accountability

Work alongside health service providers to implement, evaluate, monitor, and enhance the impact of initiatives within each priority to improve the health of the focused population, their experience of care and the value for money for the care provided.

Work with health service providers to optimize data processes to improve access, use and analysis of data to make data sharing for improvement easier and to communicate progress against measurement plans and benchmarking targets.

Continue to implement and enhance value for money assessments of LHIN-wide initiatives in order to understand impact of investments and direct alignment of initiatives to outcomes.

Establish a plan to strengthen cross-sector integration and shared accountability by leveraging Service Accountability Agreements (SAA) and enhanced improvement and compliance monitoring.

Increase transparency with publicly-available performance reporting, enhanced outcome-based reporting aligned to key initiatives, and scorecards (system-level and priority-based).

Improve public-friendly communication and posting of information including key reports and performance results.

2016-17 Progress

Enhanced Data Analysis and Data Sharing

- Adult Day Program Redesign – use and analysis of data to maximize use of adult day program resources throughout the LHIN
- Long-Term Care Home (LTCH) Redevelopment – LHIN has developed methodology to understand supply and demand for LTCH beds as LTC homes redevelop. This is part of discussions with LTCHs when plans are disclosed.
- Assisted Living (AL) Hubs - data collection and reporting to LHIN; initial evaluation of value for money
- Mental Health and Addictions Crisis Services - cross sector partners meet regularly to review crisis data to identify planning and quality improvement opportunities to improve access to crisis services and outcomes
- Senior Friendly Hospital Strategy: Senior Friendly scorecard created to help organizations evaluate performance and identify priorities
- Regional Medical Imaging: current state assessment of where categories of scans are done in the LHIN; working to create and leverage a diagnostic imaging dashboard to monitor progress towards outcomes
- Surgical Waitlist Management Strategies: implementation of Novari Access to care creates transparency of patient specific wait times between the surgeons office and hospital

- Antimicrobial Stewardship Program: pilot hospitals are contributing to pre- and post-intervention data collection and analysis. Mechanism for data collection and analysis will be rolled-out to other sites in future phases

Dashboards and Agreements

- Hospice Palliative Care Capacity Planning - regional and sub-regional dashboard are fully implemented
- Oxford and Elgin Hospice Palliative Care Outreach – Memorandum of Understanding finalized for primary care physician, chaplaincy and supportive care
- Coordinated Access for Mental Health and Addictions Services - Reach Out data is publicly available to encourage Health Service Providers to use data for planning and quality improvement
- Improvement of orthopaedic wait times (hip and knee): planned development and implementation of an Orthopaedic dashboard to drive Ortho Steering Committee priorities; Leveraged Service Accountability Agreement (SAA) process to support data cleanup
- Senior Friendly Hospital Strategy: Senior Friendly scorecard created to help organizations evaluate performance and identify priorities
- South West LHIN Rehabilitative Care: Committee has created regional dashboard to support quality improvement discussions within the group and HSPs. Length of Stay Efficiency is within the dashboard and is reported to the Board quarterly.

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

2016-17 Progress

Advance eHealth tools to improve collaboration and access to information

- Health Links – launched specialist directory and microsites on thehealthline.ca; launched Ontario Telemedicine Network (OTN) expansion in Grey Bruce
- Home and Community – through the development of Community Support Services network, a shared IT platform developed to create a shared client record for all agencies and to incorporate information in each agencies data base to enable agency to provide services
- Huron Perth & London Hospice Palliative Care - work underway with CCAC database (CHRIS) to set up reporting

eConsultation and eReferral Processes

- Clinical Services Planning**:**
- Improvement of orthopaedic wait times (hip and knee): investigating implementation of a centralized referral and booking process for all hip/knee referrals in the South West with future state opportunity to leverage Novari e-referral technologies
- Surgical Waitlist Management Strategies: developed Phase 3 plan for implementation of Novari e-referral functionality; Implementation of Novari Access to Care to improve the accuracy and transparency of surgical wait times in the South West
- Rehabilitative Care Coordinated Access - creation of electronic referral pathway from Acute to Rehab/CCC care resulting in improved access, reduced errors, improved use of system beds

APPENDIX B: Summary of IHSP Actions: Priorities and Initiatives

Priorities for the Integrated Health Service Plan 2016-19

Please note that system level performance monitoring is tracked and reported to the South West LHIN Board of Directors each quarter. The most up to date South West LHIN Report on Performance Report can be located at:
http://www.southwestlhin.on.ca/accountability/Performance.aspx

Note: **system measures = bold**, *project level measures = italics*

Ensuring primary health care is strengthened and linked with the broader health care system		
What are we trying to accomplish? Ensure equitable access to primary health care (including multidisciplinary care) by: enhancing inter-professional collaboration between primary health care models and the broader integrated system of care and; supporting quality improvement initiatives that will improve health outcomes and the experience of care.		
Outcome Objectives: **Population Health** • To improve access to primary care • To improve early identification and intervention **Experience of Care** • Reduce readmission rates for defined populations • To improve patient experience • To improve care coordination throughout the journey of care **Value for Money** • To reduce unnecessary hospitalization • To reduce avoidable emergency department visits or revisits	**What will we measure to know we have been successful?** **Population Health** • Attachment to a Primary Care Provider • **Percent of Adults who were able to see a Primary Care Provider on the Same Day or Next Day When They Were Sick** • Cancer Compliance Rates • Influenza Vaccination Rates **Experience of Care** • Hospital Readmission Rates within 30 days • Patient Involvement in Care Decisions • **Percentage of Acute Care Patients Who Have Had a Follow-up With a Physician Within 7-days of Discharge** • *Increased Utilization of Coordinated Care Plans* **Value for Money** • **Rate of Emergency Department Visits for Conditions Best Managed Elsewhere**	**Monitoring Status:** Monitoring in place In development Monitoring in place Monitoring in place Aligned to chronic disease Monitoring in place Monitoring in place Monitoring in place In development

Ensuring primary health care is strengthened and linked with the broader health care system
Initiative Status:

