South West Local Health Integration Network
Board of Directors' Meeting
Tuesday September 25, 2018, 1:00 pm to 5:00 pm
South West LHIN, 201 Queens Ave, Suite 700, London, Main Boardroom

AGENDA				
Item	**Agenda Item**	**Lead**	**Expected Outcome**	**Time**
1.0 COVENING THE MEETING				
1.0	**Call to Order, Recognition of Quorum**	Chair		1:00
1.1	**Approval of Agenda**	Chair	Decision	1:00-1:02
1.2	**Declaration of Conflict of Interest**			
2.0 APPROVAL OF MINUTES				
	2.1 July 17, 2018 – South West LHIN Board of Directors Meeting	Chair	Decision	1:02-1:05
3.0 PRESENTATION				
	3.1 Recognition of Departing Board Director	Chair	Information	1:05-1:15
4.0 APPROVAL of CONSENT AGENDA				
	Approval of Consent Agenda			1:15-1:20
	4.1 May 25, 2018 Board to Board Reference Group Minutes	Committee Chair	Information	
	4.2 June 26, 2018 Quality Committee Minutes	Committee Chair	Information	
	4.3 Service Provider 2018/19 Quarter 1 Report and LHIN Non-Discretionary Funding	M Brintnell	Information	
	4.4 Board Committee Reports	Committee Chairs	Information	
	4.5 Board Director Reports	Directors	Information	
5.0 PRESENTATIONs				
	5.1 Medical Assistance in Dying (MAID)	J Row	Information	1:20-1:35
6.0 DECISION ITEMS				
	6.1 Medical Assistance in Dying Policy	J Row	Decision	1:35-1:50
	6.2 Revised Purchased Service Budget	H Anderson	Decision	1:50-2:10
	6.3 Canadian Mental Health Association Elgin Branch – Appointment of a Supervisor	M Brintnell	Decision	2:10-2:20
	6.4 Sub-region Board-to-Board Reference Group Membership	L Showers	Decision	2:20-2:30
	6.5 Chippewa of the Thames First Nation – MSAA Approval	S McCutcheon	Decision	2:30-2:40
7.0 FOCUSSED DISCUSSION ITEMS				
	7.1 2018, Quarter 1 Financial Update	H Anderson	Information	2:40-3:30
	7.2 Sub-Region Evolution/Governance	R Sapsford	Discussion	
	7.3 Home and Community Care Review	D Ladouceur	Discussion	
8.0 CLOSED SESSION				
	8.1 Closed Session	Chair	Decision	3:30-5:00
9.0 FUTURE MEETINGS/EVENTS				
	South West LHIN Board of Directors Meeting, Tuesday October 16, 2018 Location : Owen Sound Office - 1415 First Ave West, Suite 3009, Owen Sound – Georgian Room North and South			
10.0	**Adjournment**	Chair	Decision	5:00

South West LHIN Board of Directors' Meeting

Board of Directors' Meeting
Tuesday July 17, 2018
South West LHIN, 356 Oxford Street West, London, Trillium East/West Rooms

Minutes

Present: Andrew Chunilall, Vice Chair, Acting Board Chair (via teleconference)
Linda Ballantyne, Vice Chair, Board Director
Jean–Marc Boisvenue, Board Director
Myrna Fisk, Board Director
Glenn Forrest, Board Director
Allan MacKay, Board Director (via teleconference)
Wilf Riecker, Board Director
Jim Sheppard, Board Director
Leslie Showers, Board Director
Cynthia St. John, Board Director
Aniko Varpalotai, Board Director

Regrets: Lori Van Opstal, Board Chair

Staff: Hilary Anderson, Vice President, Corporate Services
Mark Brintnell, Vice President, Quality, Performance & Accountability
Donna Ladouceur, Interim Co-CEO/Vice President, Home & Community Care
Sue McCutcheon, Acting Vice President, Strategy System Design and Integration
Ron Sapsford, Interim CEO

Stacey Griffin, Executive Office Coordinator (Recorder)

1.0 Call to Order – Welcome and Introductions

The Vice Chair Linda Ballantyne called the meeting to order at 1:30 pm. There was quorum and twelve members of the public, which included health service providers, were in attendance for parts of the meeting.

1.1. Approval of Agenda

MOVED BY: **Aniko Varpalotai**
SECONDED BY: **Jean-Marc Boisvenue**

THAT the Board of Directors' meeting agenda for July 17 2018, be approved as presented. A closed session will be held

CARRIED

1.2 Declaration of Conflict of Interest
No conflicts were declared

2.0 Approval of Minutes
2.1 June 26, 2018 South West LHIN Board of Directors Meeting

MOVED BY: Myrna Fisk
SECONDED BY: Cynthia St John

THAT the June 26, 2018 South West LHIN Board of Directors' meeting minutes be approved as presented.

CARRIED

2.2 July 5, 2018 South West LHIN Special Meeting of the Board of Directors

MOVED BY: Wilf Riecker
SECONDED BY: Jean-Marc Boisvenue

THAT the July 5, 2018 South West LHIN Special Meeting of the Board of Directors' meeting minutes be approved as presented.

CARRIED

3.0 Patient Story /Presentations
3.1 Quality Award Winners

The Board watched videos of our two Quality Awards winners, the South West Health Links for the Large Project, and Canadian Mental Health Association (CMHA) Middlesex for the Small/Medium Project and presented each project with a certificate.

Large Project Award – South West Health Links Approach to Coordinated Care Planning
A more collaborative approach to providing care for chronic patents is being achieved through the Health Links approach to Coordinated Care Planning. This approach brings the full care team together; the individual, at least two or more health service providers, social service providers, and other formal/informal supports. Together, they establish a shared understanding of the individuals' goals and develop a coordinated care plan to best support what is most important to him/her. This approach to care reduced the rate of unplanned Emergency Department (ED) visits by 26%, the rate of unplanned hospital admissions by 35%, and the length of stay in hospital by 5.8 days.

The partners include: North Perth Family Health Team, Thames Valley Family Health Team, Owen Sound Family Health Team, Grey Bruce Health Services, South Bruce Grey Health Centre, Brockton and Area Family Health Team, Oxford County Community Health Centre, Canadian Mental Health Association – Oxford, East Elgin Family Health Team and the South West LHIN.

Small/Medium Project Award – CMHA Middlesex's Improving Access to Mental Health Services
Seeking treatment is often a big step for someone dealing with a mental health problem. However, access to services often starts with an assessment, followed by a long wait. This project aimed to decrease avoidable wait times to case management services in London offered through CMHA Middlesex to service initiation (this includes referral to assessment and assessment to service initiation)

to under 14 days. This project reduced wait times for service, improved the client experience and ensured continuity of care.

3.2 Community Paramedicine Program

The Board heard a patient story on Community Paramedicine. In the South West LHIN two programs are being supported, one in Grey County and one in London Middlesex (combination of funding supports from Canada Health Infoway and funding from LHIN)

- In chronic conditions such as Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) there is a shift from doctor driven care towards more patient centered integrated care with active involvement of and self-management by the patient
- The Community Paramedicine Remote Monitoring Program enlists the expertise of community paramedics to provide at home patient education, and remote monitoring
- The Program encourages patients to take a more active role in managing their own disease as well as reduces 911 calls and emergency department visits

The Board requested further information/update on off load delay at a future Board meeting.

4.0 Approval of Consent Agenda

MOVED BY: Leslie Showers
SECONDED BY: Jean-Marc Boisvenue

THAT the consent agenda items be received and approved as circulated in the agenda package.

CARRIED

5.0 Decision Items

5.1 Community Support Services Base Funding Increase

MOVED BY: Glenn Forrest
SECONDED BY: Aniko Varpalotai

THAT the South West Local Health Integration Network Board of Directors approve the allocation of $1,490,100 from the 2018/19 Community Investment Funding Increase to provide a two percent general base funding increase to Community Support Services Health Service Providers.

CARRIED

5.2 Governance Policy Harmonization

MOVED BY: Cynthia St John
SECONDED BY: Leslie Showers

THAT the South West LHIN Board of Directors amend governance policies E-4 Operating/Business Plan and *D-1 Board Spokespeople & Media as recommended by the Governance and Nominations Committee.*

CARRIED

5.3 Terms of Reference, Indigenous Working Group

MOVED BY: Aniko Varpalotai

SECONDED BY: Myrna Fisk

THAT the South West LHIN Board of Directors approve the Terms of Reference for an Indigenous Work Group as recommended by the Governance & Nominations Committee

CARRIED

It was noted that the Committee membership includes Aniko Varpalotai, Glenn Forrest, Jean-Marc Boisvenue and Andrew Chunilall as ex-officio

5.4 Board Committee Appointment

MOVED BY: Aniko Varpalotai
SECONDED BY: Cynthia St John

THAT the South West LHIN Board of Directors appoint Board Director Jim Sheppard to the Audit Committee and Quality Committee effective immediately as recommended by the Governance & Nominations Committee.

CARRIED

6.0 Focused Discussion

6.1 May 2018 Financial Update

The Board was provided with a high level summary of significant changes to the 2018/19 projections as at LE02 (May 31, 2018).

LE02 Year End Projection - The projected surplus has increased $12.1M from the opening balanced budget. A number of items contributed to this change, the most significant of which were:

- $6.9M increase in surplus representing 60% of $11.5M of new Community Investment Funding to expand home care services. The remainder of this new funding is being held back pending allocation from the legislature. Once the remaining 40% is realized it will further increase the surplus. A working group has been established to make recommendations for the allocation of this new funding.
    - There is $15.4M in new Community Investment Funding that was announced for 2018/19. It is allocated as $11.5M to expand home care services, $2.5M to increase contract rates for home care services, and $1.4M to support sustainability of community services (this will flow through transfer payments). We have recognized $8.4M (60%) of the funding in actuals.
        - The $2.5M funding for home care service contract increases and $1.4M support for sustainability of community services are net neutral as it is projected that the related expenses will be in line with funding.
- $5.6M increase in surplus due to adjustments to Purchased Services
    - There is a $6.1M increase in surplus due to a decrease in projected Home and Community Care Purchased Services based on an analysis of current trends and a continuing shortage in the PSW workforce.
    - We are funding two Hospice beds in Huron Perth and two Hospice beds in Grey Bruce using Home and Community Care funding. This decreases our surplus by $420K.
- These increases in revenue are offset by a reduction of roughly $500K due to the transfer of the home dialysis program to LHSC.
- There were two net neutral adjustments to be noted as they have significant operational impacts:
    - The opening budget had included the Special Needs Strategy (School therapies) moving to the Ministry of Children and Youth Services as at April 1, 2018. The South West LHIN was

prepared to transition the program at that time however the transition has been put on hold pending direction from the new government.
    - There has been a delay in the transition of the Geriatric Resource Nurses to Parkwood. This is expected to occur in the coming months.(August 20, 2018)
- On June 18, 2018 we received direction from the ministry that the LHIN is to implement a freeze of discretionary spending and a freeze on hiring (with the exception of care coordination and positions serving the public). These freezes have been implemented as a cost savings measure pending the implementation of an expenditure management strategy by the new government. We are seeking an exemption for certain critical positions currently vacant.

