Hamilton Niagara Haldimand Brant
Local Health Integration Network

Minutes of the Business Meeting of the Board of Directors January 27, 2016

A meeting of the Board of Directors of the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) was held on January 27, 2016, at the Boardroom, Hamilton Niagara Haldimand Brant Local Health Integration Network, 264 Main Street East, Grimsby, Ontario, and beginning at 4:00 p.m.

Present:	Michael P. Shea, Board Chair Ruby Jacobs, Vice Chair Laurie Ryan-Hill, Member Mervin Witter, Member Helen Mulligan, Member Bill Thompson, Member
Regrets:	Dominic Ventresca, Member
HNHB LHIN Staff in Attendance:	Donna Cripps, CEO Helen Rickard, Corporate Coordinator, Recording Secretary Steve Isaak, Director, Health System Transformation Jennifer Everson, Physician Lead Derek Bodden, Director, Finance Rosalind Tarrant, Director, Access to Care Emily Christoffersen, Director, Quality & Risk Management Linda Hunter, Director, Health Links and Strategic Initiatives Trish Nelson, Director, Communications, Community Engagement and Corporate Services
Guests:	Mustafa Hirji, Associate Medical Officer of Health, Region of Niagara Jennifer Sharron, Manager, Infectious Disease, Region of Niagara Chris Gaspar, Manager, Environmental Health, Region of Niagara Dr. Carolyn Gosse, Director, Clinical Programs, St. Joseph's Healthcare Hamilton Winnie Doyle, Vice President of Clinical Services and Chief Nursing Executive, St. Joseph's Healthcare Hamilton Susan Hollis, Vice President, Business and Therapeutic Services and Chief Financial Officer Ralph Meyer, Vice President, Oncology and Palliative Care, Hamilton Health Sciences – Regional Vice President, Cancer Care Ontario Taralea McLean, Executive Director, Bridges Community Health Centre

A. Convening the Meeting

A.1 Call to Order

A quorum was present.

A.2 Approval of the Agenda

MOVED: Bill Thompson
SECOND: Laurie Ryan-Hill

That the agenda of January 27, 2016, be adopted, as circulated.

CARRIED

A.3 Declaration of Conflicts

No conflicts were identified at this time.

B. Education Session

B.1 Region of Niagara Public Health Unit Report

(**Appendix 1** appended to original set of minutes)

Key Points of Discussion:

- An overview was provided of the Niagara Public Health Unit on their outbreak management program.
- It was noted that the definition of an outbreak is set by the MOHLTC and that it is the reporting of two to three cases of illness with same the same symptoms within a specified period of time. It was also mentioned that an outbreak has ended once no new symptoms have been identified within a specific time period.
- It was noted that those Long-Term Care Homes that implemented additional cleaning programs saw a decrease in outbreaks.

B.2 Update on Integrated Comprehensive Care 2.0 Project

(**Appendix 2** appended to original set of minutes)

Key Points of Discussion:

- The goal of the Integrated Comprehensive Care Project is to provide a care plan that is seamless to the patient, resulting in a quality outcome for the patient by keeping the patient at home, reducing emergency department visits, and reducing readmissions.
- HNHB LHIN has spread this model across all HNHB acute care hospital sites with a target population of focus being hospitalized patients with a diagnosis of Chronic Obstructive Pulmonary Disease and Congestive Heart Failure.
- Patients receive 24/7 availability to an Integrated Comprehensive Care Team Member LHIN wide.
- It was noted that this program was implemented with no additional funding from the HNHB LHIN.

C. Minutes of the Last Meeting

C.1 Approval of the Minutes of December 9, 2015

MOVED: Mervin Witter
SECOND: Helen Mulligan

That the minutes of the Board Meeting – Business of December 9, 2015, be adopted as circulated.

CARRIED

D. Reports

D.1 Report of the CEO

MOVED: Michael Shea
SECOND: Bill Thompson

That the Report of the Chief Executive Officer (CEO) be received and filed.

CARRIED

Key Points of Discussion:

- It was noted that we continue to receive Syrian Refugees into the Hamilton Niagara Haldimand Brant LHIN area. Within our LHIN we have received 593 refugees with the majority in Hamilton (530).
- An overview was provided on the MOHLTC Discussion Paper released on December 17, 2015 highlighting the objectives, outcomes, and proposed LHIN responsibilities.
- Information was provided on engagement sessions that will be reaching out to all HNHB LHIN Health Service Providers, Primary Care physicians, patients, care-givers, and the public.

D.2 Report of the Chair

MOVED: Mervin Witter
SECOND: Bill Thompson

That the Report of the Chair be received and filed.

CARRIED

Key Points of Discussion:

- Recognition was given to the Vice Chair whose term will be ending in March.
- The HNHB LHIN CEO Performance and Compensation Working Group will be meeting to discuss the CEO's past performance and the future expectations of the Board. Ratification of recommendations from the Working Group will come to the Board for decision in February.
- The Nominating Committee met on January 6, 2016 and one candidate has been selected for recommendation to the Minister for appointment.
- Discussion regarding succession planning has also taken place between the Board and at the Ministry and Public Appointment Secretariats office. A new posting for current and upcoming vacancies is currently on the Public Appointment Secretariats website.

- A meeting was held with Deloitte LLP regarding the HNHB LHIN Board Evaluation. There were no recommendations from the consultants for improvement to the HNHB LHIN Board.
- The Chair attended and brought greetings at the General Internal Medicine Rapid Assessment Clinic announcement at Joseph Brant Hospital on January 20, 2016.

D.3 Report of the Audit Committee Chair

MOVED: Michael Shea
SECOND: Helen Mulligan

That the Report of the Audit Committee Chair be received and filed.

CARRIED

The Audit Committee held a meeting on January 27, 2016. The minutes of the Audit Committee meeting of December 2, 2015, were approved by the Audit Committee for receipt by the Board of Directors.

MOVED: Laurie Ryan-Hill
SECOND: Helen Mulligan

That the minutes of the Audit Committee meeting of December 2, 2015, be received and filed.

CARRIED

Audit Plan Presentation

Steve Stewart from Deloitte LLP presented the Audit Service Plan for 2016. The 2015-16 Audit has been scheduled to begin on April 25, 2016. The Audit Service Plan provides information on the scope of the audit, areas of audit risk and more.

MOVED: Laurie Ryan-Hill
SECOND: Bill Thompson

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve the 2016 Audit Plan prepared by Deloitte LLP.

CARRIED

Funding Allocations:

Indigenous Cultural Safety Health Training

The need to improve access to culturally appropriate care and health outcomes for Indigenous Peoples has been identified in the Ministry of Health and Long-Term Care Patients First: Action Plan for Health Care, HNHB LHIN Strategic Plans, and key reports such as the Truth and Reconciliation Commission of Canada's Final Report and Calls to Action.

Since the launch of Ontario's Indigenous Cultural Safety (ICS) training in May 2014, a total of 2,020 individuals have completed the ICS training across all Ontario LHINs.

In October 2015, the HNHB Aboriginal Health Network endorsed the ICS training course as an effective first step towards improving mainstream health care professionals' ability to work more respectfully and effectively with Indigenous Peoples.

MOVED: Helen Mulligan
SECOND: Ruby Jacobs

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve up to:

- $40,000 one-time in 2015-16 to support Indigenous Cultural Safety Training for the Health Service Providers listed in Appendix A; and
- $75,000 one-time in 2016-17 to De dwa da dehs nye>s Aboriginal Health Centre to support Indigenous Cultural Safety Training for HNHB LHIN health service providers.

Appendix A

2015-16 Indigenous Cultural Safety Training by Health Service Provider

Health Service Provider Name	**Number of ICS Seats Allocated**	**Re-allocation Funds**
Brantford Community Healthcare System	15	$3,750
Diabetes Education Programs (supported by NH CHC)	15	$3,750
Hamilton Health Sciences Corporation	46	$11,500
Niagara Health System	10	$2,500
Norfolk General Hospital and West Haldimand General Hospital	44	$11,000
St. Joseph's Healthcare Hamilton	30	$7,500
Total Number of Seats	**160**	**$40,000**

CARRIED

Reallocation

This reallocation covers the in-year unspent one-time reallocations. The HNHB LHIN has identified $147,568 in unspent funds through the LHIN's second quarter in-year reallocation of unspent community funds.

Funding that is not utilized within the current fiscal year will be recovered by the Ministry of Health and Long-Term Care after year-end. The HNHB LHIN closely monitors LHIN health service providers' financial forecasts to enable the recovery and reallocation of unspent funds within the current year on a one-time basis.

MOVED: Laurie Ryan-Hill
SECOND: Helen Mulligan

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve the redistribution of in year unspent one-time reallocations as outlined in Table 1 for the 2015-16 fiscal year.