Initiative Code	IHSP Initiative/Sub-Initiative	Planned End Date	% Complete 2016/17	Status 2016/17
1	Access to Primary Health Care: Improve access to primary health care by implementing recommendations from the Understanding Health Inequities and Access to Primary Health Care in the South West LHIN Project and build capacity for Primary Care	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)
1.1	*In alignment to the Patients First LHIN responsibilities, the LHIN will develop and implement a LHIN-wide strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of each community*	March 31, 2019	10%	Plan
1.2	*Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of Elgin County*	March 31, 2019	5%	Initiate
1.3	*Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of Oxford County*	March 31, 2019	5%	Initiate
1.4	*Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of London Middlesex*	March 31, 2019	5%	Initiate
1.5	*Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of Grey Bruce*	March 31, 2019	5%	Initiate
1.6	*Plan and implement the Patients First sub-LHIN strategy, working closely with patients, primary care leaders and providers to organize local primary care and to identify ways to improve care that is tailored to the needs of Huron Perth*	March 31, 2019	5%	Initiate
1.7	*Primary Care Network Structure: Continue to strengthen primary care network structure*	March 31, 2019	60%	Execute
2	Partnering for Quality: Improve primary care provider capacity to identify patients with chronic conditions and support patients to provide chronic disease management	March 31, 2017	100%	Closed - Monitored through Operations
3	Primary Care and Mental Health and Addictions (MH&A) strategy: Strengthen relationships between MH&A services and primary care and increase service capacity with existing primary care structures	March 31, 2019	0%	Not Started
4	eConsultation: Provide primary care physicians with more timely access to specialist input, potentially avoiding referrals for consultation where applicable.	March 31, 2019	25%	Execute

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

Optimizing the health of people and caregivers living at home, in long-term care and in other community settings[1]		
What are we trying to accomplish? Improve the care experiences and optimizing the health of people and caregivers living at home, in long-term care and in other community settings, being responsive to changing needs and supporting safe and independent living in a way that is sustainable/effective(ness)		
Outcome Objectives:	**What will we measure to know we have been successful?**	**Monitoring Status:**
Population Health • To increase adoption of evidence based care (High-Level) • To increase number of people receiving care in the community	**Population Health** • *Intensive Hospital to Home and Home First volumes* • Independent seniors hospitalization rate (65+) • *Compliance to or adoption of care standards being developed for Home and Community Care policy changes*	Monitoring in place In development In development
Experience of Care • To increase access to inter-professional teams (High-level) • To improve access to integrated systems of care for particular populations • To improve care coordination throughout the journey of care	**Experience of Care** • **Percentage of Home Care Clients with Complex Needs Who Received Their Personal Support Visit Within 5 Days of the Date They Were Authorized for Personal Support Services** • **Percentage of Home Care Clients with Complex Needs Who Received Their Nursing Visit Within 5 Days of the Date They Were Authorized for Nursing Services** • **90th Percentile Wait Time From Community for Community Care Access Centre (CCAC) In-Home Services: Application From Community Setting to First CCAC Service (Excluding Case Management)** • *Number of client transitions from CCAC and Community Support Services (CSS) and vice versa* • **Percentage of Home Care Clients With an Unplanned, Less Urgent Emergency Department Visit Within the First 30-Days of Discharge From Hospital** • Percentage of Home Care Clients Who had an Unplanned Readmission to Hospital Within 30-Days of Discharge From Hospital	Monitoring in place Monitoring in place Monitoring in place In development Monitoring in place Monitoring in place
Value for Money • To reduce unnecessary variation in service delivery • To prevent unnecessary long-term care admission	**Value for Money** • **Alternate Level of Care (ALC) Rate** • *Standard service packages for like type services between CSS provision to low acuity clients and CCAC provision to moderate and high acuity patients*	Monitoring in place In development
Initiative Status:		

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

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

Optimizing the health of people and caregivers living at home, in long-term care and in other community settings[1]

Initiative Code	IHSP Initiative/Sub-Initiative	Planned End Date	% Complete 2016/17	Status 2016/17
5	Home and Community Care: Implement provincial home and community care road map and policy changes related to the provision of Personal Support Services to support an integrated system of care	March 31, 2021	See sub-initiative(s)	See sub-initiative(s)
5.1	*In alignment to the Patients First LHIN responsibilities, the LHIN will develop and implement the LHIN-wide strategy to transfer the essential home care functions from the CCAC to the LHIN*	March 31, 2018	20%	Plan
5.2	*In alignment to the Patients First LHIN responsibilities, the LHIN will strengthen alignment of Care Coordinators within the appropriate areas of the health system.*	March 31, 2021	5%	Initiate
5.3	*Implementation of Collaborative Assessment and Referral Model Recommendations*	March 31, 2017	75%	Plan
5.4	*Implementation of Provincial Home and Community Care Guidelines, including Huron-Perth demonstration project*	March 31, 2019	35%	Execute
5.5	*Spread of Provincial Home and Community Care Guidelines to remaining sub-regions (Grey Bruce, London Middlesex, Elgin, Oxford)*	March 31, 2019	15%	Plan
6	Adult Day Programs (ADP): Enhance ADPs including specialized stroke programming and to ADP related transportation	March 31, 2020	See sub-initiative(s)	See sub-initiative(s)
6.1	*Adult Day Program Redesign Review*	March 31, 2018	60%	Execute
6.2	*ADP Stroke Programming in the Community linked with hospital-based programming*	March 31, 2021	0%	Not Started
7	Transitional and Life-Long Care Clinic Model: Spread model that improves transitions from the pediatric system of care to adult services where families typically experience a significant loss of support	March 31, 2020	5%	Initiate
8	Congregate Residential Living: Expand 24/7 assisted Living services for younger adults with complex needs	March 31, 2019	85%	Execute
9	Long-Term Care (LTC) Home Redevelopment: Ensure equitable access, quality and safety for residents living in LTC	December 31, 2025	See sub-initiative(s)	See sub-initiative(s)
9.1	*Support LTC Homes Planning to Redevelop Immediately*	March 31, 2019	15%	Plan
10	Assisted Living (AL) Hubs: Increase access to assisted living supports through implementation of hubs (multiple phases)	March 31, 2020	See sub-initiative(s)	See sub-initiative(s)