6.2 Integrated Health Service Plan (IHSP) and Strategic Plan

The Board received a presentation on the planning and engagement for the 2019-22 Integrated Health Services Plan, which sets the direction for the health system and outlines a collective plan for improvement and discussed the organizational strategic plan that is being created to support the South West LHIN's development as a new organization.

The Board requested to hear the outcome of community and providers sessions and suggested an education session or focused time outside of a Board session. Connection with Board to Board Reference group, would like to understand how their organizations align with the IHSP.

*****The Board took a short break from 3:10 pm to 3:20 pm***

6.3 Sub-Region Governance Planning

The Board held a generative session on Governance and Sub-Regions with the goal to clearly articulate the reason the LHIN Board is moving in this direction and confirm the vision for local governance. Attached to the minutes is the summary notes of the session as Appendix A.

7.0 Closed Session

MOVED BY: Cynthia St John
SECONDED BY: Aniko Varpalotai

THAT the Board of Directors move into a closed session at 4:09 pm pursuant to s. 9(5)(a)(g)(h) of the Local Health System Integration Act, 2006

CARRIED

LHIN staff member Ron Sapsford attended the session and LHIN staff member Mark Brintnell was permitted to attend for part of the meeting and departed at 4:21 pm. Stacey Griffin was permitted to attend for parts of the meeting and left the meeting at 4:29 pm

MOVED BY: Leslie Showers
SECONDED BY: Glenn Forrest

THAT the South West LHIN Board of Directors rise from closed session at 4:41 pm and returned to open session. The Vice Chair reported that the Board discussed the CEO Executive Search and were provided an update from the Interim CEO.

8.0 Dates and Location of Next Meeting

The next regular meeting of the South West LHIN Board of Directors Meeting will be held on Tuesday September 25, 2018.

9.0 Adjournment

MOVED BY: **Wilf Riecker**
SECONDED BY: **Jean-Marc Boisvenue**

THAT the South West LHIN Board of Directors adjourned the meeting at 4:42 pm

APPROVED: _____
Linda Ballantyne, Vice Chair

Date:_____

GENERATIVE DISCUSSION

TOPIC: **Governance and Sub-Regions – July 17, 2018**

GOAL: Clearly articulate the **reason** the LHIN Board is moving in this direction (the "WHY) and confirm the **vision** for local governance (the "WHAT").

CONTEXT:

- The South West LHIN established five (5) sub-regions with the intent that sub-regions are local planning regions that will serve as the focal point for improved health system planning, performance improvement and service integration with the common objective of improving the patient experience.
- Sub-Region Integration Tables were established to mobilize a representative group of clinical and administrative leaders to support the objectives of the new sub-regions.
- Individual Health Service Provider Boards remain in place and uphold fiduciary, strategic and generative responsibilities to the home organization. Health Service Provider Board responsibility at the sub-region/system level is less defined and lacks clarity on structure, accountability and cohesion with home organization responsibilities.
- The LHIN Board started the process to create one sub-region board to board reference group for each sub-region. Each group would meet twice a year. The LHIN Board defined the following expectations for these groups (per Terms of Reference):
    - To ensure proactive consideration of board-related issues associated with the work of the sub-region integration table;
    - To promote a system view at the board level;
    - Facilitate broader board and community engagement that promote patient-centered, inter-organization coordination, while honoring member's obligations to their respective organization;
    - Consider:
        - Strategies to promote a system view amongst health service provider board members;
        - Board perspectives on the current and future state of health care within the sub-region and broader South West LHIN and the role and expectations of board members;
        - Support for focused board and community engagement in the local sub-region areas to advance sub-region objectives related to improved population health, experience of care and value for money;
    - Engage at least annually with their respective local Sub-Region Integration Table to discuss the work plan, accomplishments to date, and potential governance implications;

- Establish a sub-region level board engagement and communication plan to help enhance system-level governance and ensure awareness of sub-region improvement and integration activities through a governance lens;
- Work with tables to identify mechanisms to support broader public engagement and awareness of advancements within their respective sub-regions as appropriate; and
- Sub-Region Board-to-Board Reference Groups are not governing bodies and will not alleviate the governance responsibilities of individual Boards of Directors.

Generative Discussion Overview/Summary:

What does the Board want to see at a sub-region level with respect to governance? If you had a blank slate for governance in the South West LHIN for health system planning, how would you want governance arranged at the sub-region level? As we plan for the next 3 year Integrated Health Service Plan (IHSP) and Strategic Plan which involves sub regions, how does the governance of South West Ontario health care system want to see itself organized at a sub region level?

Board Directors were asked to write down their thoughts, ideas or questions – What comes to your mind with respect to sub region governance

1) Advocate for integrated health services with a particular focus on the needs of their sub region communities and the Health Service Providers who can best work together to provide enhanced health care to meet those needs.
2) How can we validate local priorities and support local decisions? OR Do we need to validate their work?
3) How does First Nations and Indigenous People get captured in the different Sub- Regions? (and have a voice)
4) Sub Region Governance should be decision makers that advance the system in a more aligned and integrated approach. They should represent not only their respective organizations but have accountability to the health care system.
5) Vision – Governors at the sub-region level that are empowered by seeing change they crafted in terms of system design
    - Worry – Sub region governors are not going to be motivated if they don't see how they have influenced change
6) Are Sub-Regions the "right" structure? - Is there another structure?
    - Focus seems to be on establishing tables, meeting schedules, getting membership etc…. Is there an overarching vision?
    - What should we do with the Board to Board Reference Group? Is this really a useful Structure/partner for the LHIN Board anymore?
7) We need a forum to engage other governors to move forward with our strategies. It needs to be mutually beneficial to succeed. What motivators /incentives other than money can be used?
8) Five (5) regional authorities based on sub-regions that interact/report to the LHIN – they govern the entire system in their respective region.
9) What should governance at the sub region level look like? - How would we ensure board representation?

Short term comments separate from discussion points raised was that the CEO role is the biggest challenge for the LHIN board at the moment, would like further information education on hospice policy and would assist to have cheat sheet on acronyms

Common themes and comments raised.

- There is hesitation around sub-regions and what their connection is the Board of Directors as well as the LHIN as a whole.
- Directors advised that they were unclear on where and when the decisions were made on sub-regions and the boundaries. Did the LHIN Board approve or was that a ministry directive – decision.
- Unsure on the evolution of how sub-regions came to be. It is believed there can be extraordinary work at the sub region level, and that the perspectives around the table will be key to driving the work - the sub regions will need to see change and know they have influenced change. Needs to be meaningful and translate into something tangible.
- Representation issue – How do we identify the kind of representation that we are looking for? (Health equity, diversity, indigenous, francophone, etc.). Unsure of what numbers and types of representatives we are looking for. We have had poor responses for representation as people don't understand the purpose and what the value and outcome to create just another committee.
- We aren't reaching out to the right people in the system, i.e. in Indigenous Communities

- As a Board, we need to understand and take ownership and have a desire for what can be, we need success as a driver before asking for representatives to sit at a table. Vision at a sub-region table is that decisions made in that sub region around services, funding, new programs would be made by the health services providers as a system not just as their own individual organization – that would be a fundamental shift and would have the biggest impact. We have to have enthusiasm and communicate it.
- Unsure of legislative requirements and how geographic boundaries were pulled together. Don't believe our partners work in the boundaries now that have been defined. How do you create vision and governance for a sub-region if you represent multiple boundaries?
- Need to understand vision first… than what structure works to enable that vision.

We need to lay more groundwork re sub-regions. 90% of care is provided in the local area where the patient resides. How do you want to see those sub-systems function (and they do already 90% on their own) with a system view. How do we see the sub-regions operating as semi-independent with connection to this board? This board's interest is going to be in regional services. Working local health systems providing the majority of care in those specific regions – not so much about geography. How does this board want that governance to look? 5 SAAs instead of 200 SAAs? How do you want to see it governed?

The system has remained fractured – we haven't integrated, we continue to let it operate piece meal. If we want patients to move seamlessly then something has to give with how care is organized.
There are some moves in that direction – but what do you want to see at the end of three years? At the end of this IHSP how will governance have evolved?

Are we suggesting we have 5 mini-LHINs? 5 boards with an overarching board? The minis do the allocations, monitoring, etc.? Are we talking about devolving our responsibilities and accountabilities? Or is it worthwhile to go this direction? What is the range of possibilities and where are you comfortable? What's best for healthcare in southwestern Ontario? I don't see any legislative barriers to this.

If you have 5 SAAs it would suggest that one organization is responsible for the other – and where money flows is were action happens. You might drive the pursuit of sub-region priorities from all of the windows of the same house rather than just from your assigned window in the house. It would remove a layer to some extent which may address the criticism from those that think the LHIN is too far removed.

We are a board that governs an organization with staff that bring us reports and we make decisions based on those reports. I look down at the sub-regions, where are their resources. Who prepares their reports?

- *The LHIN has to be prepared to provide that support. You can't tell the sub-regions to perform without resources. And each organization also has administrative structures. I think there's adequate resources between the two to provide the necessary support.*

Would you think within the existing LHIN staff we have enough resources?

- *Yes, but roles may change – they're already deployed throughout the sub-regions already.*

There are creative ways at looking at this that generate savings – one CEO instead of three.
I don't want to presume that they aren't already talking to each other at the sub-region level. If the LHIN is a hub, like the center of a daisy – the core that collects and pushes out data to the sub-regions. What do they want to talk about? What do they need? Not what we need. There needs to be willingness to be a genuine partner. I'd like after three years that we're giving direction, supporting evaluation but they are making the decisions and seeing the changes.

Governors want money and decision-making authority. If they're going to be boards of communities of care they're going to want teeth. Are other LHINs evolving this process? Is there anyone to learn from?

- *Each LHIN is in a different stage but we could pursue the line of enquiry.*

- *We're asking for people but need them to have meaningful work – to take on responsibility, make decisions, and give advice to this board on decisions. You can't undertake evolution at the sub-region level unless there's a real commitment to sharing authority.*

Has there been a dialogue and engagement with sub regions what the vision and possibility is for them?

- *Does this board want to pursue this first? If it's not part of the way this board thinks about governance then let's take a different route.*

We need work at sub region level that is meaningful and advances the health system in a positive way

The Sub-Region Integration tables (SRITS) are already up and running. Work is happening in the sub region, that's where we start as governors, what gaps are we missing.

- *SRITS are our creatures and the decision-making comes back here. Planning is easier than implementing.*

Governance tables could facilitate implementation. The governance table's job is to ensure the planning is consistent with the vision.

If you had one more comment, question thought or idea what would it be?

1) The Board needs Education
    a. What is happening now in the South West regarding Integration Tables?
    b. What is happening provincially?
    c. What can we be done about Board to Board Reference Group

2) Let's just do it! Enough discussion, let's start implementing to get feedback from local governors and build out from there.

3) Who is influencing the individual decisions of the Board of Directors?

4) We need to use the MSAA as a tool for Integration. If the individual agency is partnering on a sub-region governance group, they can "Skip" some reporting issues. Thus we assume they are working.