Table 1 – 2015-16 One-Time Funding Recommendations

LHIN Health Service Provider	***Recommended Funding***
Centre de santé communautaire Hamilton Wentworth Niagara Inc.	$ 60,000
North Hamilton Community Health Centre	$ 87,568
Total	**$147,568**

CARRIED

E. New/Other Business

E.1 Integrated Health Service Plan Update

MOVED: Michael Shea
SECOND: Ruby Jacobs

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve the 2016-19 Final Integrated Health Service Plan and forward to the Ministry of Health and Long-Term Care for approval.

CARRIED

Key Points of Discussion:

- The 2016-19 Integrated Health Service Plan is to be submitted to the Ministry of Health and Long-Term Care for approval and will be posted on the HNHB LHIN website once approved.

E.2 Hamilton Health Sciences Stem Cell Transplant Pre-Capital

MOVED: Michael Shea
SECOND: Bill Thompson

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network endorse the program and services component (Part A) of the pre-capital submission for the proposed Hematopoietic Cell Therapy expansion, and forward it to the Ministry of Health and Long-Term Care.

CARRIED

Key Points of Discussion:

- Cancer Care Ontario has recommended physical space expansion to meet the current critical needs for the next three years to accommodate both inpatient and outpatient specialized facilities.
- This expansion to Juravinski Hospital Cancer Centre would see an additional 22 patient cases completed supporting a cumulative total of an additional 65 patients compared to fiscal year 2015-16.

E.3 Bridges Community Health Centre Relocation

MOVED: Mervin Witter
SECOND: Helen Mulligan

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network endorses the programs and services component (Part A) of the pre-capital submission from the Bridges Community Health Centre and forward to the Ministry of Long-Term Care

CARRIED

Key Points of Discussion:

- The Port Colborne location is currently being leased with an expiry date of October 31, 2017. The submitted proposal is to support the relocation of the current Port Colborne site to a new and safer facility nearby. There is no change to programs, services or budget anticipated.
- No capital funding is being requested of the HNHB LHIN or the ministry.

E.4 Long-Term Care Service Accountability Agreement 2016-19

MOVED: Michael Shea
SECOND: Ruby Jacobs

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network approve:

1) The LHIN's use of the draft 2016-19 Long-Term Care Service Accountability Agreement (LSAA) templates (both single and multi-home formats) as presented;

2) Authorize the Board Chair and LHIN CEO to execute LSAAs on behalf of the LHIN provided that each execution version of the LSAA is substantially the same as the draft templates attached to the minutes of this meeting.

CARRIED

Key Points of Discussion:

- It was noted that the multi-home template agreement is new for the 2016-19 agreement, and is aimed to reduce administrative burden and enhance efficiencies for all parties.

F. Closed Session

MOVED: Michael Shea
SECOND: Bill Thompson

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network move to a closed session at 6:04 p.m. to review/approve the closed minutes of October 28, 2015, to discuss a matter of personal and public interest.

CARRIED

F.1 Report of the Chair on the Closed Session

During the closed session, the Board discussed a matter of personal and public interest.

MOVED: Mervin Witter
SECOND: Ruby Jacobs

That the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network moved to a closed session at 6:04 p.m. to review/approve the closed minutes of October 28, 2015, to discuss a matter of personal and public interest and returned to an open session at 7:15 pm.

CARRIED

G. Adjournment

The Board of Directors – Business meeting be adjourned at 7:20 p.m.

Original Signed by: February 24, 2016

Michael P. Shea, Chair **Date**

Original Signed by: February 24, 2016

Donna Cripps, Corporate Secretary **Date**

Outbreak Management Quality Improvement Initiative

LHIN Board of Directors

January 27, 2016

Presenters

M. Mustafa Hirji
Associate Medical Officer of Health

Jennifer Sharron
Manager, Infectious Disease Program

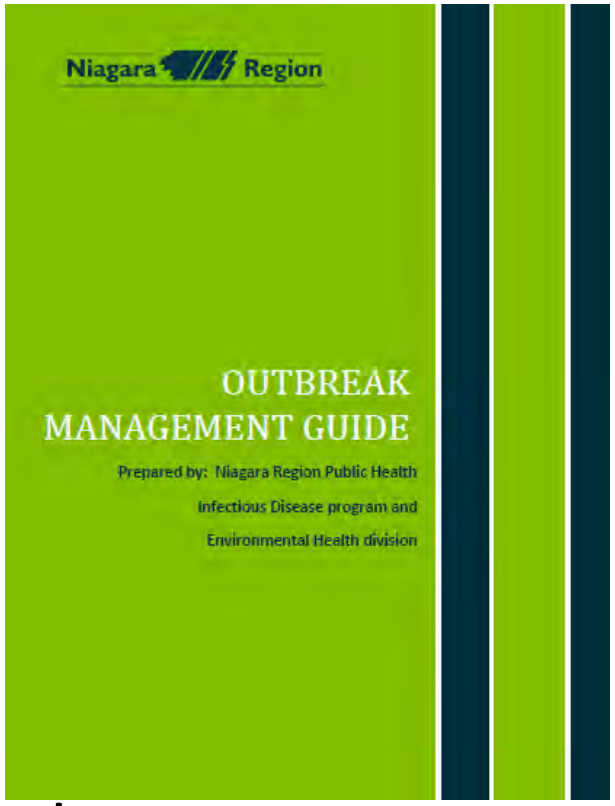
Chris Gaspar
Manager, Environmental Health (Infection Control)

Legislation—Public Health Responsibilities

- Health Protection & Promotion Act
- Immunization of School Pupils Act
- Smoke Free Ontario Act
- Mandatory Blood Testing Act
- Skin Cancer Prevention Act
- Safe Drinking Water Act
- Homes for Special Care Act
- Long Term Care Homes Act
- Child Care and Early Years Act
- Retirement Homes Act

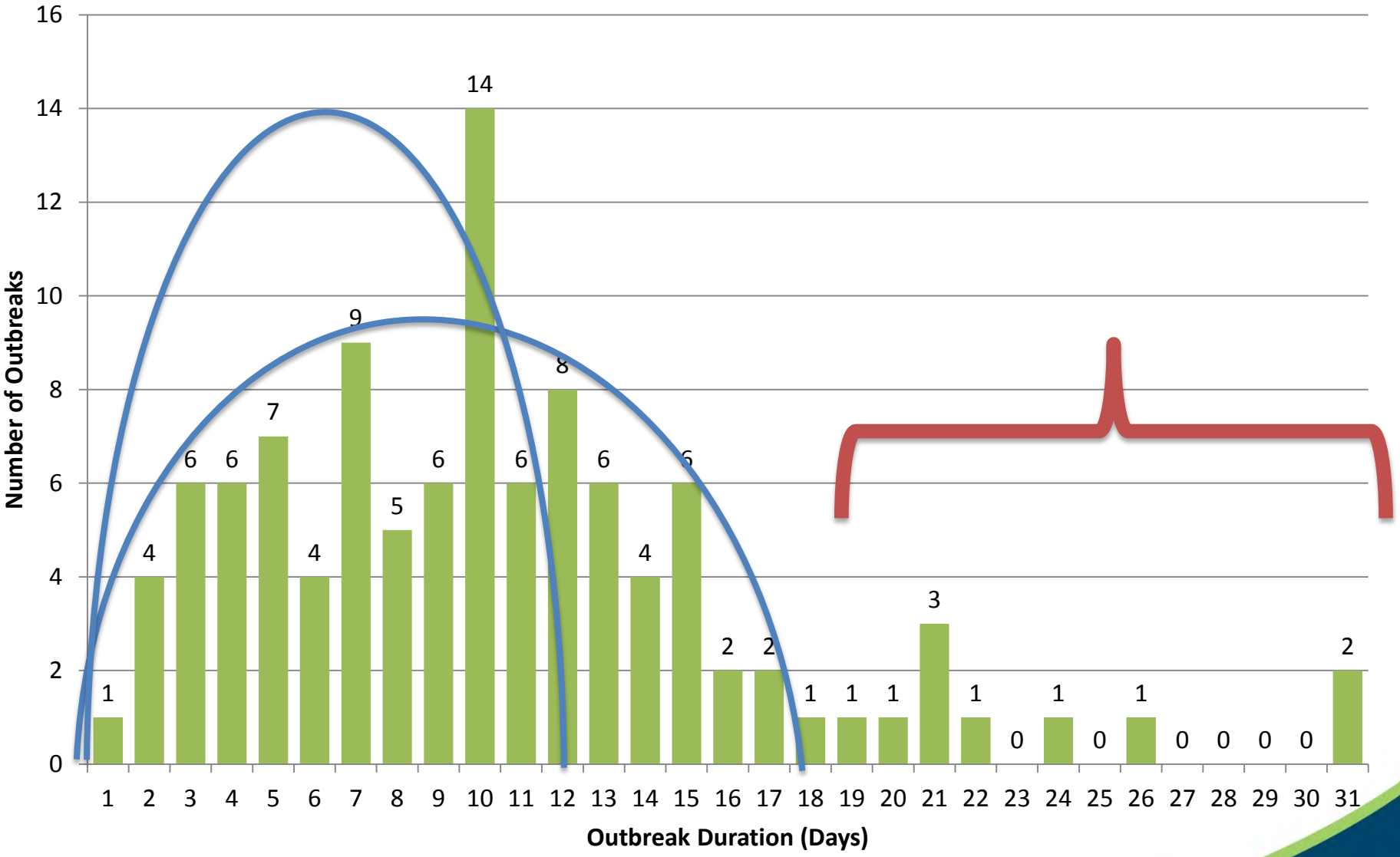
Roles in Long-Term Care Homes

- Food Safety
  - Food handler training
  - Inspections
- Infection Prevention & Control
  - Inspections
  - Education
- Outbreaks
  - Outbreaks legally must be reported
  - Support in managing outbreaks