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

Optimizing the health of people and caregivers living at home, in long-term care and in other community settings[1]				
10.1	*Further Execution of AL Hubs in Phase 1 Communities: Meaford, Woodstock, London, St. Thomas, Strathroy*	March 31, 2020	40%	Execute
10.2	*Further Execution of AL Hubs in Phase 2 Communities: Goderich, Kincardine, Listowel, Ingersoll, Tillsonburg, Stratford*	March 31, 2020	30%	Execute
10.3	*Subsequent phasing of AL Hub implementation to cover IHSP cycle*	March 31, 2020	0%	Not Started
11	Special Needs Strategy: Plan and implement coordinated care planning and integrated rehabilitation services across multiple ministries (Ministry of Children and Youth Services, Ministry of Community and Social Services, Ministry of Health and Long Term Care, Ministry of Education) for shared populations	March 31, 2019	35%	Plan
12	Dementia Care Strategy: Plan and implement the South West LHIN Dementia Strategy in alignment with the provincial dementia strategy	March 31, 2020	5%	Initiate
13	Oneida Long-Term Care empowerment: Transition the management of LTC admission process to Oneida First Nation	March 31, 2020	0%	Not Started
14	Elder Abuse Strategy: Reduce abuse within the seniors community aligned with the goals identified in the Provincial Elder Abuse Strategy recommended by the Ontario Senior's Secretariat and the South Western Ontario Regional Elder Abuse Network	March 31, 2020	10%	Initiate

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

Supporting people in preventing and managing chronic conditions		
What are we trying to accomplish? Support people in the prevention and appropriate management of chronic conditions through optimizing care coordination, enhancing accessibility, maximizing provider collaboration, in a cost effective and efficient manner		
Outcome Objectives:	**What will we measure to know we have been successful?**	**Monitoring Status:**
Population Health • To reduce the burden the illness • To increase education and training • To improve self-management among individuals	**Population Health** • Chronic Disease Prevalence and Incidence • *Service Utilization of Diabetes Education Programs*	Monitoring in place Monitoring in place
Experience of Care • To improve system navigation and care coordination • To improve patient experience	**Experience of Care** • *Confidence Scores for Patients With a Coordinated Care Plan* • *Number of Identified Users With High Care Needs on Active Care Plan* • **Percentage of Acute Care Patients Who Have Had a Follow-up With a Physician Within 7-days of Discharge** • *Support and Respect Scores For Patients With a Coordinated Care Plan*	Monitoring in place Monitoring in place Aligned to primary care Monitoring in place
Value for Money • To reduce unnecessary hospitalizations and readmissions • To Increase care in the community	**Value for Money** • **Readmissions Within 30-Days for Selected Health Based Allocation Model (HBAM) Inpatient Grouper (HIG) Conditions** • *Utilization of Acute and Ambulatory Services For Residents With Active Care Plans* • **Hospitalization Rate for Ambulatory Care Sensitive Conditions** • **Rate of Emergency Department Visits For Conditions Best Managed Elsewhere**	Monitoring in place Monitoring in place Monitoring in place Aligned to primary care

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

Initiative Status:		

Initiative Code	IHSP Initiative/Sub-Initiative	Planned End Date	% Complete 2016/17	Status 2016/17
15	Optimized Access for chronic condition management programs and services: Develop/implement a model for coordinated access to diabetes management programs and services. Expand and align model to programs and services for other chronic conditions as appropriate	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)
15.1	*Diabetes Coordinated Access: Pilot to develop the use of a standardized, centralized diabetes intake and referral process to improve service delivery, data collection and communication. Focus on City of London with a plan to spread across the South West LHIN.*	March 31, 2017	100%	Closed - Monitored through Operations
16	Integrated Chronic Disease System of Care: Develop/implement integrated chronic disease prevention and management strategies across the continuum of care for people living with chronic conditions to improve access and coordination and increase standardization of best practices among and within system partners.	March 31, 2019	5%	Initiate
17	Health Links: Support development and spread of the provincial Health Links coordinated care plan and associated electronic tools; Utilize experience based design methods in improvement processes of each local Health Link as part of the Health Links program implementation	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)
17.1	*London Middlesex Health Link implementation: Development of a process for identifying people with high care needs, engaging with individuals to determine their goals, establishing a comprehensive care team, facilitating a care conference, and documenting and implementing a coordinated care plan. Focus in London Middlesex sub-region.*	March 31, 2017	100%	Closed - Monitored through Steering Committee
17.2	*North and South Grey Bruce Health Links implementation: Development of a process for identifying people with high care needs, engaging with individuals to determine their goals, establishing a comprehensive care team, facilitating a care conference, and documenting and implementing a coordinated care plan. Focus in North and South Grey Bruce.*	March 31, 2017	50%	Execute
17.3	*Oxford Health Link implementation: Development of a process for identifying people with high care needs, engaging with individuals to determine their goals, establishing a comprehensive care team, facilitating a care conference, and documenting and implementing a coordinated care plan. Focus in Oxford sub-region.*	March 31, 2018	5%	Execute
17.4	*Elgin Health Links implementation: Development of a process for identifying people with high care needs, engaging with individuals to determine their goals, establishing a comprehensive care team, facilitating a care conference, and documenting and implementing a coordinated care plan. Focus in Elgin sub-region.*	March 31, 2018	5%	Execute

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

17.5	*Huron Perth Health Link implementation: Development of a process for identifying people with high care needs, engaging with individuals to determine their goals, establishing a comprehensive care team, facilitating a care conference, and documenting and implementing a coordinated care plan. Focus in Huron Perth sub-region.*	March 31, 2017	100%	Closed – Monitored through Steering Committee
18	Tele-homecare Program: Pilot and spread the use of tele-homecare technologies for people with certain chronic conditions across the LHIN using self-management and remote communication tools people can use in their own homes	March 31, 2017	100%	Closed - Monitored through Operations
19	South West Self-Management Program: Build system capacity to support people to attain their goals for their health	March 31, 2017	100%	Closed - Monitored through Operations
20	Francophone Chronic Disease Self-Management: To enhance and/or build on services for the management and prevention of chronic diseases, in person or through Ontario Telemedicine Network (OTN)	March 31, 2019	10%	Initiate
21	Culturally Safe Care for Aboriginal populations: In partnership with First Nations, Aboriginal, and Metis people advance culturally safe chronic disease care including the planning and implementation of culturally safe approaches to Health Links	March 31, 2019	50%	Execute
22	Francophone Health Link strategy: identify strategy to support Health Link implementation related to meeting the needs of the francophone population consistent with the Health Link, health equity impact assessment findings	March 31, 2019	25%	Plan