5) Sub-Region tables need power and direction. But we need to hear from them first as to what they would look like.

6) Time for action – need to be bold and progressive

7) How long should it take to get sub-region governance up and running effectively?

8) Can we be comfortable with giving decision making to others when ultimately we (the LHIN Board) are accountable?

9) We as a LHIN Board <u>NEED</u> to encourage/push change…. A paradigm shift in our own thinking

South West LHIN

South West LHIN Board-to-Board Reference Group
Friday, May 25, 2018 – 1:30 to 3:30 pm
Stratford - South West LHIN, 65 Lorne Avenue East - Avon/Maitland Rooms

Minutes
Draft

Present: Leslie Showers, South West LHIN, Group Chair
John Haggarty, South Bruce Grey Health Centre
Kimberlee Haines, London Health Sciences Centre
Philip McMillan, Alzheimer Society, Huron County
Rosemary Rognvaldson, Listowel Wingham Hospital Alliance
Cynthia St. John, South West LHIN
Ruby Withington, Tillsonburg District Memorial Hospital

Staff: Sue McCutcheon, Acting Vice President, Strategy, System Design & Integration
Dan Brennan, Director, Communications via teleconference
Marilyn Robbins, Executive Office Assistant *(Recorder)*

Regrets: Andrew Chunilall, South West LHIN
Brian Orr, Participation House Support Services
Bruce Smith, St. Joseph's Health Care London
Diane Sullivan, Southwest Ontario Aboriginal Health Access Centre

1.0 PREAMBLE

Minutes of a meeting of the South West LHIN Board-to-Board Reference Group held on Friday, May 25, 2018 in Stratford.

2.0 CALL TO ORDER & MEMBERSHIP UPDATE

At 1:30 pm Leslie Showers, Group Chair called the meeting to order. Leslie reported that Brian Orr, Board Chair - Participation House has formally assumed the seat previously occupied by Maria Sinosic at the South West LHIN Board-to-Board Reference Group.

3.0 AGENDA

MOVED BY: Philip McMillan
SECONDED BY: Ruby Withington

To approve the agenda of the May 25, 2018 meeting of the South West LHIN Board-to-Board Reference Group as presented.

CARRIED

4.0 MINUTES

MOVED BY: John Haggarty
SECONDED BY: Cynthia St. John

To approve the minutes of the February 8, 2018 meeting of the South West LHIN Board-to-Board Reference Group as presented.

CARRIED

5.0 GOVERNANCE ENGAGEMENT APPROACH

Leslie Showers, Group Chair provided a brief overview of the items to be discussed pertaining to the development of the Sub-region Board-to-Board Reference Groups and recruitment for same. All of the expressions of interest received to date were included in the meeting materials.

Comments included…

- While governance experience is sought perhaps a new way to look at recruitment is to include those without governance experience so as to have more diverse participation and perspective.
- The South West LHIN Board-to-Board Reference Group will continue to operate along with the new Sub-region groups.
- Perhaps we should recruit differently. Attend group gatherings in the community to present to non-traditional candidates with a pitch customized to local interests.
- Conflict of interest needs to be defined if considering paid staff participants.
- People want to know when and what time the meetings are in order to determine if they can participate.
- People are just not interested and there's too much going on with disarray at the LHIN and changes in healthcare overwhelming people.
- This is about having passion for change and being interested in the work of your fellow governors. We can't make people do this, they have to want to do this.
- Meeting only two times per year seems token but we want the sub-region groups to make their own rules as to time of day, place, and priorities.
- Do we understand the goal and form of the sub-regions? It's hard to recruit people when you don't know exactly what you're recruiting for. What are the benefits and the desired outcomes? If we understood the sub-regions and Sub-region Integration Tables (SRITs) then we'd better understand how they intersect with the reference groups and therefore how to best recruit.

Staff explained that the sub-regions were conceived to be the geographies in which most of a patient's journey takes place. While each organization is responsible for a piece of the patient journey, it's evident that the transitions between organizations need improvement. The staff point of view on how to improve this has been formed by way of the Sub-region Integration Tables (SRITs) and support from the board governance level is needed to give these staff the confidence to embark on exploring and implementing needed changes, and to provide a higher-level view of the sub-region landscape. The Sub-region Board-to-Board Reference Groups provide a mechanism for governor influence – these groups of leaders from different organizations could together be quite powerful in driving change for patients.

The committee was supportive of having a communications plan developed to create further awareness and understanding of what sub-regions are, the goals of each, and what the respective Board-to-Board Reference Groups hope to achieve. Staff suggest that sub-regions have always existed and that they are now only more formalized to focus on local system service planning and delivery.

The committee considered a pilot approach to launch two or three of the groups as critical mass for membership is achieved, and then learning from those before launching in other sub-regions.

The committee debated the potential merits and conflicts of expanding membership beyond bona fide Health Service Provider governors. It was suggested to describe the Board-to-Board Reference Groups as having an advisory role. Advisory groups comprised of governors from different organizations sharing their ideas, and working together to solve challenges.

The committee debated next steps – whether to proceed with the launch or to postpone until further interest is secured, and what to do with those expressions of interest already received.

It was generally agreed to…

- Communicate that more interest is sought as there have not been many expressions of interest submitted in some of the sub-regions.
- Communicate that the launch will be postponed until the fall as we are not yet ready and are continuing to work on plans.
- Further vet the expressions of interest and interview applicants prior to recommending membership.
- Assure those who have submitted that their applications are appreciated and being held for consideration in the near future as plans to launch continue to be developed. Thank them for their interest and their patience.

The committee considered the balancing act of allowing the sub-region groups to self-identify some parameters while giving them enough structure and direction to invest their time. A one-pager outlining the following was suggested…

- What are sub-regions?
- What is the purpose?
- What will they do?
- When will they meet?
- What experience is needed?
- Do you need organizational representation?
- Can you be from outside health?
- Can you be a staff member?
- What degree of influence will you have?
- How does this group relate or not relate to the Sub-region Integration Tables (SRITs)?
- How will your voices be heard? How do we connect and to whom?
- How will the Sub-region Board-to-Board Reference Groups govern themselves? Who will Chair?

It was agreed that a firm understanding of sub-regions is foundational to building interest in the Sub-region Board-to-Board Reference Groups along with clear messaging as to why we need governor involvement. These groups, while advisory to this South West LHIN Board-to-Board Reference Group and the Board of the South West LHIN, need also to be advisory to their respective SRIT – the tables that are in position to execute improvement initiatives.

MOVED BY: Philip McMillan
SECONDED BY: John Haggarty

To pause launching the Sub-region Board-to-Board Reference Groups until the fall of 2018. In the interim a communications plan should to be developed to address outstanding questions and educate on sub-region form and objectives. The May 29 webcast should proceed as scheduled to communicate the revised timeline and provide further education about the goals for local governance engagement.

CARRIED

ACTION: Staff to send a message to all applicants about the status of their application along with a short Q&A resulting from the May 29 webcast.

6.0 INTEGRATED HEALTH SERVICE PLAN (IHSP) DEVELOPMENT UPDATE

Sue McCutcheon, Acting Vice President, Strategy, System Design & Integration reported that both an IHSP and a strategic plan for the new LHIN organization are being developed over the next few months. Internal staff engagement is scheduled to start in June with the timing of broader stakeholder engagement to be worked out in view of LHIN leadership changes and the June 7 provincial election. Sue noted that the IHSP is a Ministry-mandated three-year plan from a system perspective about how the LHIN and LHIN Board further improve the delivery of health services in the South West. A draft is due to the Ministry in October.

7.0 QUALITY SYMPOSIUM UPDATE

Dan Brennan, Director, Communications provided a brief report on the rationale for cancelling the May 31 Quality Symposium noting that during the writ period the government is only supposed to do urgent, and non-controversial regular business and while the rules are not black and white it was decided to cancel due to the profile of the keynote speaker and the sensitivity around this election. No decision has been made on rescheduling the event but rather a revisiting of the purpose and structure of the event, and how it reflects the priorities of the new LHIN organization.

Dan departed the meeting.

8.0 ROUND TABLE & ADJOURNMENT

Attendees were invited to provide feedback to the LHIN and to volunteer any news or updates related to their respective organizations.

It was suggested that there is currently considerable criticism of the LHIN as far as the direction, purpose, and role. LHIN Board leadership is not visible locally and people need to be educated on what the future direction of the LHIN is going to be, along with what the sub-regions are going to be. Patient and family committees should be approached to participate at the sub-region level.

Staff shared that the LHIN does have an Annual Business Plan for 2018/19 that is centred on three overarching priorities and suggested that more promotion of it externally might serve to demonstrate the LHIN's current direction.

LHIN board members thanked attendees for sharing with them their advice on the governance work as well as for sharing their broader comments on the LHIN.

The meeting adjourned at 3:20 pm.

APPROVED: _____
Leslie Showers, CHAIR
SOUTH WEST LHIN BOARD-TO-BOARD REFERENCE GROUP

Date: _____

South West LHIN

South West LHIN Board – Quality Committee

Tuesday, June 26, 2018 – 10 am to noon
LHIN Office – Community Rooms East/West at 1147 Dundas Street, Woodstock

Minutes

Approved by committee – September 6, 2018

Present: Linda Ballantyne, Board Vice Chair and Quality Committee Chair
Jean-Marc Boisvenue, Board Director
Myrna Fisk, Board Director
Aniko Varpalotai, Board Director

Guests: Allan Mackay, Board Director
Wilf Riecker, Board Director
Jim Sheppard, Board Director

Regrets: Andrew Chunilall, Acting Board Chair
Glenn Forrest, Board Director

Staff: Mark Brintnell, Vice President, Quality, Performance and Accountability
Steven Carswell, Director, Quality
Stacey Griffin, Executive Office Coordinator
Donna Ladouceur, Vice President, Home and Community Care
Ron Sapsford, Interim CEO
Marilyn Robbins, Executive Office Assistant *(Recorder)*

1. Call to Order

Linda Ballantyne, Quality Committee Chair called the meeting to order at 10:04 am. No members of the public were in attendance.

2. Approval of Agenda & Minutes

MOVED BY: Aniko Varpalotai
SECONDED BY: Jean-Marc Boisvenue

TO approve the agenda for the June 26, 2018 meeting of the South West LHIN Quality Committee.

CARRIED

MOVED BY: Aniko Varpalotai
SECONDED BY: Jean-Marc Boisvenue

TO approve the minutes of the May 22, 2018 meeting of the South West LHIN Quality Committee.

CARRIED

3. Accreditation Update

Mark Brintnell, Vice President, Quality, Performance and Accountability (QPA) referred to the briefing included in the meeting materials summarizing accreditation work underway noting that the *Governance Functioning Tool* will be discussed at Thursday's meeting of the Governance & Nominations Committee. Mark reported that plans to hire outside resources to support the accreditation process have been paused due to the province's recent freeze of discretionary spending and hiring, and there are a number of vacant staff positions on the QPA Team. Despite these staff capacity challenges, Mark is confident that the accreditation process will not be compromised.