	Number of Outbreaks	Residents Affected	Staff Affected
2009–2010	35 21 Enteric 14 Respiratory	961 (~27 people/outbreak)	433 (~12 people/outbreak)
2010–2011	31 6 Enteric 25 Respiratory	493 (~16 people/outbreak)	173 (~6 people/outbreak)
2011–2012	45 19 Enteric 26 Respiratory	1,022 (~23 people/outbreak)	403 (~9 people/outbreak)
2012–2013	52 20 Enteric 32 Respiratory	1,047 (~20 people/outbreak)	412 (~8 people/outbreak)
2013–2014	40 15 Enteric 25 Respiratory	644 (~16 people/outbreak)	241 (~6 people/outbreak)

Outbreak Durations (All Types) July 2012 - June 2014



Niagara Region

Outbreak Quality Improvement Initiative

1. Increased outbreak management support for LTCHs

2. Outbreak Management Dashboard

3. Debrief meeting with LTCH after each outbreak

Prevention	Staff Influenza Immunization Coverage
Surveillance	Days to declare outbreak
Infection Control	Environmental checklist
	Resident Attack Rate
	Staff Attack Rate
Outcome	Length of Outbreak

Niagara Region Public Health Outbreak Management Dashboard

Date:
Facility:
Outbreak Number:
Outbreak Type:
Aetiologic Agent:

	Key Performance Indicator		Current Performance	Indicator Status: Target (Green)	Indicator Status: Fair (Yellow)	Indicator Status: Alert (Red)	Comparator Performance*: Facility (Historical)	Comparator Performance*: All LTCFs in Niagara
1	**Length of Time to Report the Outbreak to Niagara Region Public Health** (days)			< 2.0	2.0 - 4.0	> 4.0		3.6
2	**Environmental Health Checklist Score**			> 13.0	11.0 - 13.0	< 11.0	*Unavailable*	*Unavailable*
3 a)	**Resident Attack Rate** (%) - Facility			< 10.0	10.0 - 20.0	> 20.0		18.3
b)	**Resident Attack Rate** (%) - Affected Area			*TBD*	*TBD*	*TBD*	*Unavailable*	*Unavailable*
4	**Staff Attack Rate** (%)			< 5.0	5.0 - 10.0	> 10.0		6.1
5	**Staff Influenza Immunization Coverage Rate** (%)			> 95.0	80.0 - 95.0	< 80.0		47.8
6	**Duration of Outbreak** (days)	Enteric		< 10.0	10.0 - 14.0	> 14.0		14.8
		Respiratory		< 10.0	10.0 - 18.0	> 18.0		18.5

*Comparator performance calculated based on five-year average (2009-2013)

Niagara Region

Improvement in 2014–2015

Metric	2014–2015	5 Year Historical	Target
Staff Influenza Immunization			
Days to declare outbreak			
Environmental checklist			
Resident Attack Rate			
Staff Attack Rate			
Length of Outbreak (Enteric)			
Length of Outbreak (Respiratory)			

Improvement in 2014–2015

Metric	2014–2015	5 Year Historical	Target
Staff Influenza Immunization		47.8%	95%
Days to declare outbreak		3.6 days	< 2 days
Environmental checklist		--	13
Resident Attack Rate		18.3%	< 10%
Staff Attack Rate		--	--
Length of Outbreak (Enteric)		14.8 days	< 10 days
Length of Outbreak (Respiratory)		18.5 days	< 10 days

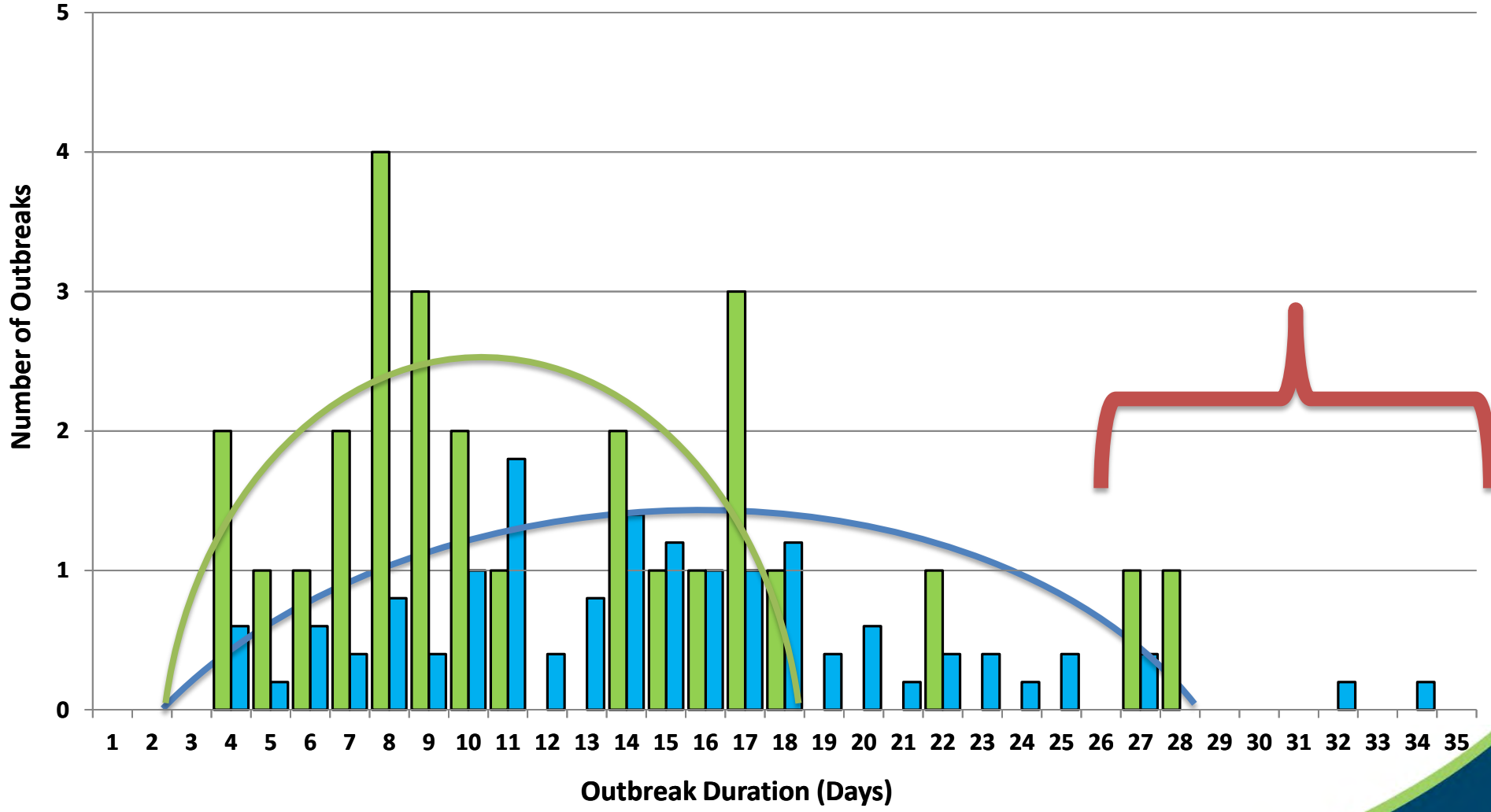
Improvement in 2014–2015

Metric	2014–2015	5 Year Historical	Target
Staff Influenza Immunization	58.3%	47.8%	95%
Days to declare outbreak	2.5 days	3.6 days	< 2 days
Environmental checklist	15.9	--	13
Resident Attack Rate	15.5%	18.3%	< 10%
Staff Attack Rate	30.8%	--	--
Length of Outbreak (Enteric)	12.1 days	14.8 days	< 10 days
Length of Outbreak (Respiratory)	15.6 days	18.5 days	< 10 days