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

Strengthening mental health and addiction services and their relationship with other partners		
What are we trying to accomplish? Ensure services and supports are continually improving, easier to access and translate into high quality care where people and their caregivers, impacted by mental health and/or addictions and/or responsive behaviours can thrive.		
Outcome Objectives: **Population Health** • To reduce the burden of illness • To enhance capacity planning to increase the number of people receiving care in the community **Experience of Care** • To improve access to integrated systems of care • To improve patient experience **Value for Money** • To optimize utilization of resources • To reduce unnecessary variation in service delivery	**What will we measure to know we have been successful?** **Population Health** • Access to Primary Care for Patients With Mental Health/ Substance Abuse Conditions • *Percent of Long-Term Care Residents Whose Behavior Has Not Changes and is at the Worst Level* • *Police and Emergency Medical Services (EMS) Involvement/Time on Call* • Mental Health and Substance Abuse Hospitalization Rate **Experience of Care** • **Repeat Unscheduled Emergency Visits Within 30-Days for Mental Health Conditions** • **Repeat Unscheduled Emergency Visits Within 30-Days for Substance Abuse Conditions** • Follow-Up Appointment Booked Within 30-Days of Discharge From Hospital • Readmissions Within 30-Days for Patients with Mental Health/ Substance Abuse Conditions • **Average Wait Time for Mental Health Case Management** • Patient experience: [future: from Ontario Perceptions of Care (OPOC)] • *Emergency Department Length of Stay For Admitted Patients With Mental Health/ Substance Abuse Needs* **Value for Money** • *Crisis Unit Costs* • Number of Residents With Responsive Behaviors Discharged From Long-Term Care • Alternate Level of Care (ALC) Days and Cases with Behavioural and Mental Health Specialized Needs and Barriers	**Monitoring Status:** Alternate in development Alternate in development Monitoring in place Monitoring in place Monitoring in place Monitoring in place Monitoring in place In development Monitoring in place In development NEW In development Alternate in development Alternate in development Monitoring in place

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

Initiative Status:

Initiative Code	IHSP Initiative/Sub-Initiative	Planned End Date	% Complete 2016/17	Status 2016/17
23	Mental Health and Addictions (MH&A) Crisis Services: Continue to refine what the crisis services needs are in each geographic area to ensure equitable access, consistency and quality of crisis services across the LHIN and reduce reliance on police and emergency departments(EDs) for those experiencing a crisis	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)
23.1	*Crisis Centre: Completion of capital renovations to allow crisis stabilization beds to move to the Centre; monitoring of impact of new Centre*	March 31, 2019	85%	Execute
23.2	*Implementation of Emergency Medical Services (EMS) Protocols with Crisis Center: Designation of the Crisis Center as an alternate site of LHSC to enable protocols for the Middlesex-London Emergency Medical Services to safely divert individuals in need of crisis/emotional support to the Crisis Centre.*	March 31, 2018	15%	Plan
23.3	*Crisis Standardization LHIN-Wide Project: establishment of equitable access to MH&A Crisis services across the South West LHIN based on: Standardized service delivery criteria/ description; Consistent application of service expectations; Targets (e.g. Staff/client ratios); Outcomes; and LHIN funding/functional center*	March 31, 2019	15%	Plan
24	MH&A Supportive Housing: Implement provincial program and leverage municipal partnerships to increase supports within housing	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)
24.1	*2016/17 investments in support of the implementation of the Mental Health & Addiction Strategy – Phase 2, 1,000 New Supportive Housing Units*	March 31, 2018	15%	Plan
25	Intensive MH&A Case Management: Evaluate pilot program / evidence based model to create sustainable outcomes for spread consideration	March 31, 2018	80%	Plan
26	Coordinated Access for MH&A Services: Continue to implement and improve coordinated screening & intake and waitlist processes to streamline access to services as well as create a common portal of entry for people accessing mental health and addiction services. Facilitate the coordination of Aboriginal MH&A services with main stream MH&A services	March 31, 2018	See sub-initiative(s)	See sub-initiative(s)
26.1	*Reach Out: launch of a new bi-lingual phone line, available 24/7.Reach Out offers callers: crisis support, friendly listening, information and education, or an appointment with a mental health and addictions professional. Families, caregivers, and health care providers are also encouraged to use the line to learn about resources for loved ones or clients.*	March 31, 2018	75%	Monitor
26.2	*Coordinated Access Thames Valley Table and Reporting Implemented: Creation of a table to support coordinated access in the South and robust reporting to drive quality improvement in case management, crisis services and other aspects of coordinated access.*	March 31, 2018	5%	Initiate
27	Ontario Perceptions of Care (OPOC) Tool: Implement the OPOC tool which seeks to understand and improve experience of care for people impacted by mental health and/or addiction issues	March 31, 2018	60%	Execute
28	MH&A Peer Support Strategy: Development and implement a Regional Peer Support strategy based on the recommendations in the "Development of a Peer Support Strategy for the South West LHIN" 2015 report.	March 31, 2018	50%	Execute

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

29	Strategy for Moderate Mental Illness: Develop a strategy to respond to the increasing demand for services from moderately mentally ill clients and identify the role of primary care in supporting individuals with mild to moderate mental health problems.	March 31, 2019	0%	Not Started
30	Mental Health & Addictions Capacity Planning: Develop and implement clinical protocol; utilize CritiCall Bed Board to monitor occupancy; optimize existing resources to meet mental health system needs	March 31, 2018	50%	Execute
31	New Staged Screening and Assessment Screening for Addictions: Improve the screening and assessment of clients receiving substance use services through the implementation of a staged protocol across the South West LHIN and support sustainable implementation through coaching, fidelity monitoring and evaluation.	March 31, 2018	60%	Plan
32	MH&A Education Strategy: Conduct an education needs and readiness assessment for MH&A providers to identify key topics and priority areas for education	March 31, 2018	25%	Execute
33	Behavioural Supports Ontario (BSO) System of Care: Continue to meet the needs of older adults with or at risk of responsive behaviours due to mental health and addictions, dementia, or other neurological conditions to maintain or improve their quality of life and that of their caregivers by improving equitable access to coordinated, effective and efficient services and supports	March 31, 2022	80%	Execute
33.1	*Kensington: Creation of proposal to submit to Ministry to receive designation of a specialized unit, implementation and evaluation of unit.*	March 31, 2021	25%	Plan
33.2	*McGarrell Place: Creation of proposal to submit to Ministry to receive designation of a specialized unit, implementation and evaluation of unit.*	March 31, 2021	25%	Plan
33.3	*Lee Manor: Creation of proposal to submit to Ministry to receive designation of a specialized unit, implementation and evaluation of unit.*	March 31, 2022	10%	Initiate
34	Grey Bruce MH&A Integration & Collaboration Project: Working with MH&A Senior Leaders and Boards in Grey Bruce to identify opportunities for Board to Board engagement, education and further integration of MH&A services to improve care.	March 31, 2018	20%	Plan
35	Review the Continuum of Addictions Services: Understanding of current state and identifying gaps to ensure client's needs are met along the continuum of addictions (e.g. withdrawal management, managed alcohol, drug strategy, community treatment).	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)
35.1	*Current state review of withdrawal management and treatment services in London Middlesex (e.g. methadone clinics, saboxone)*	March 31, 2018	20%	Plan
36	Francophone Strategy: Ensure French language service capacity for key service functions (case management, counseling, crisis response, treatment, tier/bedded capacity, maintenance, family services and support); Optimize MH&A service delivery, including BSO, for the Francophone population in London	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)