4. Enterprise Risk Management

Mark Brintnell, Vice President, Quality, Performance and Accountability reported that a renewed approach to Enterprise Risk Management (ERM) is being developed, and provided a brief review of the *Corporate Risk Profile* included in the meeting materials. Staff propose that this document would be presented for the board's consideration at the start of each fiscal year to ensure the appropriateness of the risks, risk owners, and risk ratings. A semi-annual risk management update would be presented to the board with additional reporting being provided in the event of changing risks. Staff reported that mitigations for each risk are currently in development and descriptions of each would be included in reporting to the board.

The committee considered the document and the proposed approach to board reporting suggesting that risk owners be identified by position rather than name. Some minor typos were noted for correction in the Impact Table appended to the *Corporate Risk Profile.* The group debated the merits of risk monitoring being assigned to a committee of the board, and discussed board education needs regarding risk management.

It was agreed that at the board meeting to follow, the Enterprise Risk Management item included in the consent section of the agenda would be moved into the section for discussion, and a motion put forward to assign risk management oversight to the Audit Committee.

5. 2018/19 Work Plan

The committee reviewed the draft *Annual Work Plan (2018-19)* included in the meeting materials. The Committee Chair asked that the work plan incorporate colour-coding to illustrate the items completed, and for the work plan to be included in every meeting package along with the version maintained in the board portal.

ACTION: Staff will adjust the work plan template to include a status component and include same in every meeting package.

6. Quality Improvement Plan Update

Steven Carswell, Director, Quality referred to the briefing note included in the meeting materials to provide a status update on how the South West LHIN is progressing on key change activities included in the *2018-19 Home and Community Care Quality Improvement Plan* (QIP).

The committee noted that the “Equitable” dimension of the plan and specifically the ‘Indicator: # of indigenous patients identified for palliated care” showed a number of initiatives as delayed. Steven responded that this work is on-going but delayed due to staff and leadership changes. The committee reflected on long-standing issues pertaining to service for Indigenous and French language patients and considered the need for difficult discussions around bolder, broader strategies for engagement and relationship-building. Expectations, accountabilities, and responsibilities need to be made clear along with an understanding of the province’s direction on health equity. It was agreed to have further discussion on Indigenous engagement and health equity at Thursday’s meeting of the Governance & Nominations Committee, and at the July board meeting subject to the approval of the board chair.

7. Emerging Themes & Risks

Committee members were invited to identify emerging themes.

Donna Ladouceur, Vice President, Home and Community Care provided an update on the recent breach of CarePartners systems that has forced LHIN staff to revert to a manual process referring the most urgent cases to other providers, an onerous and ongoing challenge for all involved. Staff expect CarePartners will return to serving their full volume of patients by tomorrow, the service interruption resulting in some delays and some wait-listing. Donna summarized that the CarePartners experience serves as a wake-up call regarding cyber risk.

The shortage of Personal Support Workers (PSWs) is an on-going issue. It was suggested that some generative discussion on how to support patients differently in the home, and alternate care delivery models is needed as the shortage of both PSWs and nurses is expected to continue. The modernization of service provider contracts, and the direction of the new government was briefly discussed. The Interim CEO stated that at the board meeting to follow, he would be raising this issue.

An update on CMHA Elgin will be presented at the July meeting of the board.

Donna and Steven will serve as witnesses at the Long-Term Care Homes Public Inquiry underway in St. Thomas. The committee considered the potential impact of the results. Staff and LHIN Legal are monitoring the inquiry daily. The board can expect an update in the closed part of the board meeting to follow.

8. Other Business and Adjournment

The next meeting of the Quality Committee is scheduled for Thursday, September 6 at 2 pm.

The meeting adjourned at 11:32 am.

APPROVED: _____

Linda Ballantyne, CHAIR
QUALITY COMMITTEE

Date: _____

Report to the Board of Directors

Service Provider 2018/19 Quarter 1 Report and LHIN Non-Discretionary Funding

Meeting Date: **September 25, 2018**

Submitted By: **Mark Brintnell, Vice President, Quality, Performance and Accountability**
Michelle McKellar, Director, Provider Contracts and Allocation

Submitted To: ☒ **Board of Directors** ☐ **Board Committee**

Purpose: ☒ **Information** ☐ **Decision**

Purpose

The purpose of this report is to present highlights from the assessment of the South West LHIN Health Service Provider (HSP) and Service Provider Organization (SPO) 2018/19 first quarter (Q1) performance. In addition, non-discretionary (i.e. directed) funding provided to the LHIN in Q1 is also summarized.

Hospital Sector

Performance Highlights and Actions to Improve[1,2]

- Hospital emergency department performance compared to target corridors improved over Q4 2017/18; wait time compliance for high acuity patients was 100% within corridor and the wait times for low acuity patient was 85% within corridor. Results for Q1 have historically tended to benefit from spring/summer weather, however as a direct comparator, the results for Q1 2018/19 improved from Q1 2017/18 (92%/69% high/low acuity).
  - *LHIN interventions to improve and sustain improvements to ED waits: New strategies supported through Pay-for-Results (P4R) funding are underway at five hospital sites and a Knowledge Transfer initiative is supported to spread ideas and strategies more broadly in the LHIN to three additional high-volume sites; Regional Access and Flow and Holiday Surge planning; and Mental Health Capacity Planning.*

- Recent hospital improvements regarding HSAA targets for diagnostic imaging did not continue into Q1, both CT and MRI target compliance rates are 80% compared to 100% at the end of last fiscal year. Clinical standards for MRI wait times are not being met in most cases; the situation is the same

[1] For a more complete inventory of interventions expected to impact performance, please refer to the Priority Summary Reports included within the South West LHIN Report on Performance available at: http://www.southwestlhin.on.ca/accountability/Performance.aspx

[2] For each instance of a Health Service Provider's quarterly performance falling outside of the allowable indicator corridor, the LHIN initiates a series of progressive performance management steps that typically include: explanation of variance, improvement plan, enhanced reporting requirements, or a performance meeting.

across the province - South West LHIN MRI aggregate wait time result was the second best for all LHINs in Q4 2017/18 at 53% within the target wait time versus the 90% provincial standard.
  - *LHIN interventions to improve MRI: Regional Medical Imaging Integrated Care Project; MRI Performance Improvement Program (PIP) Scorecard; targeted funding in Q4 of last fiscal year to address long waits.*

- Three of six South West LHIN hospitals performing hip and knee replacements continue to struggle to meet access targets.
  - *LHIN interventions to improve hip and knee wait times: a centralized intake and scheduling process with implementation aligned with the provincial MSK (musculoskeletal) strategy; analysis and clean-up of open cases on surgeons' wait lists; working with Orthopaedic Steering Committee on short and longer-term actions including sharing of individual surgeon wait time data with primary care physicians; and targeted funding in 2018/19.*

- South West LHIN hospitals continue to report heightened challenges with mental health and substance abuse pressures and London Health Sciences Centre (LHSC) experienced exceptional ED revisit rates for the Q1 period of April through June 2018. Initiatives taken by Grey Bruce Health Services (GBHS) have resulted in revisit rates within the targeted range for substance abuse.
  - *LHIN interventions to improve ED revisits: focus on London Emergency Department Frequent Users; Enhanced Community Capacity: Crisis Response & Transitional Case Management; Crisis Centre; LHIN-wide capacity planning; Peer Support Strategy; Addictions Services Assessment (current state of withdrawal management services); London Emergency Medical Services (EMS) process for transporting patients to the Crisis Centre instead of ED.*

- Alternative Level of Care (ALC) days in acute beds remains the 3rd lowest among Ontario LHINs. H-SAA target level compliance has slipped slightly since Q4 2017/18 - only 8 of 17 hospitals met their ALC targets. Two of five hospitals with Coordinated Access have rehab-appropriate patients in rehab beds and 5 of 10 met Complex Continuing Care (CCC) eligibility targets for CCC. A high proportion of patients deemed ALC in CCC beds as well as declining occupancies continue to challenge hospitals to meet targets.
  - *LHIN interventions to improve ALC: Coordinated Access (CCC/Rehab, Assisted Living/ Supportive Housing/ Adult Day Programs); Behavioral Supports Ontario (BSO); action planning with Chief Nursing Executives (CNEs) including a Home First 'refresh', spread of ALC avoidance practices first tested at LHSC, a focus on strategies for extraordinary needs patients, and a Regional Access and Flow Memorandum of Understanding (MOU); LHIN Levels of Care and Respite Care investments.*

- Six of 18 hospitals experienced a higher rate of readmissions than expected for the period of *April through June of 2018. Excess readmissions for acute myocardial infarction and diabetes drove up rates. Fewer readmissions for chronic obstructive pulmonary disease (COPD) were observed.*
  - *LHIN interventions to improve readmissions: A growing number of coordinated care plans are in place for complex patients; improvement initiatives with discharge practices are underway with St. Thomas Elgin General Hospital and LHSC; enrollment of patients in a care pathway supported by an integrated funding bundle and Telehomecare has begun to demonstrate improvements in readmissions for patients with COPD.*

<u>Financial Highlights</u>

- No financial data required for first quarter.

Community Sector

Performance Highlights and Actions to Improve

- Not all CHCs met the Q1 corridors for diagnostic access and safe and effective best practice measures. The targets are set to a high standard, so a slip in compliance over one quarter is not an immediate cause for concern. CHCs maintained improvements in their access measure (i.e. panel size) despite continued pressures in attracting and retaining physicians and nurse practitioners and all five were within performance corridors for this measure.

- All LHIN Home & Community Care wait time measures are within performance corridors with the exception of the 90th percentile wait time from community for home care services indicator.
    - *In terms of the 90th percentile wait time indicators from application/hospital discharge to first home care service, referrals from the community have decreased by 5 days and are now aligned with the provincial standard and referrals from hospital have increased by 3 days, 4 days higher than the provincial standard. Both indicators are expected to see improvement by the 3rd quarter in 18-19 due to enhancements made to the referral management process and the transfer of the geriatric resource nursing services to St Joseph's Health Care.*
    - *In terms of the 5 Day wait time measures, PSW staff shortages and to a lesser affect, nursing staff shortages, are still driving poor performance as demonstrated by reductions in referral acceptance, increased missed care and anecdotal feedback from the Service Provider Organizations. In addition, basing service performance on the service authorization date is misleading; patient availability date allows for greater equity across our chronic/complex home and community care populations and is a more accurate measure of performance.*

Financial Highlights

- No financial data required for first quarter

Long-Term Care Sector

Performance Highlights and Actions to Improve

- For Q1 of 2018/19, 91% of homes are meeting the requirement to report on residents with responsive behaviours who have been discharged from the homes (with rationale), as well as reporting where 1:1 staffing has been introduced to help support residents with responsive behaviours to remain in the respective long-term care homes. These local performance measures were introduced to better appreciate the sector's contribution to ensuring appropriate utilization of hospital beds and reducing ALC days and ED visits for residents with responsive behaviours.