Improvement in 2014–2015

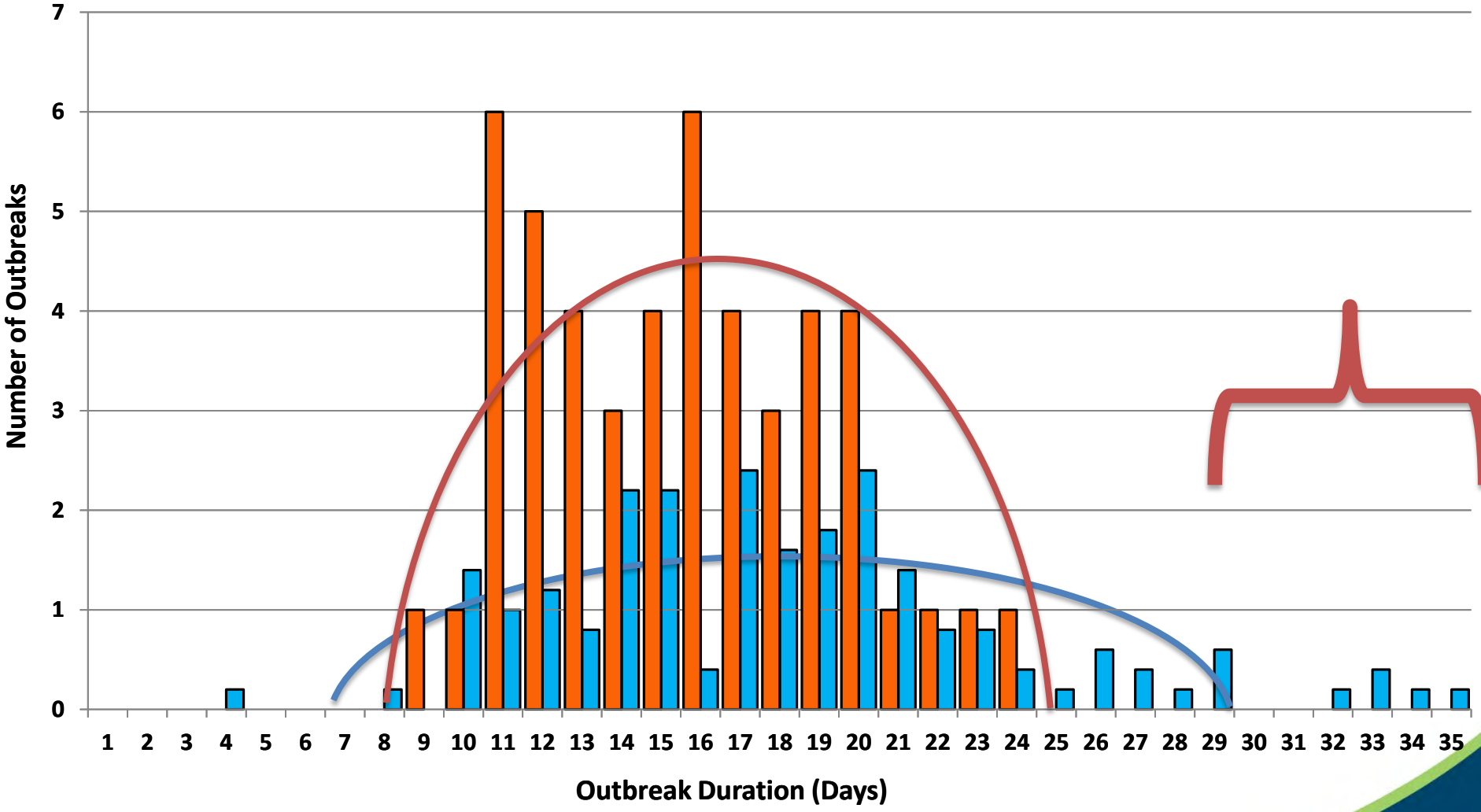
Metric	2014–2015	5 Year Historical	Target
Staff Influenza Immunization	58.3% (+10.5%)	47.8%	95%
Days to declare outbreak	2.5 days (-1.1 days)	3.6 days	< 2 days
Environmental checklist	15.9	--	13
Resident Attack Rate	15.5% (-2.8%)	18.3%	< 10%
Staff Attack Rate	30.8%	--	--
Length of Outbreak (Enteric)	12.1 days (-2.7 days)	14.8 days	< 10 days
Length of Outbreak (Respiratory)	15.6 days (-2.9 days)	18.5 days	< 10 days

Outbreak Duration - ENTERIC



Niagara Region

Outbreak Duration - RESPIRATORY



Niagara Region

Highlights from Evaluation

- Improved communications, strengthened relationships

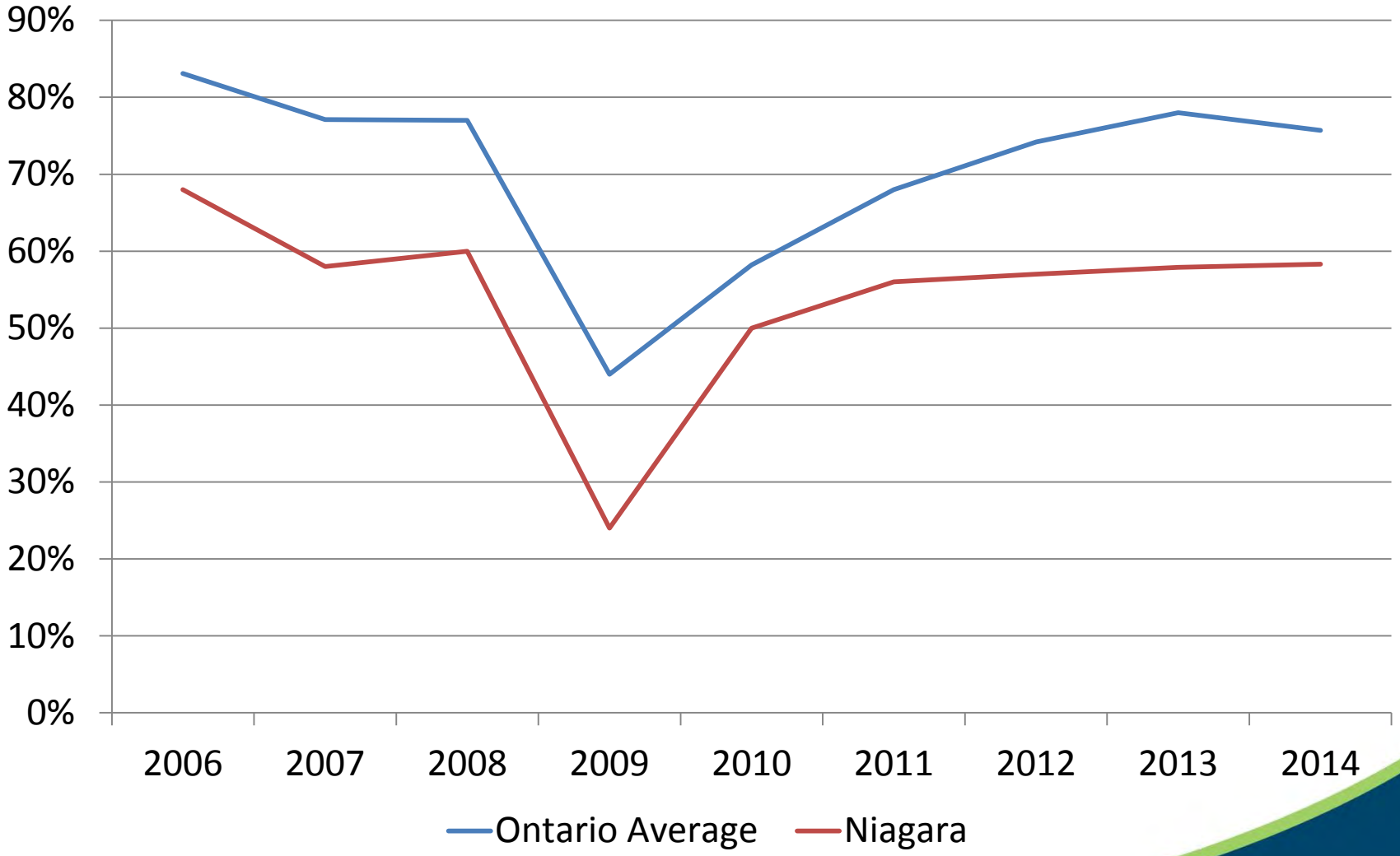
- Identifying improvements in infection control and outbreak management, especially surveillance