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

Ensuring timely access to hospital-based care, LHIN-wide, multi-community, and local level		
What are we trying to accomplish? Timely access to high quality, effective and efficient hospital-based treatment and care appropriately aligned at the LHIN-wide, multi-community and local level		
Outcome Objectives:	**What will we measure to know we have been successful?**	**Monitoring Status:**
Population Health • To increase adoption of evidence based care **Experience of Care** • To decrease wait times for access to services, specialists and/or procedures • To improve patient experience • To improve care coordination throughout the journey of care **Value for Money** • To optimize utilization of resources	**Population Health** • *Percent of Hospitals That Have Implemented (or are in Progress) to Address Issues of Delirium* • *Percent of Hospitals That Have Participated in Regional Senior Friendly Home Activities (Networking Days, Webcasts, and Steering Committee) (target 100%)* • *Percent of Hospitals That Will Participate in the Provincial Action Program and Those Hospitals Will Showcase Their Work in a South West LHIN Forum to Build Capacity, Share Learnings Across the Region (target 75%)* • Percent of Hospitals in the South West LHIN Demonstrating Improvement in Quality-Based Procedure (QBP) Evidence-Based Care Pathways (QBP Adoption Survey) **Experience of Care** • **Readmissions Within 30-Days for Selected HBAM Inpatient Grouper (HIG) Conditions** • **Percentage of Priority 2, 3, and 4 Cases Completed Within Access Target for: (CT, MRI, Hip, Knee)**, (additional Monitoring: cancer, cardiac, cataract) • Percent of Discharge Summaries Sent Within 48 Hours • *Percentage of Stroke Patients Receiving Care in a Designated Stroke Centre* • 90th Percentile Wait Time From Referral to Specialist Appointment for Primary Unilateral Hip/Knee Total Joint Replacement (wait 1) • **90th Percentile Length of Stay for Complex Patients** • **90th Percentile Length of Stay for Minor Uncomplicated Patients** • **Hospital Standardized Mortality Ratio** • Time to Inpatient Bed • Intensive Care Unit Avoidable Days • Percent of Life or Limb Transfers in 4 Hours **Value for Money** • **Health-Based Allocation Model (HBAM) Variance** • *Stroke QBP Actual Cost* • *Hip, Knee QBP Actual Cost vs QBP Price* • *Wait Times and QBP Volumes: Allocated versus Completed* • *Number of Acute Days Avoided By Supporting Medically Fragile In the Community*	Monitoring in place Monitoring in place Monitoring in place Monitoring in place Aligned to chronic disease Monitoring in place Monitoring in place NEW Monitoring in place In Development Monitoring in place Monitoring in place Monitoring in place Monitoring in place Monitoring in place In Development Monitoring in place NEW in development NEW In development Monitoring in place NEW In development

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

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

Initiative Status:

Initiative Code	IHSP Initiative/Sub-Initiative	Planned End Date	% Complete 2016/17	Status 2016/17
37	Clinical Services Planning: Develop a coordinated and standardized approach to the implementation of Quality Based Procedures (QBP), patient care planning, admission/discharge/transition processes and capacity planning across the continuum of care to ensure implementation of the recommendations related to Stroke (hospital and community based care) vision care, perinatal care and diagnostic imaging; including the development, implementation and spread of Integrated Funding Models (IFMs) based on experience from Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD).	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)
37.1	*Stroke Phase 1 - Implementation and Evaluation of Directional Recommendations*	March 31, 2018	80%	Execute
37.2	*Stroke Phase 2 - Community Capacity. Development and Implementation of Recommendations.*	March 31, 2019	25%	Plan
37.3	*Vision Care - Development of a case-based approach to clinical decision-making and coordination of care to people with complex eye problems and people with complex medical conditions*	May 31, 2016	100%	Closed - Monitored through Operations
37.4	*Vision Care - Development and testing of a process to collect pre- and post-cataract surgery visual acuity scores as a way to measure the clinical outcome of cataract surgery*	March 31, 2017	100%	Closed - Monitored through Operations
37.5	*Vision Care - Development and testing of a strategy to improve visual screening rates among people living with diabetes in the South West LHIN*	March 31, 2017	100%	Closed - Monitored through Steering Committee
37.6	*Regional Medical Imaging Integrated Care project*	March 31, 2018	35%	Execute
37.7	*Improvement of orthopaedic wait times (hip and knee): Collaboration between Orthopaedic Surgeons and hospitals through the Orthopaedic Steering Committee to identify and prioritize and implement key initiatives to improve wait times for elective hip and knee replacements*	March 31, 2018	10%	Plan
38	Waitlist Management Strategies: Implement a surgical eBooking, wait list management, automated (complex) Wait Time Information System (WTIS) reporting and pre-op standardization system. Investigate strategies to improve Wait 1 and Wait 2 in priority areas	March 31, 2019	See sub-initiative(s)	See sub-initiative(s)
38.1	*Cross-LHIN Implementation of Novari*	March 31, 2019	30%	Execute