Financial Highlights

- No financial data required for first quarter

LHIN Home Care – Service Provider Organizations (SPOs)

Performance Highlights and Actions to Improve

- Embedded within this quarterly performance report for the first time is the SW LHIN contracted home care providers and their compliance with performance targets.
- For Q1, there was a slight improvement in referral acceptance for Personal Support Services compared to Q4 of the previous fiscal year (87% vs 85%). This is higher than the provincial result of 74.67% however falls below the target of 94%. A shortage of Personal Support Workers (PSWs) across the region continues to impact indicators related to referral acceptance, 5 day wait time, as well as missed care. Missed care for Personal Support Services continued to be outside of corridor for Q1.

- Referral acceptance rates for nursing services in Q1 were impacted by localized health human resource shortages in specific sub-regions within the South West.
    - *Targeted recruitment efforts are underway by the Service Provider Organizations for nurses as well as PSWs.*
- Missed care for therapies is primarily related to late initial visits with the result being heavily impacted due to the smaller number of visits.
- Discharge reporting in Q1 was outside the target corridor for most therapies and nursing. This was due in large part to a technological system outage that impacted the submission of reports from a SPO to the LHIN.

Non-Discretionary Funding

The LHIN Board receives information about new discretionary funding provided to the LHIN, in all cases except for spending sanctioned using CEO delegation of authority policy, the Board is asked to consider approval of all new discretionary initiatives. In order to keep the Board apprised of the non-discretionary (directed) funding provided to the LHIN, Appendix 2 lists all new directed funding added during Q1 2018/19.

Attachments:
Appendix 1 – HSP and SPO Performance Results
Appendix 2- Listing of new non-discretionary funding added during Q1 2018/19.

Q1 Appendix 1

2018/19 Service Accountability Agreement Review: Performance Outcomes 2018/19					
Performance Grouping	**Sector**	**Target Compliance Rate**			
		Q1	**Q2**	**Q3**	**Q4**
Primary Health Care					
Access to primary care	CHC	80%			
Cervical cancer screening	CHC	60%			
Colorectal cancer screening	CHC	60%			
Breast cancer screening	CHC	60%			
Inter-professional diabetes care rate	CHC	100%			
Influenza vaccination rate	CHC	80%			
Access to Services					
90th Percentile Wait from Hospital	LHIN	100%			
% Nursing Visit Within 5 days	LHIN	100%			
% Personal Support Worker (PSW) Visit Within 5 days	LHIN	100%			
90th Percentile Wait from Community	LHIN	0%			
ALC Rate (Total)	HOSP	47%			
% ALC Days (Acute)	LHIN	0%			
Adult Day Program Occupancy	CSS	100%			
Preventing and Managing Chronic Conditions					
Readmission within 30 days for selected HBAM Inpatient Grouper Conditions	HOSP	67%			
Mental Health and Addictions Services					
30d ED revisit rate for Mental Health (LHSC & GBHS only)	HOSP	0%			
30d ED revisit rate for Substance Abuse (LHSC & GBHS only)	HOSP	50%			
Hospital-Based Care					
90th Percentile ED LOS Non-Admitted High Acuity Patients	HOSP	100%			
90th Percentile ED LOS Non-Admitted Low Acuity Patients	HOSP	85%			
MRI-- % P2,3,4 within target	HOSP	80%			
CT-- % P2,3,4 within target	HOSP	80%			
Hip-- % P2,3,4 within target	HOSP	50%			
Knee-- % P2,3,4 within target	HOSP	50%			
% Eligible Pts in Complex Continuing Care (CCC)	HOSP	50%			
C diff infection rate	HOSP	79%			
Rehabilitative Services					
% Eligible Pts in Rehab	HOSP	40%			
Local Conditions					
theHealthline.ca	HOSP	100%			
French Language Services (LHSC, SJHC only)	HOSP	100%			
French Language Services	LHIN	100%			
French Language Services	CHC	100%			
French Language Services	CMHA	100%			
Indigenous Cultural Safety Training	HOSP	0%			
Indigenous Cultural Safety Training	LHIN	100%			
Indigenous Cultural Safety Training	CSS	10%			
Indigenous Cultural Safety Training	CHC	100%			
Indigenous Cultural Safety Training	CMHA	3%			

Q1 Appendix 1

2018/19 Service Accountability Agreement Review: Performance Outcomes 2018/19					
Performance Grouping	**Sector**	**Target Compliance Rate**			
		Q1	**Q2**	**Q3**	**Q4**
Home and Community Care - Service Delivery Measures					
Safety					
Dietary Missed Care	SPO	80%			
Dietary Discharge Reporting	SPO	80%			
Visit Nursing Missed Care	SPO	69%			
Visit Nursing Discharge Reporting	SPO	54%			
Shift Nursing Missed Care	SPO	0%			
Shift Nursing Discharge Reporting	SPO	83%			
Personal Support Services Missed Care	SPO	21%			
Occupational Therapy (OT) Missed Care	SPO	58%			
OT Discharge Reporting	SPO	83%			
Physiotherapy (PT) Missed Care	SPO	70%			
PT Discharge Reporting	SPO	70%			
Speech Language Pathology (SLP) Missed Care	SPO	100%			
SLP Discharge Reporting	SPO	89%			
Social Work (SW) Missed Care	SPO	100%			
SW Discharge Reporting	SPO	67%			
Medical supplies:	SPO				
Errors in Orders	SPO	100%			
Fill Rate	SPO	100%			
Repair or Replacement Requests	SPO	100%			
Emergency Repair or Replacement Requests	SPO	100%			
Regularly Scheduled Deliveries	SPO	100%			
Individually Scheduled Deliveries	SPO	100%			
Sourcing Exception Items	SPO	100%			
Special Deliveries	SPO	100%			
Dietary Referral Acceptance Rate	SPO	100%			
Accessible					
Personal Support Services Five Day Wait Times	SPO	79%			
Nursing Five Day Wait Times	SPO	69%			
Visit Nursing Referral Acceptance Rate	SPO	69%			
Shift Nursing Referral Acceptance Rate	SPO	50%			
Personal Support Services (PSS) Referral Acceptance Rate	SPO	36%			
Occupational Therapy (OT) Referral Acceptance Rate	SPO	92%			
Physiotherapy (PT) Referral Acceptance Rate	SPO	90%			
Speech Language Pathology (SLP) Referral Acceptance Rate	SPO	100%			
Social Work (SW) Referral Acceptance Rate	SPO	100%			

Appendix 1

M-SAA Indicators:

CORE--All Community Sectors	
Fund Type 2 Balanced Budget	Fund Type 2 Balanced Budget
% Spent on Admin	Proportion of Budget Spent on Administration
Total Margin	Percentage Total Margin
Variance- Forecast:Actual $$	% difference between actual service expenditures at Q4 and forecasted year-end expenditures at Q3
Indiv. Served	TOTAL Individuals Served
Visits F2F, phone, cont.out	TOTAL Visits Face-to-Face (F2F), Telephone, In-house, Contracted Out
Hours of Care	TOTAL Hours of Care (In-House & Contracted Out)
Not Uniquely ID'd Svc Rec Interactions	TOTAL Not Uniquely Identified Service Recipient Interactions
Group Sessions	TOTAL Group Sessions
IP/Res Days	TOTAL Inpatient/Resident Days
Attendance Days (F2F)	TOTAL Attendance Days Face-to-Face (F2F)
Meals Delivered	TOTAL Meals Delivered
Group Participant Attendances	TOTAL Group Participant Attendances (Registered & Non-Registered)
Service Provider Interactions	TOTAL Service Provider Interactions
Variance- Forecast: Actual Svcs	% difference between forecasted units of service and actual units of service
SECTOR SPECIFIC INDICATORS: LHIN Home & Community Care	
90P Wait from Hospital	Wait Time From Hospital Discharge to Service Initiation (Hospital Clients) (90th Percentile)
90P Wait from Community	Wait Time for Home Care Services – Application to First Service (Community Setting) (90th Percentile)
% Nursing Visit Within 5d	% of Home Care Clients who received their Nursing Visit within 5 days of the date they were authorized for Nursing Services
% PSW Visit Within 5d	% 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
% ALC Days	Percentage Of Acute Alternate Level Of Care (ALC) Days (Closed Cases)
ALC Rate	(see under H-SAA)
SECTOR SPECIFIC INDICATORS: CHC	
Cervical	Cervical Cancer Screening Rate (PAP Tests)
Colorectal	Colorectal Cancer Screening Rate
Diabetes	Inter-professional Diabetes Care Rate
Influenza	Influenza Vaccination Rate
Breast	Breast Cancer Screening Rate
Access to Primary Care	current # of CHC clients as a % of clients the CHC is expected to serve (based on full team & client complexity)
Retention Rate	% of general practitioners & nurse practitioners (NP) full-time positions that are occupied

H-SAA Indicators:

CORE--Hospital	
90P ED LOS complex	90th Percentile Emergency Department (ED) Length Of Stay For Complex (CTAS I-III) Patients
90P ED LOS minor/ uncomplic.	90th Percentile ED Length Of Stay For Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients
Hip-- % P2,3,4 within target	Joint Replacement (Hip): % Priority 2, 3, and 4 cases completed within Target
Knee-- % P2,3,4 within target	Joint Replacement (Knee): % Priority 2, 3, and 4 cases completed within Target
MRI-- % P2,3,4 within target	Diagnostic Magnetic Resonance Imaging (MRI) Scan: % Priority 2, 3, and 4 cases completed within Target
CT-- % P2,3,4 within target	Diagnostic Computed Tomography (CT) Scan: % Priority 2, 3, and 4 cases completed within Target
C. diff	Rate Of Hospital Acquired Clostridium Difficile Infections
Readmissions within 30 days	Rate Of Hospital Readmissions within 30 days of Previous Hospital Discharge (for select conditions)
ALC Rate	% of Total Hospital Patient Days Acccounted for by Current (open) ALC Cases plus ALC Discharged/Discontinued Cases for that Period.
Current Ratio (proj. YE)	Current Ratio (Consolidated – All Sector Codes And Fund Types) (projected year-end)
Total Margin	Total Margin (Consolidated – All Sector Codes And Fund Types)
Weighted Pt Days: CCC	Complex Continuing Care Weighted Patient Days
Weighted Cases: ED	ER weighted Cases
Weighted Cases: IP Acute	Total Inpatient Acute Weighted Cases
Weighted Visits: DS	Day Surgery Weighted Visits
Visits: Amb Care	Ambulatory Care Visits
Visits: ED & Urg Care	Emergency Department And Urgent Care Visits
Days: IP MH	Inpatient Mental Health Days
Days: IP Rehab	Inpatient Rehabilitation Days
(LOCAL) A Local Performance Indicator chosen by the South West LHIN to be applied to select providers to drive improvement.	
Stroke/TIA adm to Stroke Unit	(LOCAL) % of Stroke or Transient Ischemic Attack (TIA) Patients Treated on a Stroke Unit.
30d ED Revisit Rate for Mental Health	(LOCAL) Repeat Unscheduled Emergency Visits Within 30 Days For Mental Health Conditions
30d ED Revisit Rate for Substance Abuse	(LOCAL) Repeat Unscheduled Emergency Visits Within 30 Days For Substance Abuse Conditions
% Eligible Pts in Rehab	(LOCAL) % of Rehab Beds Occupied by Rehab-Eligible Patients (vs. ALC or vacant)
% Eligible Pts in CCC	(LOCAL) % of Complex Continuing Care (CCC) Beds Occupied by CCC-Eligible Patients (vs. ALC or vacant)
Hospice Palliative Care	(LOCAL) Annual reporting of alignment with best practices for hospice palliative care (Q3).
ICS	(LOCAL) Indigenous Cultural Safety--training plan submitted for staff
FLS	(LOCAL) French Language Services--plans submitted to identify & serve French-speaking clients
Coordinated Access (% GAIN screened)	(LOCAL) Percentage of Patients Screened at Point of Intake Using Global Appraisal of Individual Needs Screener
ADP Occupancy	(LOCAL) Quarterly Average % of available Adult Day Program Spaces Utilized by Clients
theHealthLine.ca	(LOCAL) HSP has reviewed and revised, as needed, information on theHealthLine.ca in the last 12 mo
Residents with Responsive Behaviours Discharged from LTC	(LOCAL) Long-Term Care home has met reporting obligation for this data.
1:1 Staffing Implemented for Residents with Responsive Behaviours	(LOCAL) Long-Term Care home has met reporting obligation for this data.