- On-site support and debrief were helpful

Improvements Planned

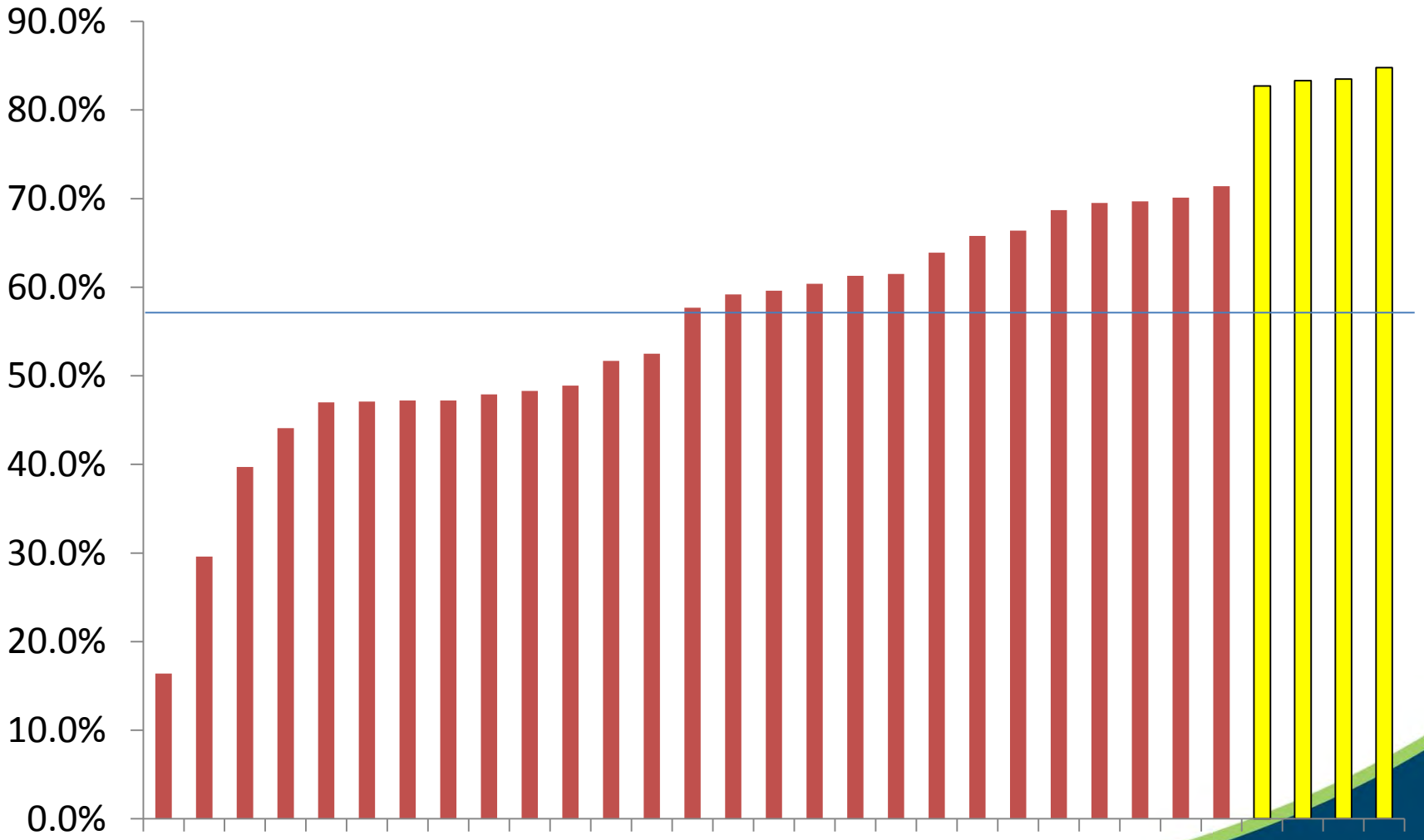
- Environmental health checklist
  - Inclusion of food inspections findings for enteric outbreaks
- Identify learnings from homes that consistently have the best metrics
- Identify new supports, especially for influenza vaccination

Staff Influenza Vaccination



Niagara Region

2014-2015 LTCF Influenza Vaccination



Niagara Region

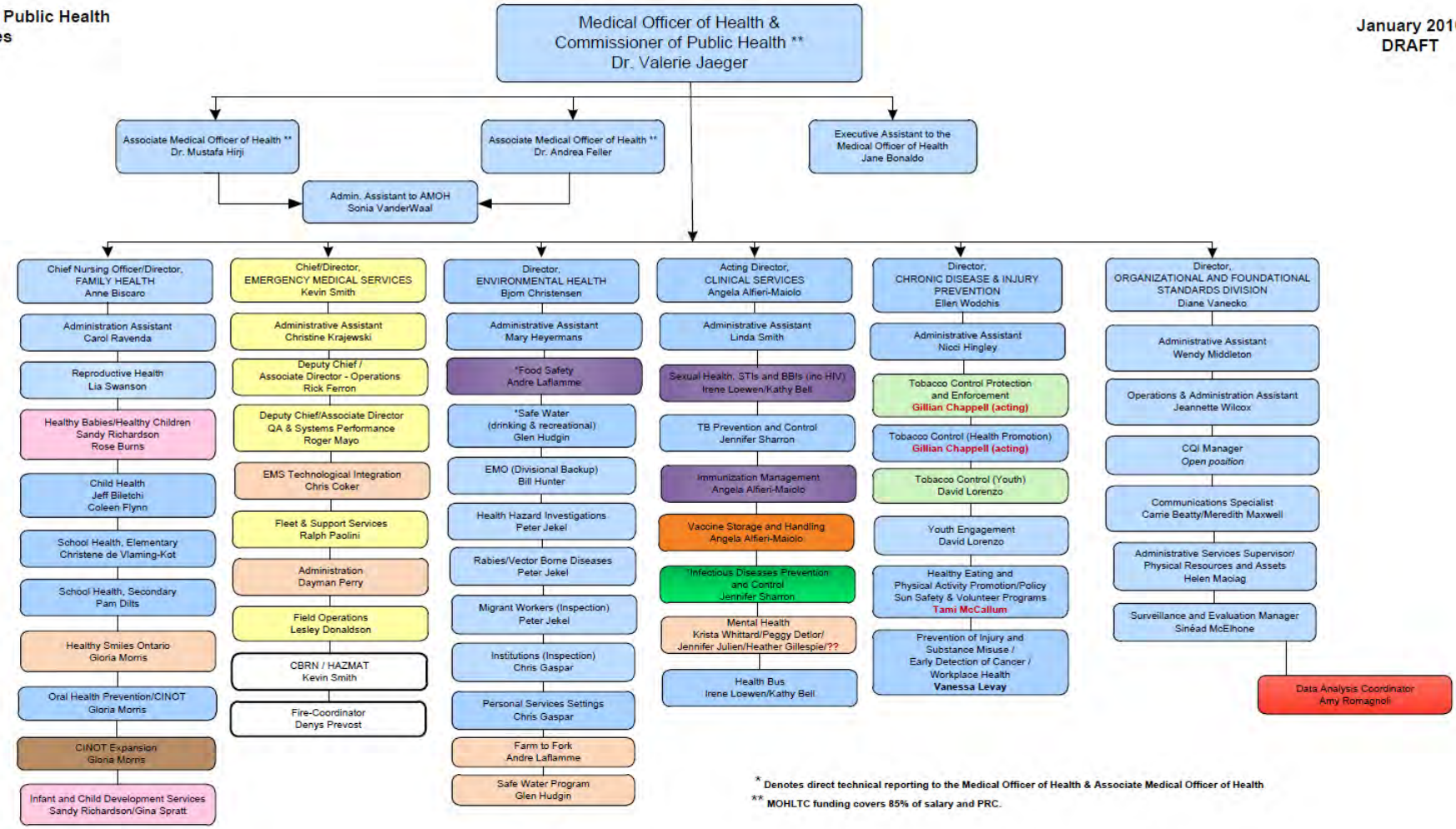
Expansion of Initiative

- Retirement Homes
- Child Care Facilities

	Number of Outbreaks	Residents Affected	Staff Affected
2010–2011	7 2 Enteric 5 Respiratory	108 (~15 people/outbreak)	29 (~4 people/outbreak)
2011–2012	7 6 Enteric 1 Respiratory	192 (~27 people/outbreak)	70 (~20 people/outbreak)
2012–2013	23 10 Enteric 13 Respiratory	481 (~21 people/outbreak)	92 (~4 people/outbreak)
2013–2014	11 8 Enteric 3 Respiratory	234 (~21 people/outbreak)	81 (~7 people/outbreak)
2014–2015	22 7 Enteric 15 Respiratory	470 (~21 people/outbreak)	82 (~4 people/outbreak)

Niagara Region Public Health
Funding Sources

January 2016
DRAFT



* **Denotes direct technical reporting to the Medical Officer of Health & Associate Medical Officer of Health**

** **MOHLTC funding covers 85% of salary and PRC.**

- 100% Ministry of Children and Youth Services
- 75%/25% Public Health Division, MOHLTC
- 100% Health Promotion Division, MOHLTC
- 100% MOHLTC One-Time Funding
- 100% Ministry of Education Funding
- 100% Niagara Region
- 50%/50% MOHLTC
- 75%/25% Health Promotion Division, MOHLTC
- 100% MOHLTC
- 75%/25% MOHLTC & Fees Based
- Partially 100% MOHLTC and 75/25% MOHLTC & Fee Based

June 8, 201
Last revised d

Niagara Region

Ontario Public Health Standards

- The board of health shall **provide public health management of cases and outbreaks to minimize the public health risk in accordance with** the Infectious Diseases Protocol, 2008 (or as current); **the Institutional/Facility Outbreak Prevention and Control Protocol**, 2008 (or as current); and provincial and national protocols on best practices.