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Ensuring timely access to hospital-based care, LHIN-wide, multi-community, and local level				
38.2	*Wait 1 strategies: Improve access to acute care services through primary care implementation of booking and scheduling of appointments in acute care; bring visibility to surgical waitlists in primary care offices with a focus on patient choice; investigate opportunities for improved waitlists through centralized booking/queuing*	March 31, 2019	0%	Not Started
39	Critical Care Strategy (Critical Care Services Ontario): Improve timely access and quality of care through capacity management through the Provincial Hospital Resource System (PHRS), sustainability of Life or Limb – No Refusal Policy, and implementation of clinical best practice guidelines.	March 31, 2017	100%	Closed - Monitored through Operations
40	Chronic Mechanical Ventilation (CMV) System of Care: Implementation of CMV recommendations across continuum of care (Acute, Sub-Acute, Community) and Long-Term Care (LTC) feasibility study, exploration of new service delivery models and standardize data capture and reporting.	March 31, 2017	See sub-initiative(s)	See sub-initiative(s)
40.1	*To document the barriers and resources required by LTC Homes to support residents with tracheotomies, chronic non-invasive mechanical ventilation (NIV) and/or cough assist; to develop strategies to address barriers and develop care processes to support solutions.*	March 31, 2017	100%	Closed - Monitored through Operations
40.2	*To establish a performance dashboard and sustainable reporting mechanisms related to healthcare provision and utilization among Long Term Mechanical Ventilation (LTMV) persons.*	March 31, 2017	100%	Closed - Monitored through Operations
40.3	*To investigate magnitude of need of CMV care in LTC Homes compared with other settings. Depending upon need identified, develop business case to outline related costs and decision algorithms.*	March 31, 2017	100%	Closed - Monitored through Operations
41	Senior Friendly Hospital Strategy: Grow and sustain Senior Friendly Hospital strategy (organizational support, processes of care, emotional and behavioral environment, ethics in clinical care and research, physical environment)	March 31, 2017	75%	Execute
42	Patient Flow Strategies: Optimize patient flow (access, efficiency, effectiveness) within and across Hospitals. through a targeted improvement approach including establishment of a Learning Collaborative to align with the Emergency Department (ED) pay for results and knowledge transfer sites to enable sustainability and spread of leading practices	March 31, 2018	80%	Monitor
43	Antimicrobial Stewardship: Create opportunities to spread best practices for antimicrobial stewardship across hospitals to reduce hospital acquired infections (e.g. Clostridium (C) difficile)	June 30, 2017	90%	Monitor

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

Enabling a rehabilitative approach across the care continuum

What are we trying to accomplish?

Supporting improved patient experiences, clinical outcomes, and transitions through improved access , efficiency, effectiveness, quality, integration, value and equity in the delivery of rehabilitative services across the care continuum

Outcome Objectives:	What will we measure to know we have been successful?	Monitoring Status:
Population Health • To improve early identification and intervention	**Population Health** • Number of Seniors Served (Stratification of Risk, Admission/ Readmission Rates) • LHIN-Wide Adoption of Provincially Standardized Definitions and Eligibility Criteria for Bedded Rehabilitation	In development In development
Experience of Care • To improve access to integrated systems of care for particular populations • To improve patient experience	**Experience of Care** • Falls in the Last 30-Days Among Long-Term Care Home Residents • Rate of Emergency Department Visits Resulting From Falls (Per 100,000 Population 65 and Over)	Monitoring in place Monitoring in place
Value for Money • To reduce unnecessary variation in service delivery • To improve service efficiency • To reduce unnecessary hospitalization	**Value for Money** • Percent Alternate Level of Care (ALC) Days/Rate (ALC Rehab) • **Length of Stay Efficiency for Inpatient Rehab** • Percent Eligible Patients in Rehab Beds • *Coordinated Access: Wait From Referral to Bed Acceptance/Decline*	Monitoring in place Monitoring in place Monitoring in place Monitoring in place

Initiative Status:

Initiative Code	IHSP Initiative/Sub-Initiative	Planned End Date	% Complete 2016/17	Status 2016/17
44	Falls Prevention Strategy: Support spread of the South West Falls Prevention Strategy including opportunities to meet Francophone needs.	March 31, 2017	100%	Closed - Monitored through Operations
44.1	*Creation of new Exercise & Falls Prevention classes in Retirement Homes (through Physiotherapy Reform)*	March 31, 2017	100%	Closed - Monitored through Operations

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

Enabling a rehabilitative approach across the care continuum				
45	Rehabilitation Capacity Plan and Implementation: Plan and implement the adoption of provincially standardized bedded rehabilitation definitions and eligibility criteria, and plan and implement a bedded rehabilitation capacity plan	March 31, 2019	25%	Plan
45.1	*The adoption of provincially standardized bedded rehabilitation definitions and eligibility criteria*	March 31, 2018	70%	Execute
45.2	*To plan and implement a bedded rehabilitation capacity plan.*	March 31, 2019	25%	Plan
46	Community Physiotherapy Reform: transition funding and accountability for publicly funded physiotherapy clinics from MOHLTC to LHINS.	March 31, 2018	0%	Not Started
47	Coordinated Access: Support ongoing implementation and improvement of Coordinated Access thru Community Care Access Centre (CCAC).	March 31, 2017	75%	Execute
48	Assess and Restore: Plan and implement the provincial Assess and Restore Guideline in collaboration with other LHINs and in alignment with Ministry of Health and Long-Term Care expectations	March 31, 2018	40%	Plan

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

Putting people with life-limiting illnesses and their families at the centre of hospice palliative care

What are we trying to accomplish?

To put individuals with life-limiting illnesses and their families at the centre of care to optimize their quality of life by improving equitable access to coordinated, effective, efficient quality services and supports.

Outcome Objectives:	What will we measure to know we have been successful?	Monitoring Status:
Population Health • To improve early identification and intervention • To reduce the burden of illness • To increase # of people receiving care in the community	**Population Health** • Average Palliative Performance Scale (PPS) on Admission to Residential Hospice • Average Length of Stay (LOS) in Residential Hospice	Monitoring in place Monitoring in place
Experience of Care • To increase access to inter-professional teams • To improve patient experience • To improve care coordination throughout the journey of care • To support patient choice in place of death	**Experience of Care** • **Percentage of Palliative Care Patients Discharged From Hospital With Home Support** • Percentage of Palliative Care Clients With Hospital Readmission Within 30-Days by Region by Fiscal Quarter • Percentage of Patients Dying in Their Place of Choice • *Deaths Supported in Long-Term Care* • *Source of Admission to Residential Hospice*	Monitoring in place In development Monitoring in place Monitoring in place Monitoring in place
Value for Money • To increase # of people receiving care in the community	**Value for Money** • Percentage of Complex Palliative Clients Supported by the South West Community Care Access Centre (CCAC) Who Died in Hospital • Percentage of Palliative Care Clients That Died in Hospital by Region by Fiscal Quarter • *Occupancy Rate in Residential Hospice Setting*	Monitoring in place Monitoring in place Monitoring in place

