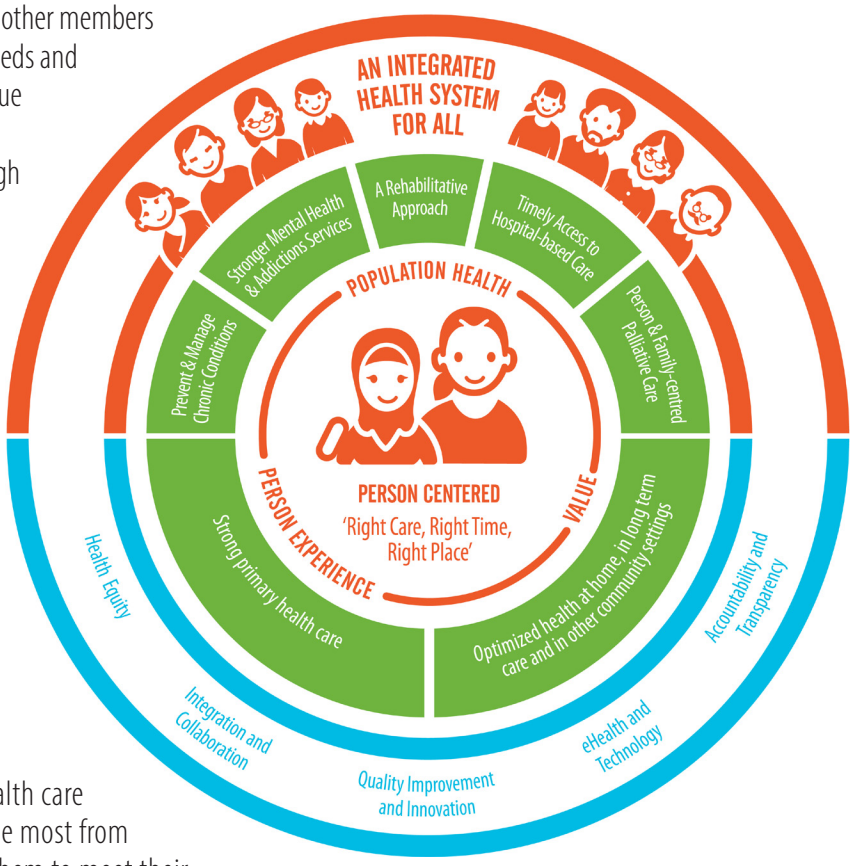
An integrated system of care for all in the South West LHIN

After listening to those people who use the health system as both patients and caregivers, health service providers, local networks, municipal leaders and other members the public, we designed a plan that is intended to reflect the needs and future directions of the health system. We are pleased to continue enhancing the health system to better meet the needs of our patients, clients and residents across our geography. And through a shared commitment, we will have quality care, improved health, and better value in all of our communities.

The South West LHIN is also committed to working with the government in its proposed plan for structural reform outlined in the discussion paper Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario while ensuring the continued delivery of high quality care to the people in our LHIN.



A population health approach

Since the LHIN's inception, it has focused on specific populations that have a greater need for many different health care resources and services. These are the people who benefit the most from having care providers that work with each other and with them to meet their needs and preferences. This includes the following priority populations:

- Aboriginal populations
- Francophone populations
- People living with or at risk of chronic disease(s)
- People living with mental health and/or addiction issues
- People who are frail and/or have medically complex conditions/disabilities

VISION:

A health system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren

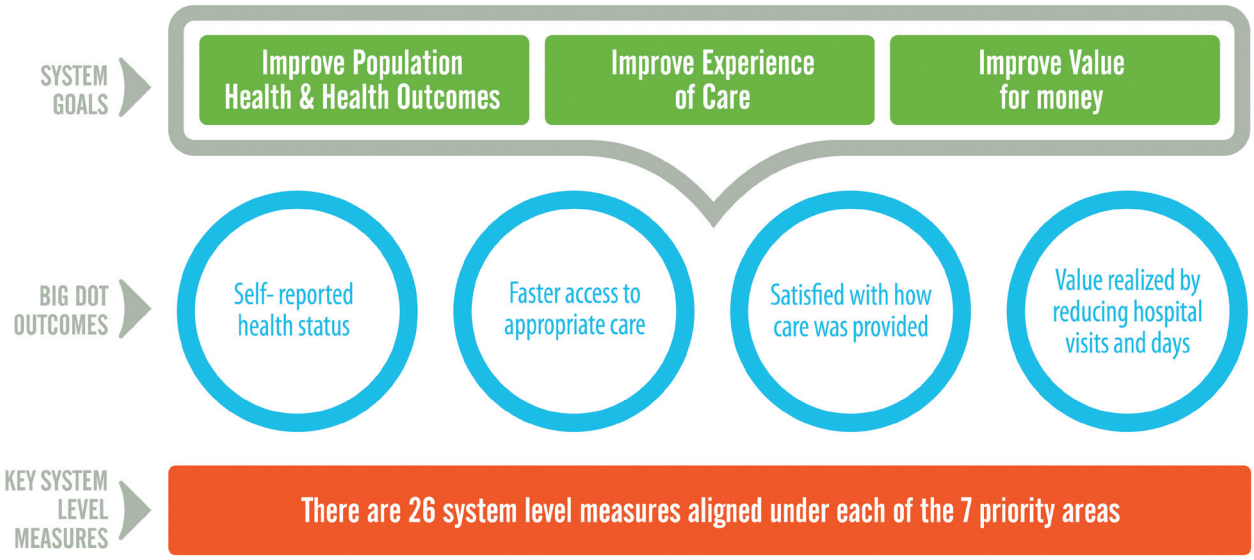
MISSION:

The South West LHIN is accountable for bringing people and organizations together to build a health system that balances quality, access and sustainability to achieve better health outcomes

VALUES:

Compassion, Courage, Evidence-Informed, Innovation, Integrity, Trust and Respect, Culture and Diversity

Measuring Success



How will we know we have been successful?

Stronger primary health care that is linked with the broader health care system

- Faster access to primary care when you are sick.
- Fewer visits to the Emergency Department for conditions that are better managed in primary care.
- More people see their primary care provider following discharge from hospital.

Optimized health for people and caregivers living at home, in long-term care and in other community settings

- Faster access to care provided by personal support workers and nursing in the community.
- Fewer people waiting in the hospital for care in the community.

Stronger mental health and addiction services and relationships with other partners

- Fewer people returning to the Emergency Department due to better connections to community supports.
- Fewer people needing to be hospitalized for mental health conditions.
- Fast access to mental health care in the community.

Supporting people in preventing and managing chronic conditions

- Improved transitions of care following a hospital stay.
- Fewer people need to be hospitalized for chronic conditions.

Timely access to hospital-based care at the LHIN-wide, multi-community, and local level

- Faster access to care in Emergency Departments.
- Faster access to surgical and diagnostic procedures.
- Improved cost alignment to provincial standard.

A rehabilitative approach across the care continuum

- More people able to access rehabilitative services to maximize recovery.

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

- More people with palliative care needs being supported at home.