Appendix 1

Service Provider Organization (SPO) INDICATORS	
Errors in Orders	Measures the rate of orders completed without errors. (Target 98%)
Fill Rate	Measures the number of orders completed without substitution of a CCAC specified product, or failure to fill. (Target 98%)
Repair or Replacement Requests	Measures the monthly completion rate for repairs or replacement requests. (Target 98%)
Emergency Repair or Replacement Requests	Measures the monthly completion rate for emergency repairs or replacement requests. (Target 98%)
Regularly Scheduled Deliveries	Measures the monthly completion rate of regularly scheduled deliveries. (Target 98%)
Individually Scheduled Deliveries	Measures the monthly completion rate of individually scheduled deliveries. (Target 98%)
Sourcing Exception Items	Measures the monthly completion rate for sourcing of Exception items within the timeframes. (Target 98%)
Special Deliveries	Measures the monthly completion rate of Special Deliveries. (Target 100%)
Referral Acceptance Rate	Measures the percentage of requests accepted to provide visit and/or hourly service to new patients (referrals) within the specified response timeframe. (Target 94%; Shift Nursing Only 100%)
Missed Care	Measures the incidence of care that is not provided in accordance with the Patient Care Plan because a visit is missed or the SPO does not have the capacity to deliver the care. (Target 0.05%)
Discharge Reporting	Measures compliance with timeframes for discharge report submission. (Target 94%)
5 Day Wait Times (Nursing)	Measures patient's timely access to nursing services within the target 5 day timeframe. (Target 95%)
5 Day Wait Times (PSS)	Measures timely access to personal support services for complex patients within the target 5 day timeframe. (Target 95%)

Appendix 2

Non-Discretionary (Ministry Directed) 2018/19 Quarter 1 Ministry-LHIN Accountability Agreement (MLAA) Funding

Initiative	Sector	Base (B) or Onetime (O)	Fiscal	Annual*	Quarter
Expansion of Access to Interdisciplinary Primary Care	Community Health Centre	B	$1,304,100		Q1
Base funding to sustain MH&A services (2% base increase)	Community Mental Health and Addictions	B	$1,698,400		Q1
Post Construction Operating Program (PCOP)	Hospital	B		$3,962,400	Q1
2018/19 Hospital Funding Increase: Base Impact and Investments	Hospital	B		$34,752,800	Q1
2018/19 Hospital Funding Increase: HSFR Net Impact and Non-Targeted Investr	Hospital	B		$31,599,380	Q1
2018/19 Hospital Funding Increase: One-Time Investments	Hospital	O	$6,981,935		Q1
2% Base Funding Increase for Small Hospitals	Hospital	B	$3,346,500		Q1
2018/19 Hospital Funding Increase: Conversion: 2017/18 One-Time Sustainability Investment to Base	Hospital	B		$3,565,600	Q1
2018/19 Hospital Funding Increase: Net Quality Based Procedures	Hospital	B		$3,159,770	Q1
ER Pay for Results (P4R)	Hospital	O	$5,620,800		Q1
Wait Times Surgical and Diagnostic Imaging Volumes Funding	Hospital	O	$1,116,050		Q1
Cataract Backlog Funding	Hospital	O	$245,085		Q1
Provincial Programs (cardiac services, bariatric, neurosurgical, etc)	Hospital	B+O	$3,470,400	$624,000	Q1
Alcohol Associated Liver Disease Pilot Program	Hospital	O		$401,400	Q1
Critical Care Nurse Training	Hospital	O		$447,200	Q1
Enhanced Services at Sexual Assault & Domestic Violence Treatment Centre	Hospital	B	$69,600		Q1
Neonatal Intensive Care Unit (NICU) Level 3 Bassinette Allocations	Hospital	O		$1,200,000	Q1
Recruitment and Retention	Hospital & Community Health Centre	B	$549,800		Q1
Long Term Care Homes Base Funding (funding formula and various initiatives)	Long Term Care Homes	B	$26,070,615		Q1
Home Care - Expansion of Services	SW LHIN Home Care	B	$11,453,200		Q1
Total			**$61,926,484**	**$79,712,550**	

*The annual amount will be paid in fiscal 2018/19 unless the amount is prorated by the ministry for partial year funding and then the fiscal column is used to differentiate fiscal from annualized; in some cases not all the annual funding will be utilized in 2018/19 due to timing constraints - funding is listed 'as provided' rather than as applied.

Agenda item 4.4

Report to the Board of Directors

Board Committee Reports

Meeting Date: **September 25, 2018**

Submitted To: ☒ **Board of Directors**

Purpose: ☒ **Information Only**

Audit Committee

With the addition of Enterprise Risk Management monitoring to the responsibilities of the Audit Committee, a meeting will be scheduled for this fall.

Board-to-Board Reference Group

The South West LHIN Board-to-Board Reference Group is to meet on Thursday, September 20 to develop a recommendation for the board's consideration regarding membership in the new Sub-region Board-to-Board Reference Groups. That decision item will be a late submission for the board's consideration at the September 25 meeting.

Governance & Nominations Committee

The Governance & Nominations Committee is next scheduled to meet on Friday, September 28. Items to be discussed include the preliminary survey results from the Accreditation Canada Governance Functioning Tool and continuing policy development work. The materials will be available on the board portal.

Quality Committee

The Quality Committee met on Thursday, September 6 to discuss items including the patient relations process, accreditation, patient safety and risk reporting, and patient engagement survey results. The board can expect a more fulsome update at the October 16 meeting. The Quality Committee is next scheduled to meet on Thursday, November 1 at 2 pm.

Agenda item 4.5

Report to the Board of Directors

Board Director Reports

Meeting Date: **September 25, 2018**

Submitted To: ☒ **Board of Directors**

Purpose: ☒ **Information Only**

South West LHIN Board Directors reported attending the following events.

Linda Ballantyne

- July 17, 2018 – South West LHIN Board of Directors meeting
- Aug, 23, 2018 – South West LHIN Quality Committee Prep Meeting
- Sept 6, 2018 – South West LHIN Quality Meeting

Wilf Riecker

- July 17, 2018 – South West LHIN Board of Directors meeting
- July 23. 2018 – South West LHIN CEO Search Committee Teleconference
- August 3, 2018 – South West LHIN CEO Search Committee Teleconference
- August 29, 2018 – South West LHIN CEO Search Committee Teleconference with Ron Sapsford
- September 13, 2018 – South West LHIN CEO Search Committee Teleconference - Credentials review

Cynthia St. John

While I've enjoyed some rest and relaxation this summer with a couple weeks of vacation, I have done some South West LHIN Board member work since our last meeting. I've participated in CEO Search Committee work and I have worked on preparing for the September governance committee meeting.

Aniko Varpalotai

- Governance Committee preparation meetings
- Chaired the first meeting of the Indigenous Work Group – August 23
- Attended Quality Committee meeting – September 6

South West **LHIN** | **RLISS** du Sud-Ouest

Patient Story:

Marilyn Gretzky

told by her husband, Al Gretzky

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

South West **LHIN** | **RLISS** du Sud-Ouest

MAiD in the South West LHIN

Report to the Board of Directors

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

Purpose

The following presentation will provide the Board of Directors with an update on Medical Assistance in Dying (MAiD), and request to expand the organization's current scope of involvement in MAiD to include MAiD provision.

We respectfully are seeking **approval** for the updated South West LHIN MAiD policy which includes this expanded scope.

Background

- In June of 2016 the federal government passed Bill C-14 which outlines the requirements that patients must meet to be eligible to receive MAiD, and the types of health professionals legally able to provide MAiD (Physicians and Nurse Practitioners).

- In keeping with legislation, the South West LHIN began to support patients with navigation/ coordination and assessment for MAiD, and facilitated the necessary connections between healthcare providers and patients and caregivers seeking MAiD.