INTEGRATED COMPREHENSIVE CARE PROGRAM

ICC 2.0: HNHB LHIN Wide COPD and CHF Program

HNHB LHIN Board – January 27th, 2016

Ms. Winnie Doyle
Dr. Carolyn Gosse

Key Objectives of Integrated Funding Models

Objectives	Courses of action
Promote patient-centred care across the care continuum	Through establishing one plan of care that is entirely seamless to the patient
Improve quality and reduce unwanted or unwarranted variation of patient care pathways	Through adopting best practices based on clinical consensus and best available evidence provided by Expert Panels Through introducing outcome-based measures
Improved efficiency	Through more integrated use of resources
Inform policy	Through testing innovative delivery of bundled hospital and community-based care and integrated payment models focused on value

Achieving these objectives is expected to translate to the following **outcomes**:

- 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

ICC 2.0 Background

- St. Joseph's Health System (SJHS) piloted Integrated Comprehensive Care Program (ICCP) 2012

- HNHB LHIN partners approved by the MOH Integrated Funding Models Expression of Interest (EOI) to test innovative approaches to integrate funding over a patient's episode of care

- All selected project must use existing resources -no new funding for clinical care

- Critical to success is physician leadership and participation

Goals

- To establish a seamless patient centered care continuum from hospital to home, from both the patient and funders perspective

- To improve the patient experience by implementing the Integrated Comprehensive Care Program LHIN wide

- To improve quality outcomes and reduce unwanted or unwarranted variation in patient care pathways (reduced LOS, reduced ED Visits and unplanned hospital readmissions, improve productivity of hospital and homecare and reduce overall cost)

Goals

- To improve efficiency of the healthcare system by integrating resources across the continuum
- To inform policy by implementing the SJHS Integrated Comprehensive Care program scaled LHIN wide.
- To fully engage key stakeholders (e.g. physicians) and patients/family in the HNHB LHIN Integrated Comprehensive Care program.

ICC 2.0 EOI Proposal

- In HNHB LHIN COPD and CHF top reasons for hospitalization:
  - 9,157 ED visits and 4,514 discharges to home
  - 44% return to the ED in 60 days and 33% readmitted with 60 days

- HNHB LHIN Integrated Funding Model EOI - spread this model across all HNHB acute care hospital sites with the **target population of focus being hospitalized patients with a diagnosis of COPD and CHF discharged home requiring home support (~2388 patients annually)**

ICC 2.0 Key Principles

- **Scaling of the SJHS Integrated Comprehensive Care Program** to provide a centralized and accessible single model of care
- **Integrated Care Coordinators -** to manage the seamless care pathway across the continuum
- **Integrated Care Paths** to standardize care across LHIN hospitals and community care to minimize unwarranted variation, complications, and unnecessary health care resource utilization and ensure care is provided in the most cost effective setting
- **Lead Homecare Agency** to maximize continuity, expertise and efficiency
- **Strong Client Engagement** to improve health outcomes and develop personalized action plans

ICC 2.0 Key Principles

- **High Team Engagement** to ensure continuity of care and thorough assessment of patient needs over the care path
- **24/7 Availability** for patients to have access to an Integrated Comprehensive Care Team Member
- The Integrated Comprehensive Care Team will have **timely access** to **Medical Expertise** to prevent readmissions; and when admitted to maintain continuity of care
- Access to clinical information that is integrated across the continuum - **electronic Client Health Record**

HNHB Partner Organizations

- Brant Community Health System
- HNHB CCAC
- HNHB LHIN
- Haldimand War Memorial Hospital
- Hamilton Health Sciences
- Joseph Brant Hospital
- Norfolk General Hospital
- Niagara Health System
- West Haldimand General Hospital
- St. Joseph's Healthcare Hamilton & St. Joseph's Homecare
- HNHB Primary Care Lead, LHIN Zone Chiefs & Chair McMaster University Department of Family Medicine
- North Hamilton Community Health Centre
- Centre de Sante Communautaire
- Niagara Falls Community Health Centre

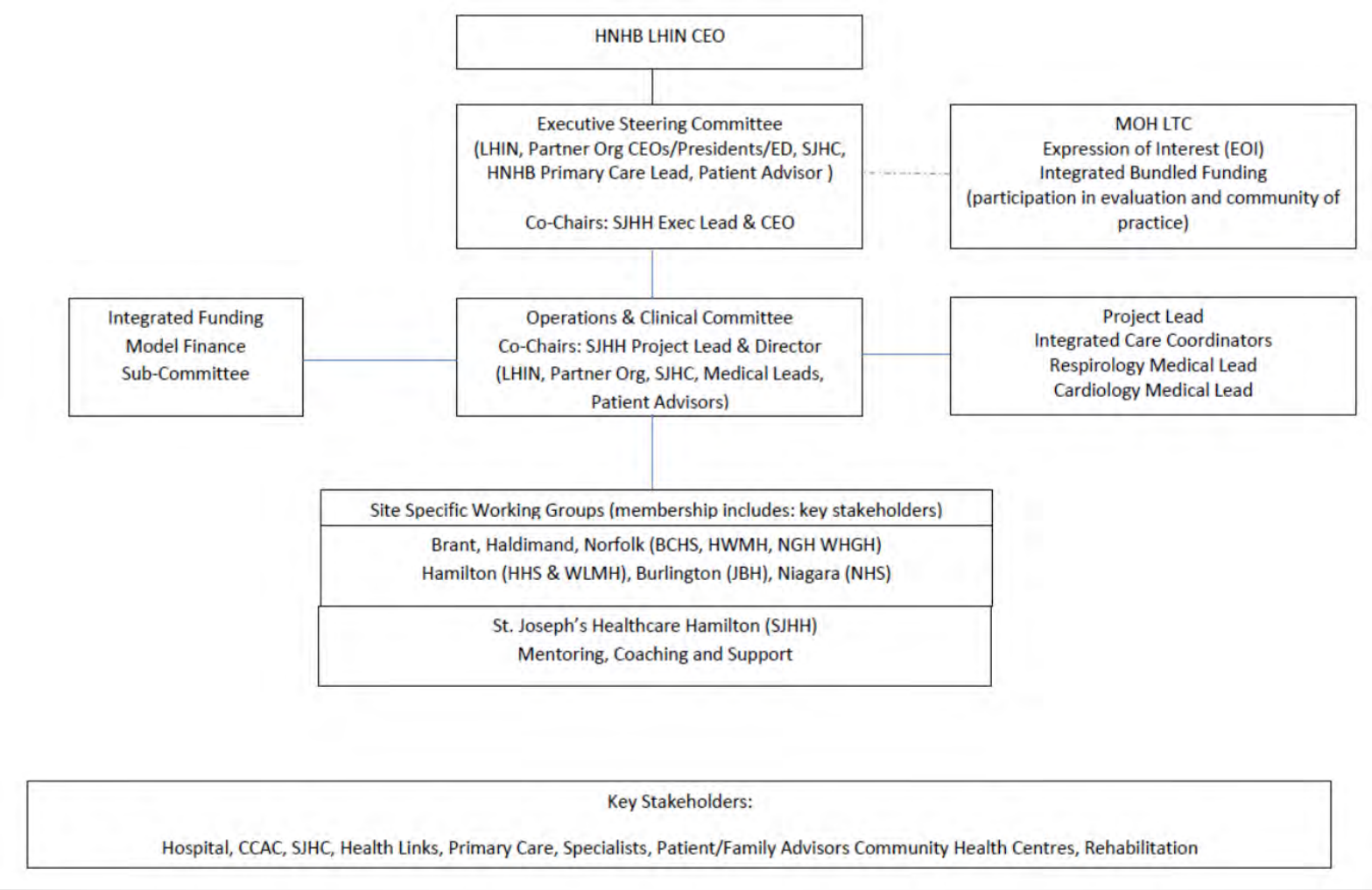
HNHB ICCP

- Governance Structure
  - ❑ Executive Steering Committee
  - ❑ Operations/Clinical Committee
    - Integrated Funding Model Finance Sub-Committee
    - Zone Working Groups (Burlington, Hamilton, South, Niagara)
  - ❑ HNHB COPD and CHF Physician Leads