Initiative Status:

Initiative Code	IHSP Initiative/Sub-Initiative	Planned End Date	% Complete 2016/17	Status 2016/17
49	Integrated Hospice Palliative Care (HPC) System: Continue to develop an integrated system of HPC aligned with provincial Declaration of Partnership	March 31, 2020	See sub-initiative(s)	See sub-initiative(s)

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

Putting people with life-limiting illnesses and their families at the centre of hospice palliative care				
49.1	*Grey Bruce HPC Outreach: Establishment of the Grey Bruce Palliative Care Outreach Team as a secondary level consultation team providing support in home and community services in Grey and Bruce counties. Ongoing monthly monitoring of the program's identified performance indicators is in place and reported to the Grey Bruce HPC Collaborative.*	March 31, 2017	100%	Closed - Monitored through Steering Committee
49.2	*Oxford & Elgin HPC Outreach*	March 31, 2017	100%	Execute
49.3	*Huron Perth & London Middlesex HPC Outreach*	March 31, 2018	10%	Execute
49.4	*HPC Capacity Planning: Build and implement recommendations for bedded and non-bedded palliative resources in a variety of care settings*	March 31, 2019	50%	Execute
49.5	*HPC Education: Develop and implement a strategic approach to educating providers and communities about HPC*	March 31, 2018	35%	Execute
49.6	*Aboriginal Approach to HPC: In partnership with First Nations, Aboriginal, and Metis people plan and implement culturally safe approaches to Aboriginal Hospice Palliative Care*	March 31, 2017	75%	Initiate

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

APPENDIX C – Integration Activities

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

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
Access to Care: Complex Continuing Care / Rehabilitation Bed Realignment	As part of the Access to Care strategy to help people move out of acute hospitals and into other care settings as quickly, smoothly and safely as possible, the Complex Continuing Care and Rehabilitation (CCC/Rehab) initiative will ensure that these valuable services are provided consistently and equitably across the region. The CCC/Rehab initiative includes realignment of CCC/Rehab beds to support access and equity of care. The Rehabilitative Care Committee is doing further bedded and community capacity planning that will inform future realignment. The CCC/Rehab initiative also includes implementing coordinated access (CA) to CCC/Rehab level of care.	South West LHIN Facilitated Service Integration	This initiative will improve outcomes for patients and families, and for the health system as a whole. It will: • Develop the CCAC role as the one point of access so that patients/clients across the South West get the right care at the right time and place. • Ensure that admission to CCC/Rehab beds is based on consistent assessment processes and criteria. • Ultimately, this work will reduce wait times and improve utilization for CCC and rehab beds, and reduce the number of patients designated as ALC. • The goal is to provide the right care in the right place at the right time, which when combined with local strategies, is anticipated to reduce the volume of alternate level of care days in the long term and provide for the best possible outcomes for individuals and their families.	2014/15 – 2017/18 Bed realignment in Huron Perth was completed in 16/17. CA to CCC/Rehab level of care has been implemented throughout the South West LHIN with the exception of London Health Sciences Centre and St. Joseph's Health Care London (Parkwood) which are scheduled to implement the CCC pathway in 17/18. The Rehab pathway is TBD depending on results of the CCC work.
London Enhanced Crisis Services: MH&A Crisis Centre	Since the fall of 2012, community partners have been working together to develop a comprehensive community based crisis service and Crisis Center where services are co-located	Health Service Provider Initiated Service Integration	• Comprehensive community based crisis service to improve the client experience, better coordinate resources, streamline access to service, reduce ED repeat visits, reduce police intervention, and provide the right care at the right time in the right place	2012/13 – 2017/18

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
	and available 24/7. Building on the successful relationship with London Police Services, the partners are looking at the expansion of protocols to the Middlesex London Emergency Medical Services (MLEMS).		• Expansion of protocols and use of a detailed algorithm by MLEMS will divert individuals in need of crisis/emotional support to the Crisis Centre.	
Back Office Collaboration and Integration Project (BOCIP)	The BOCIP will focus on enabling effective and efficient use of system resources to achieve the highest quality back office services by identifying best practice parameters to inform provider back office operations. Phase 1 is complete. Phase II: Develop implementation plan and prioritize administrative Areas for all HSPs to move to minimum standards and best practices; Identification of Subject Area Experts (SME's) to assist with implementation strategies and reviewing best practices and minimum standards; Service Accountability Agreement (SAA) obligations regarding expectations for all HSPs to move towards minimum standards and best practices; LHIN and Steering Committee to assess status and identify any action/change requirements	South West LHIN Facilitated Service Integration	The objectives of the BOCIP project are to assist health service providers across the South West LHIN in achieving: • Improved accuracy and reduced errors related to reporting requirements • Improved trust, transparency and effective communication between and amongst Health Service Providers • Increase in cross sector relationships • To meet or exceed established leading practices within their organization • Increase business intelligence and decision making at the Health Service Provider level • Streamline processes and eliminate/reduce duplication	2015/16 - 2018/19
Integrated Funding Model: Connect Care to Home	Patients with moderate intensity needs related to COPD and CHF discharged home from LHSC will experience an integrated and coordinated system of care based	Integration through funding	• Improved quality outcomes for patients (e.g., keeping people at home, reducing ED visits, reducing readmissions, ALC) • Improved patient, caregiver, and provider experience • Improved efficiencies and value for money	2015/16 – 2017/18

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
	on evidence-based practice as they transition from hospital to the community for up to 60 days. Focused on integrating current hospital and CCAC funding, patients will be supported by an innovative eShift model that allows for remote monitoring of patients and other technology, 24/7 access to the clinical team, navigator, clinical care coordinator, dedicated home care provider, ambulatory clinics, and electronic medical record as well as connections with specialists and primary care.			
Palliative Care Integration	Realignment of current palliative care beds and resources from an acute setting at LHSC to a non-acute setting at Parkwood Institute, St. Joe's.	Health Service Provider Initiated Service Integration	• Right care in the right place at the right time: It has been identified that there are patients in acute care palliative care beds whose needs would be better met outside of acute care. The outcome of this will better align resources to needs of the patients. • Patient experience: The renovation will create 18 single rooms in a home or hospice-like environment overlooking the grounds at Parkwood Institute. This creates more privacy and a much more respectful, peaceful, patient-centered environment for patients and families.	2016/17 – 2017/18
Mental Health & Addictions Coordinated Access	MH&A providers in the South (Oxford, Elgin and Middlesex) are working collaboratively to implement a coordinated access model. The majority of elements are in place; monitoring, quality improvement and spread potential to continue into 2017/18.	Health Service Provider Initiated Service Integration	• Coordinated screening and intake process • Shared calendar using Connex Ontario • Coordinated waitlist relief strategies • Coordinated referral process(es) • Use of evidence based screening and assessment tools • One number: 24/7 phone, web chat and email service providing information, crisis and support line for people with mental health or addictions concerns including warm transfers to local crisis teams and electronic referrals to community MH&A agencies.	2014/15 – 2017/18