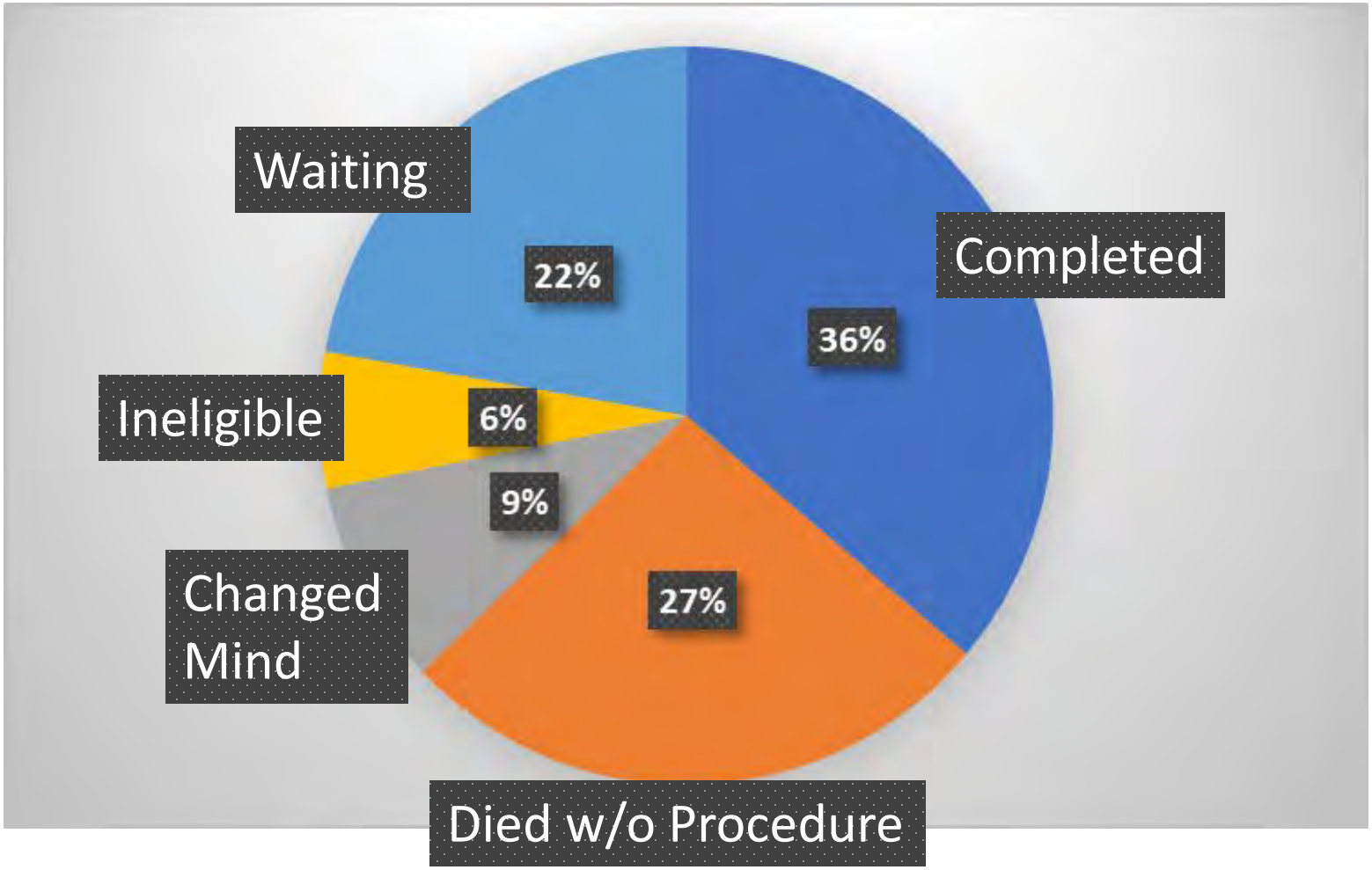
South West LHIN Data Collection

Outcomes of MAiD Requests

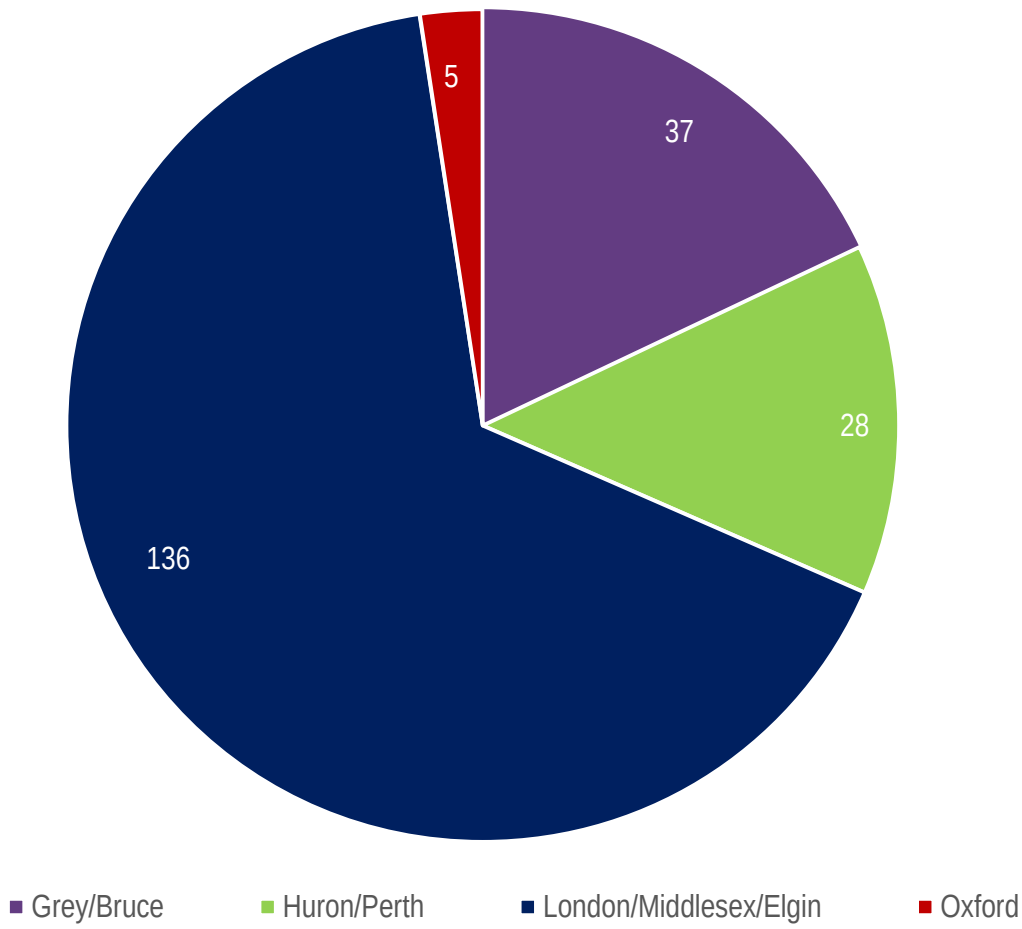
- Since the date the legislation passed, there have been over 550 requests for MAiD within the South West LHIN across all health sectors (ie hospital, community, LTC).

- The outcomes of requests are varied, with only a portion of requests ending in a completed MAiD procedure

Request Outcomes (South West LHIN) : Approximately 500 total requests



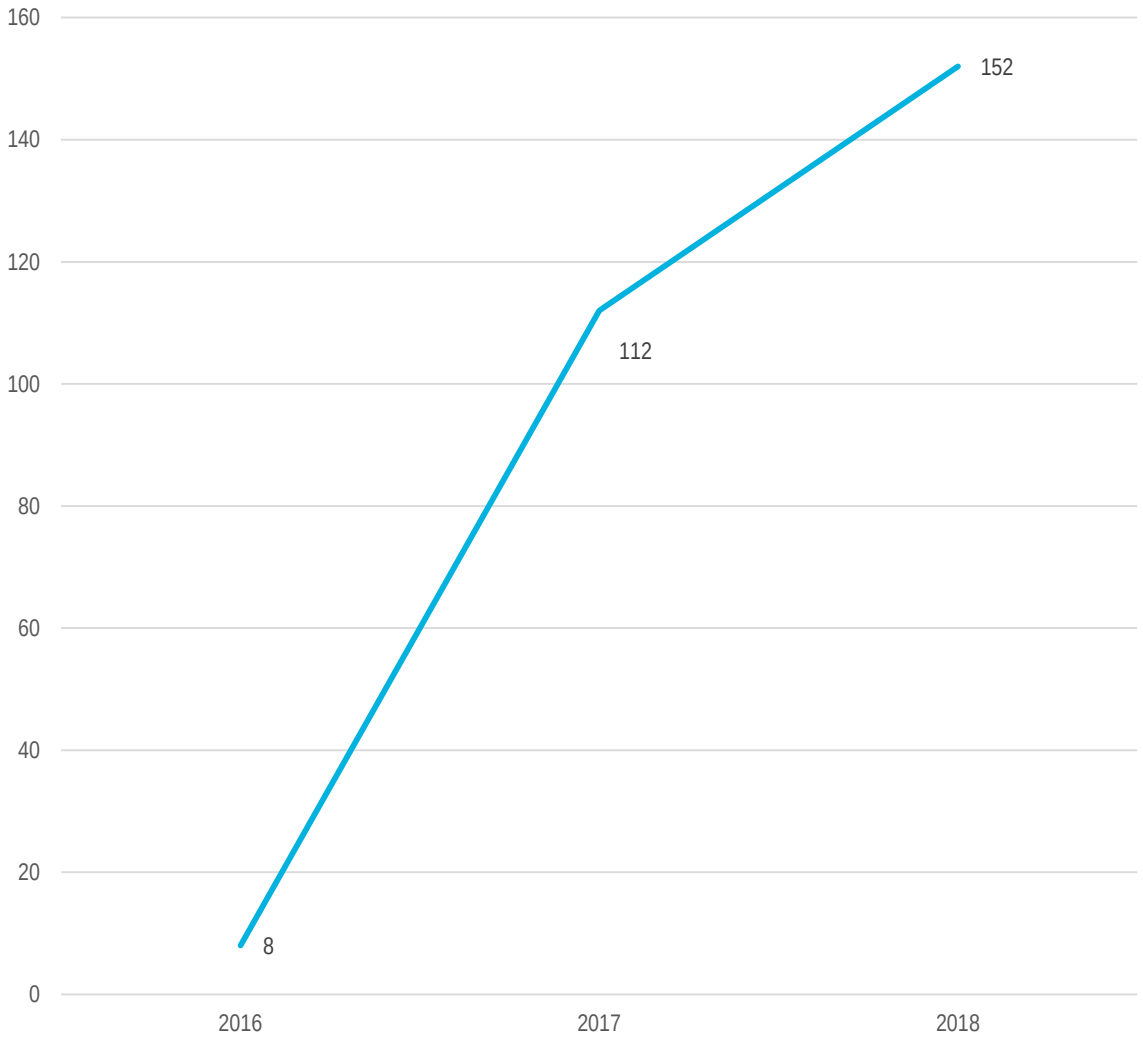
Number of Completed MAiD Cases by County (all sectors)



As of July 31, 2018 there have been a reported **1,847** MAiD deaths in Ontario.

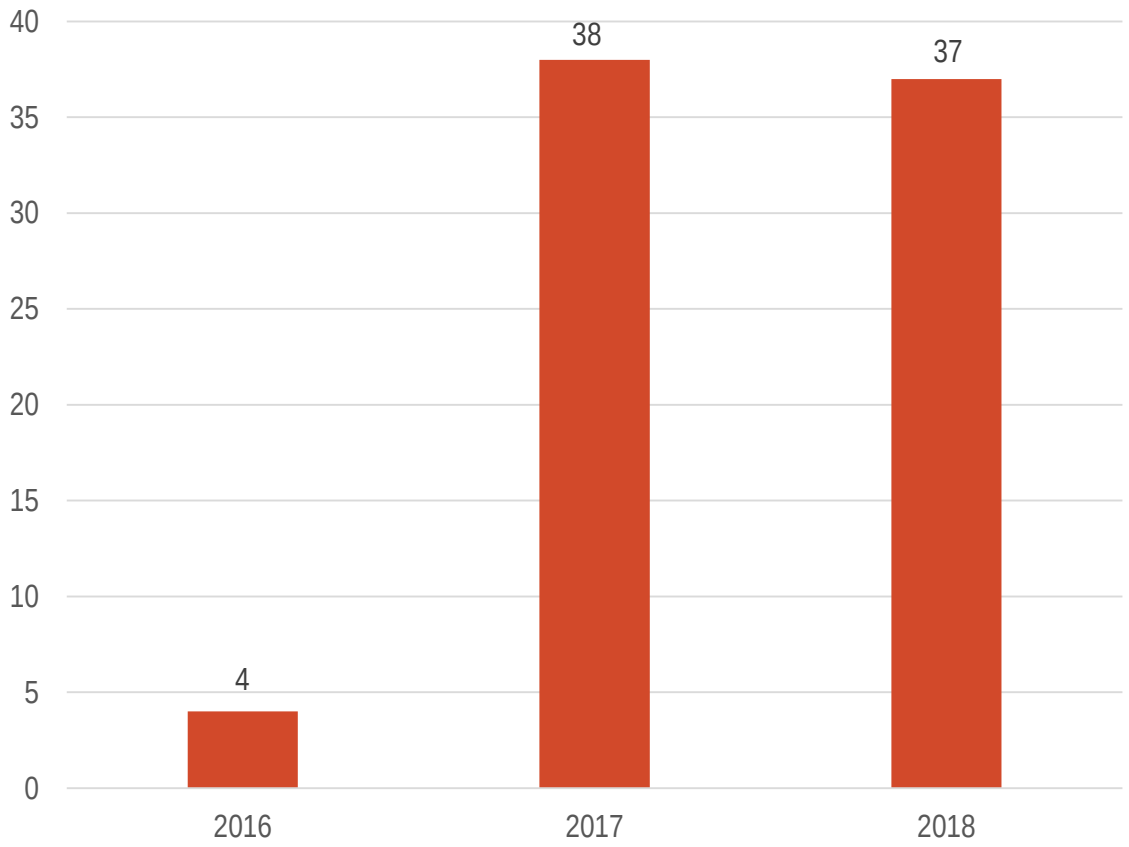
Of those, there have been a reported **206** MAiD deaths within the South West LHIN geography (all sectors).