- Phased approach
  - Burlington Zone (JBH)
  - Hamilton Zone (GEN, JH, WL)
  - South Zone (BCHS, NGH, HWMH, WHGH)
  - Niagara (NHS)

- Zone Planning
  - Formed working group with key partners
  - Current and Future State Mapping
  - Hospital Physician Lead(s) (COPD/CHF)
  - Integrated Care Coordinator(s)
  - Lead Home Care Agency

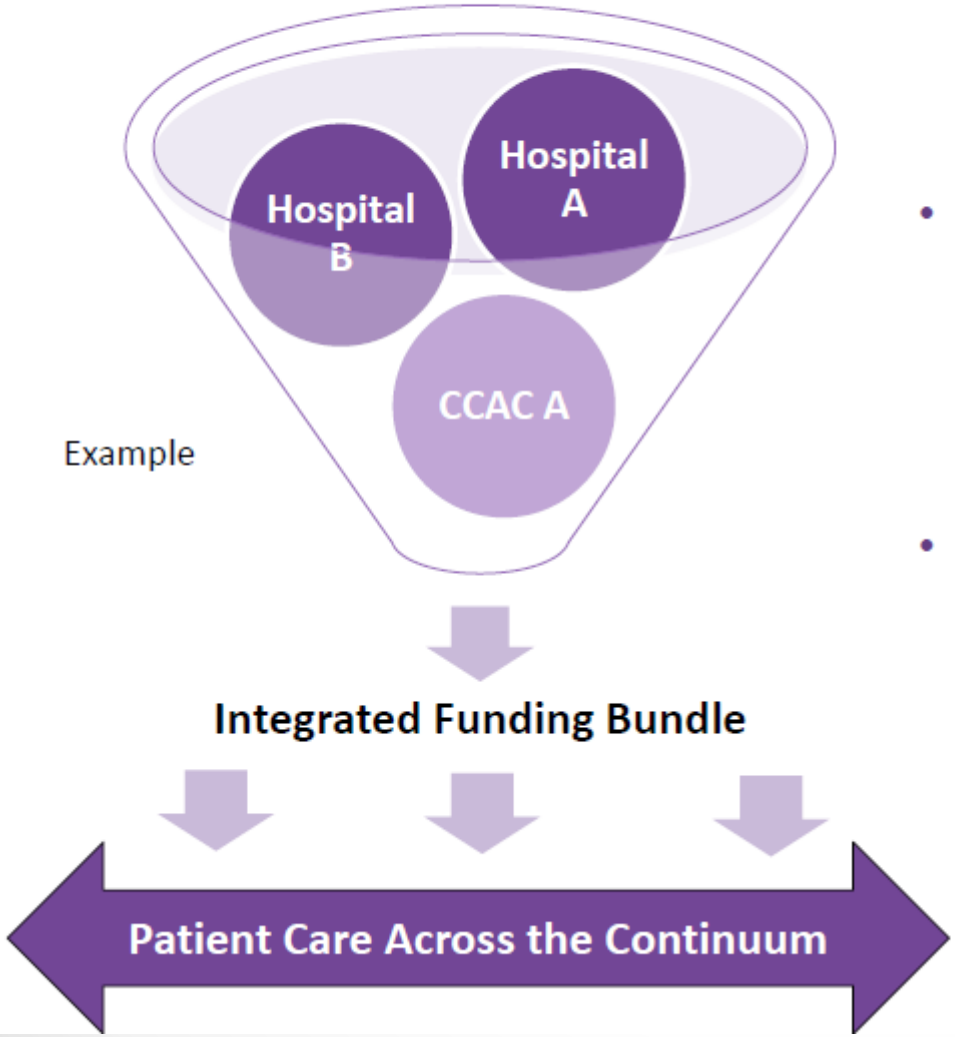
ICC Governance Structure



Accomplishments to date

Develop Governance Structure	
Approve Terms of Reference	
Approve Project Charter - V2 as per MOH	
Approve Communication Plan	
Approve Integrated Funding Model Principles	
Approve Home Care Model Principles	
Approve Metrics/indicators	
Identify key finance issues for LHIN and MOH	
Finalize phasing schedule	
IDEAS Team Accepted Application	
Approve HNHB ICC MOU	
Review CCAC and ICC Coordinator Roles	
Develop Integrated Funding Model	