Initiative	Brief Description	Integration Type	Anticipated Impact	Est Timeline
			• Bilingual services • Possible growth of the model to other counties and/or LHINs	
Mental Health & Addictions (MH&A) Peer Support	Integration of peer support programs into lead MH&A organizations, at a sub-region level, to improve access to services and provide a better experience for clients with MH&A concerns by strengthening peer support services across the South West LHIN	HSP Initiated and South West LHIN Facilitated Service Integration	• Availability of peer support wherever individuals are in their recovery journey including locations such as the community, hospital, outpatients, work and school, as well as wherever they live - urban, rural or remote locations across the South West LHIN • Coordinated services and resources between peer support and other MH&A health providers • Defined peer support roles and formalized training standards and resources based on promising practices • Stabilized peer support services embedded in the MH&A continuum of care and within sustainable peer support hubs and organizations; Monitoring and evaluation of peer support services	2015/16 - 2017/18
Canadian Red Cross Assisted Living and Case Management services	Divestment of Canadian Red Cross run Assisted Living and Case Management (RAI CHA Assessor) services to other LHIN funded partners.	Health Service Provider Initiated Service Integration	• Sustainability of services • Operational efficiencies and better value for money • Better alignment with Lead Agency functions for client intake and assessment in Oxford and Elgin • Better integration of services • Patients should experience a seamless transition	2016/17 – 2017/18
Grey Bruce Mental Health & Addictions	Exploration of integration opportunities for LHIN-funded Community Mental Health and Addictions organizations in Grey Bruce	Health Service Provider Initiated Service Integration	• A more integrated system of mental health and addiction services for clients with improved access and navigation • Operational efficiencies • Reduced duplication • Improved performance	2016/17 – 2018/19

Performance Measurement Framework

Strategic Direction	Measure / Indicator 2016-17
1.0 Work with Partners to Provide Safe, High Quality Patient – Driven Care	1.1 We ensure a **Patient Centered** experience. **Indicator:** Patient/Caregiver overall rating of South West CCAC services (KPI 1) *Source: CCEE*
	1.2 We ensure **Safe**, high quality care. **Indicator:** Adverse Events (number) *Source: South West ETMS*
	1.3 We ensure **Access** to the right community-based care at the right time. **Indicator:** Adult Day Program Occupancy *Source: South West*
	1.4 Partnerships result in **Effective**, integrated solutions and improved clinical outcomes. **Indicator:** Home First impact measured by number of hospital days saved *Source: South West BI*
2.0 Great Place to Work	2.1 Employees are satisfied and engaged. **Indicator:** Full-time permanent voluntary staff turnover *Source: HROD*
	2.2 We support a healthy and safe work place. **Indicator:** Average of responses from three questions on the organization's Occupational Health and Safety Pulse Survey. *Source: HROD*
3.0 Use Resources Wisely	3.1 We ensure value for money, using the principles of economy, efficiency, and effectiveness to achieve our goals. **Indicator:** Balanced budget *Source: Finance*
	3.2 We are increasing productivity through innovation and technology. **Indicator:** Percentage of Purchased Service budget spent on Complex/Chronic *Source: South West*

Quality Plan

Please note that the Quality Improvement Plan(QIP), submitted annual to Health Quality Ontario is a part of the South West CCAC's Quality Plan

AIM	Measure / Indicator 2016-17
Safety	**(A)** Percentage of Adult Long-Stay Home Care Patients who Record a Fall on their Follow-up (RAI-HC) Assessment *Data Source: OACCAC - QIP Measure*
	(B) Percentage of Patients (Long-Stay) that have Medication Management Conducted at Transition *Data Source: RAI + Note Template*
Effective	**(C)** Avoidable Emergency Department Visits by CCAC Patients *Data Source: OACCAC - QIP Measure*
	(D) Avoidable Hospitalizations and Readmissions of CCAC Patients *Data Source: OACCAC - QIP Measure*
	(E) Percentage of Acute Alternate Level of Care (ALC) Days (Closed Cases) *Data Source: MSAA*
	(F) Alternate Level of Care (ALC) Rate *Data Source: MSAA*
	(G) Number of Care Conferences *Data Source: CHRIS Workloads + CCP*
	(H) Patients with MAPLe Scores High/Very High Living in the Community Supported by CCAC *Data Source: RAI + HCD*
Access	**(I)** Percentage of Patients Requiring Nursing Services that are seen within 5 Days of Service Authorization (patient choice is not included in calculations) *Data Source: CHRIS - QIP Measure*
	(J) Percentage of Complex Patients Requiring Personal Support Services that are seen within 5 Days of Service Authorization (patient choice is not included in calculations) *Data Source: CHRIS - QIP Measure*
	(K) 90th Percentile Wait Time from Hospital Discharge to Service Initiation (hospital setting) *Data Source: MSAA*
	(L) 90th Percentile Wait Time from Home Care Services – Application to First Service (community setting) *Data Source: MSAA -*
	(M) Percentage of Palliative Patients who have Identified a Location of Choice *Data Source: EOL Referral Code in CHRIS*
	(N) Percentage of Palliative Patients who Identified a Location of Choice who Actually Died in their Location of Choice *Data Source: EOL Referral Code in CHRIS - QIP Measure*
	(O) Adult Day Program Occupancy *Data Source: MSAA*
Patient-Centered	**(P)** Patient and Caregiver Overall Rating of South West CCAC Services *Data Source: KPI 1 from CCEE – QIP Measure*
	(Q) Patient and Caregiver Overall Rating of Facilitation of Care by Care Coordinator *Data Source: KPI 5 from CCEE*
	(R) Patient and Caregiver Overall Satisfaction with Connection to Community Services *Data Source: KPI 6 from CCEE*