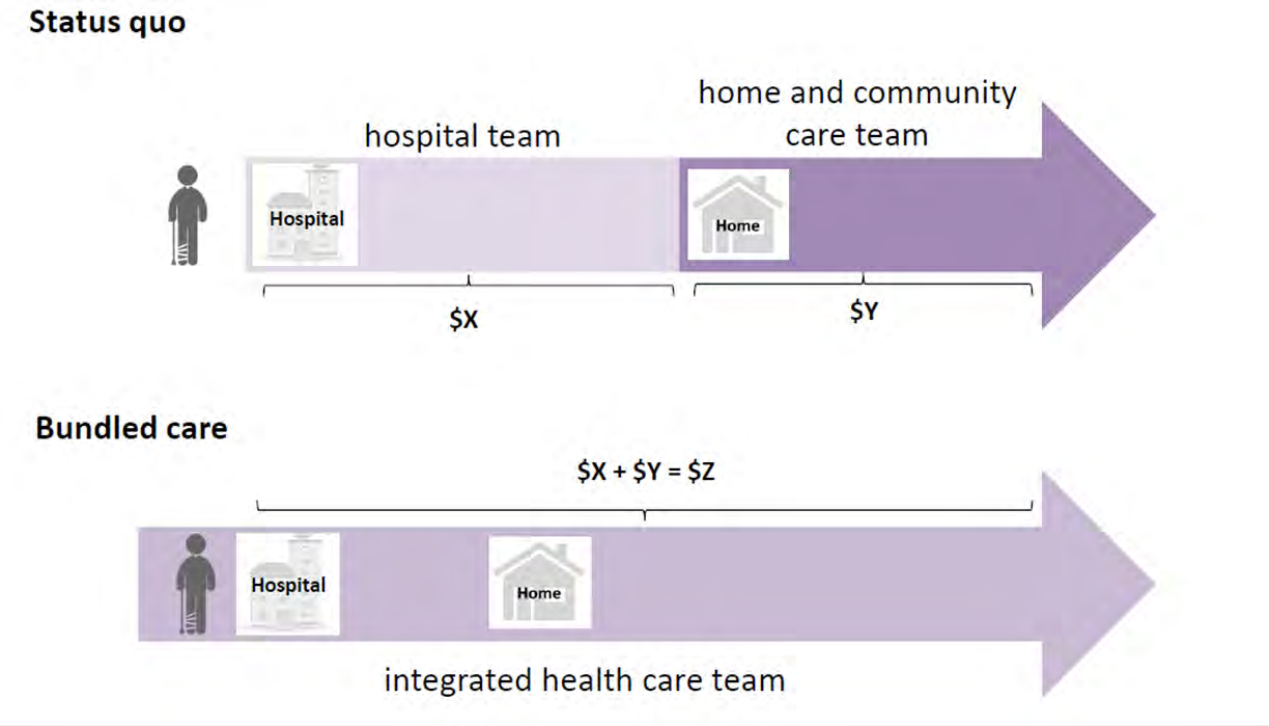
Creating the Integrated Funding Bundle



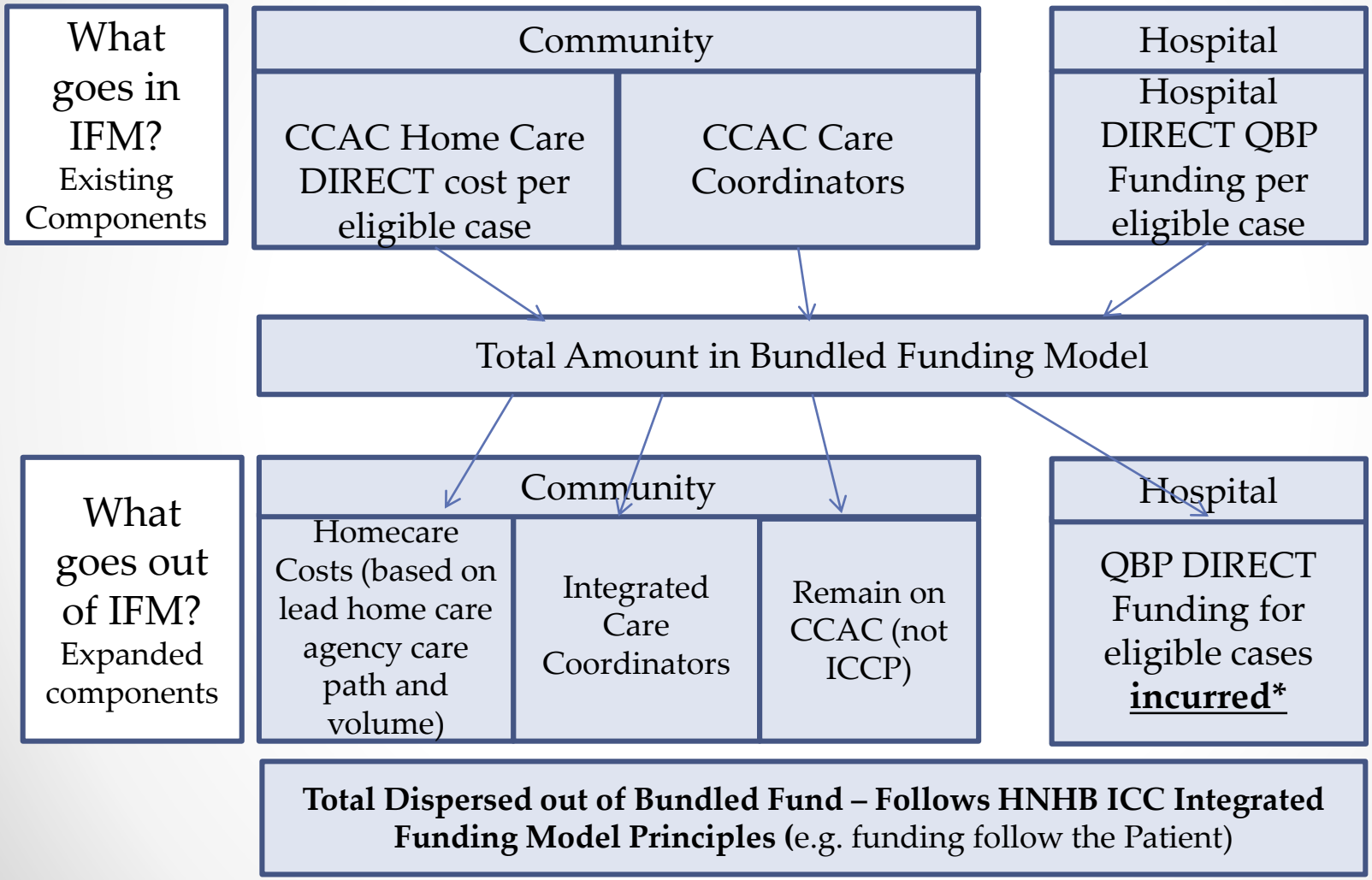
- The process of creating the bundle involves the pooling of funding that is currently used to treat the population involved in the project
- The pool of resources will be the Integrated Funding Bundle

Integrated Funding Model

- The ICC 2.0 will utilize existing funding across participating providers (hospital and CCAC) to develop the “integrated funding model”.
- Funding will follow the patient/client in the most efficient and client centered manner across the integrated continuum



ICC 2.0 Integrated Funding Model DRAFT v3



- July 30th – V3

*Costs incurred should incorporate savings in one day stay earlier discharge and reduction in readmissions (percent to be agreed upon)

Key Success Factors:

- Strong CEO and VP leadership + regular meetings to identify and address issues
- Finance and home Care Model Principles developed early on – ensured all partners were on same page conceptually
- Leverage experience, structures and expertise of SJHS team members (SJHH and SJHC)
- Primary Care Physician Lead – supporting physician engagement (hospital and community physicians)
- HNHB Physician Leads (COPD and CHF)
- MOH and LHIN support and leadership
  - Requirement of “bundle”
  - Low rules

Key Learnings:

- Partner organizations begin the project with varying levels of comfort with:
  - Open and transparent dialogue (vulnerability)
  - Tolerance for ambiguity and uncertainty
  - Trust
  - Shared risk (and shared gains)
- Change management strategies, communications and engagement are all key to support project partners through this process
- Can’t communicate enough

Benefits/Risks

- LHIN partners working together to deliver integrated care
- Testing spread and scale of ICC model of care across academic, community, rural, urban

- Achieving operational efficiency
- Carving out volumes/dollars – what is left behind
- Fidelity to key principles across all LHIN zones to test the ICC model
- Gain and risk sharing
  - Risk scenarios

Discussion and Questions

Appendix

ICC – High Level Process

1.0 Patient Screening → 2.0 ICC Program Intake → 3.0 ICC Planning/ Discharge → 4.0 Homecare Support → 5.0 Patient Transition

Timing	During ED/acute hospital visit	During acute hospital visit, prior to discharge	During acute hospital visit, prior to discharge	60 days – as per COPD/CHF homecare pathway	From two weeks prior to transition to transition at 60 days.
Key steps/ outputs of this stage include	**1.1** COPD/CHF Pt admitted to hospital. **1.2** Patient receives care from Hospital Care Team **1.3** COPD/CHF Pt identified by Meditech report and/or team **1.4** Patient screened by ICC-C (confirm dx, eligibility) **1.5** ICC-C identifies if patient has existing CCAC, Health Links, or Palliative support	**2.1** Patient provides consent for ICC **2.2** ICC-C completes intake form with patient **2.3** Patient chart updated (ICC Sticker, information sheet and order form) **2.4** Patient receives program information (binder, other info)	**3.1** ICC-C meets with patient and hospital team daily, identifies d/c barriers **3.2** Patient is reviewed during daily rounds **3.3** ICC Coordinator arranges services/freq, equipment and O2 for discharge **3.4** ICC-C informs home care team of upcoming discharge **3.5** Patient is discharged (documents scanned in Procura - EMR) **3.6** Notification of ICC enrollment faxed to Primary Care/Specialist	**4.1** Patient receives care from members of SJHC team (RN, RT, etc.) in their home as per the care pathway **4.2** ICC-C hosts virtual rounds weekly with home care team **4.3** ICC Coordinator calls patients on Days 7, 30 and 60. **4.4** ICC-C monitors updates/notes in Procura **4.5** Patient calls the 24/7 line if concerns – ICC-C determine s if physician consultation is required	**5.1** ICC-C assesses patient for transition 2 weeks prior to program completion. **5.2** Patient and ICC-C identify discharge plan **5.3** If patient requires CCAC services post discharge, ICC-C completes CCAC referral **5.4** CCAC confirms eligibility and initiates services (phone or in person as appropriate) **5.5** ICC-C notifies Primary Care/Specialist of discharge from ICC (transfer as appropriate based on patient risk)

ICC-C = Integrated Care Coordinator
SJHC – St. Joseph's Home Care

ICC 2.0 HNHB LHIN Zone Planning

Zone	Burlington	Hamilton			South				Niagara		
Hospital	**JBH**	**HHS-GEN**	**HHS-JH**	**HHS-WLMH**	**BCHS**	**HWMH**	**NGH**	**WHGM**	**NHS-GNG**	**NHS-Wel**	**NHS-NF**
Zone Team Formed	July	October	October	October	Nov	Nov	Nov	Nov	Jan	Jan	Jan
Current State Mapping	Jul-17	Sept 17th	Sept 17th	Sept 17th	Nov 6th	Nov 6th	Nov 6th	Nov 6th	Jan 8th	Jan 8th	Jan 8th
Future State Mapping	Jul-28	Sept 30th	Sept 30th	Sept 30th	Nov 18t	Nov 18t	Nov 18th	Nov 18th	Feb 2nd	Feb 2nd	Feb 2nd
Hire ICC	Aug	Dec-Jan	Nov	Nov	Jan/Feb	Jan/Feb	Jan/Feb	Jan/Feb	Feb	Feb	Feb
Patient Engagement	July-Aug	Sep-Nov	Sep-Nov	Sep-Nov	Nov-Feb	Nov-Feb	Nov-Feb	Nov-Feb	Jan-Mar	Jan-Mar	Jan-Mar
Homecare schedule established	Aug	Sept-Nov	Sept-Nov	Sept-Nov	Nov-Feb	Nov-Feb	Nov-Feb	Nov-Feb	Dec-Feb	Dec-Feb	Dec-Feb
Training/shadowing'	July-Aug	Jan	Jan	Nov	Jan-Feb	Jan-Feb	Jan-Feb	Jan-Feb	Feb-Mar	Feb-Mar	Feb-Mar
Recruit Patients	October	Feb	Jan	Jan	Feb	Feb	Feb	Feb	Mar	Mar	Mar
Review process	October	Feb	Feb	Feb	Feb-Mar	Feb-Mar	Feb-Mar	Feb-Mar	Apr	Apr	Apr
Physician Indicator - Survey	Jan	May	April	April	May	May	May	May	June	June	June
Target Date	**October**	**Jan**	**Jan**	**Jan**	**Feb**	**Feb**	**Feb**	**Feb**	**Mar**	**Mar**	**Mar**

	Not on Target
	In Progress
	Completed
	Not Started

Ontario
Local Health Integration Networks
Réseau local d'intégration des services de santé