Number of MAID Referrals per Year (as of July 31 2018) South West LHIN, Community Based Referrals.



Of the 500 requests for MAiD within the South West LHIN across all health care sectors, 272 of those requests have been in the community.

Completed MAiD Procedures in the Community (as of July 31/18)



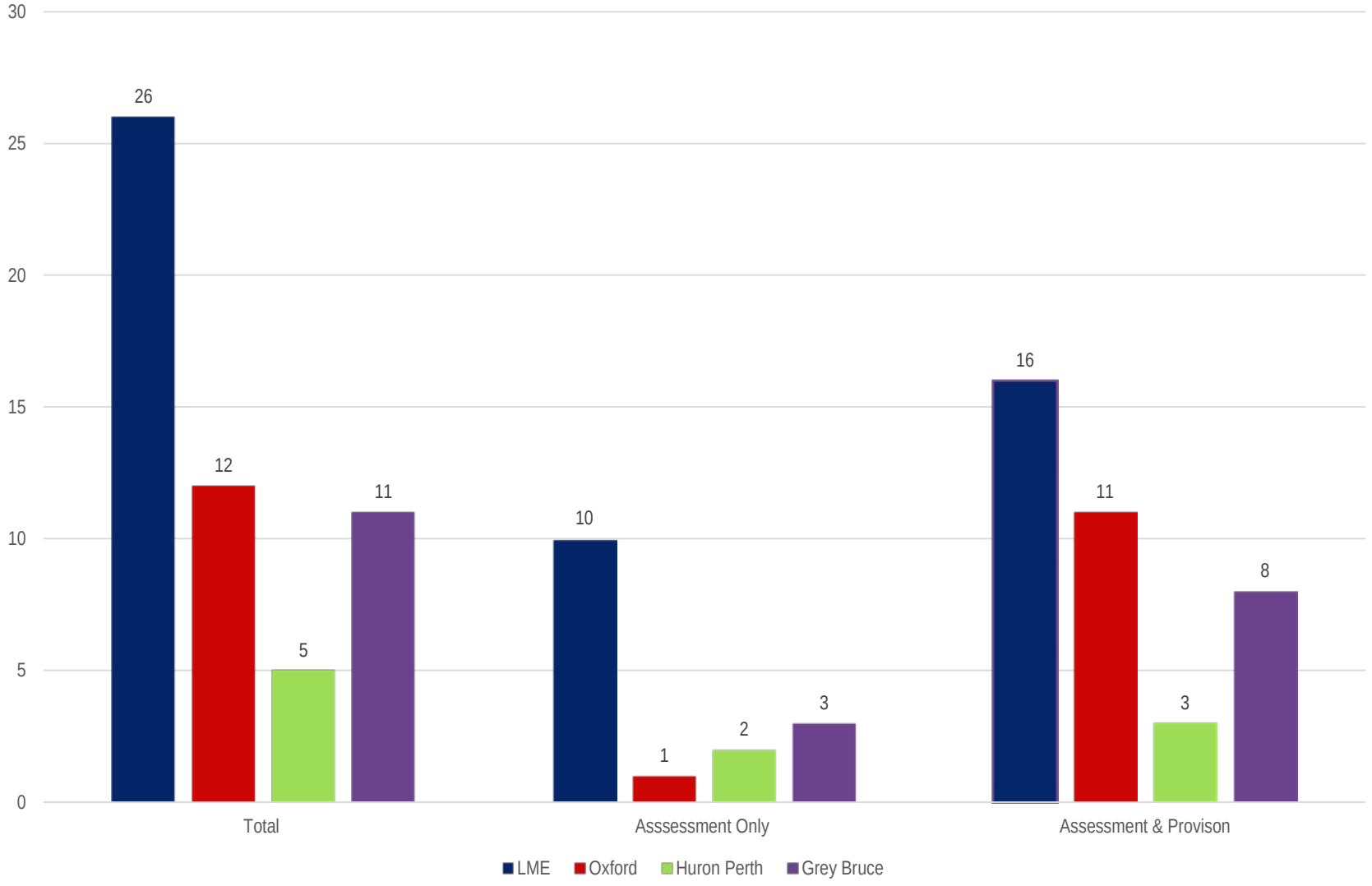
Of the 272 requests, there have been 79 procedures completed in the community within the South West LHIN as of July 31, 2018. Approximately one third of assessments lead to a completed MAiD procedure

MAiD Assessors and Providers within the South West

- Each MAiD request requires two eligibility assessments by two separate clinicians (Physician or NP). Typically one of the Assessors also acts as the Provider.

- Across the South West, there are MAiD assessors and providers in each Sub Region. Some individuals elect to only complete assessments, while some elect to do assessments and provisions. This number continues to grow as MAiD becomes increasingly more accepted within the healthcare community, and the general public.

Number of MAiD Assessors and Providers Across South West, by Sub Region



Decision Required:
MAiD Policy Adoption

Request

- Based on the scope of the current legislation, the ever increasing number of requests for MAiD assessments and provisions, and the opportunity for continuity of care for community based palliative patients, the South West LHIN wishes to support their Nurse Practitioners (NP's) in providing the legislated full scope of practice, including the Provision of MAiD.

- The South West LHIN will not take on the sole responsibility of MAiD provisions and will continue to work with community physicians and the newly added NP's to deliver the full mandate of MAiD.

Request

- The South West LHIN had previously established an organizational policy and supporting documents in order to support staff within their respective roles to provide navigation/ coordination and assessment. To support the provision of MAiD by NP's employed by the South West LHIN, a revised MAiD policy has been developed to support NP's to work to their full legislated scope of practice with respect to MAiD.

- Approval to adopt this policy is being sought

DISCUSSION

Agenda item 6.1

Report to the Board of Directors

Medical Assistance in Dying

Meeting Date: **September 25, 2018**

Submitted By: **Steven Carswell, Director of Quality**
Jennifer Row, Director of Home and Community Care
Julie Campbell, MAiD Navigator
Nicole Saunders, Quality Improvement Advisor

Submitted To: ☒ **Board of Directors** ☐ **Board Committee**

Purpose: ☐ **Information Only** ☒ **Decision**

Suggested Motion:

THAT the South West LHIN Board of Directors approves the updated South West LHIN MAiD policy as presented expanding the current scope.

Purpose

The following briefing note will provide the Board of Directors with an update on the organization's request to expand the current scope of involvement in Medical Assistance in Dying (MAiD) by including the provision MAiD. We respectfully are seeking **approval** for the updated South West LHIN MAiD policy which includes this expanded scope. The intent for developing the MAiD policy was to ensure staff employed by the South West LHIN follow the ethical principles of accountability, collaboration, dignity, equity, respect, transparency, fidelity and compassion while supporting patient choice at end-of-life.

In addition, one appendices has been included for review:

- **Appendix A –** Medical Assistance in Dying Policy

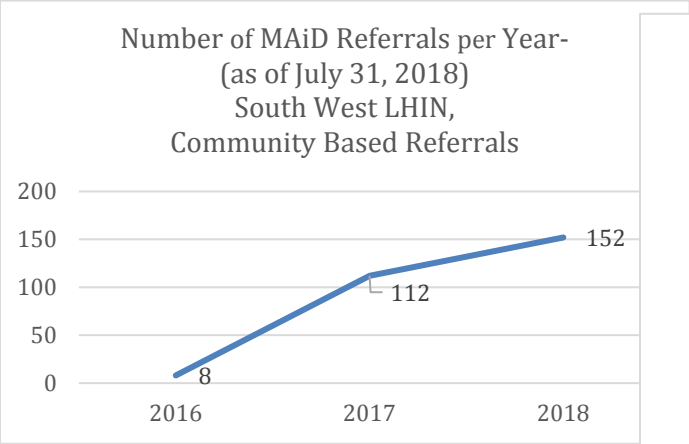
Background

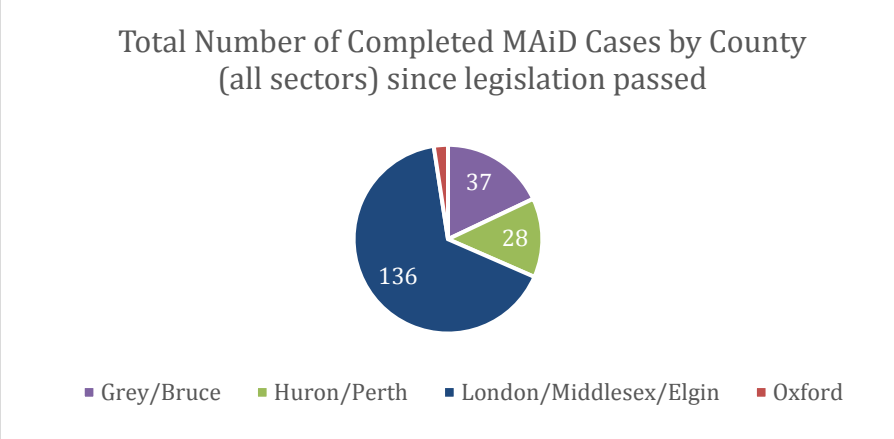
In June 2016 the Canadian Federal Government passed Bill C-14 which outlined the legislation surrounding MAiD, including eligibility requirements patients must meet to receive MAiD, and the types of health professionals legally able to assess and/or provide MAiD (Physicians and Nurse Practitioners). In keeping with legislation, the South West LHIN began to support patients with navigation/ coordination and assessment for MAiD in spring 2016, and facilitated the necessary connections between healthcare providers, patients and their caregivers seeking MAiD.

Demographics

As of July 31, 2018 there have been a reported **1,847** MAiD cases completed in Ontario. Of those, there have been a reported **206** MAiD deaths within the South West LHIN geography.

Since the date the legislation passed, there have been approximately 500 requests for MAiD within the South West LHIN across all health sectors (i.e. hospital, community, Long Term Care). The outcomes of requests are varied, with only a portion of requests ending in a completed MAiD procedure. The charts below represent the outcomes of all MAiD requests in the South West LHIN.

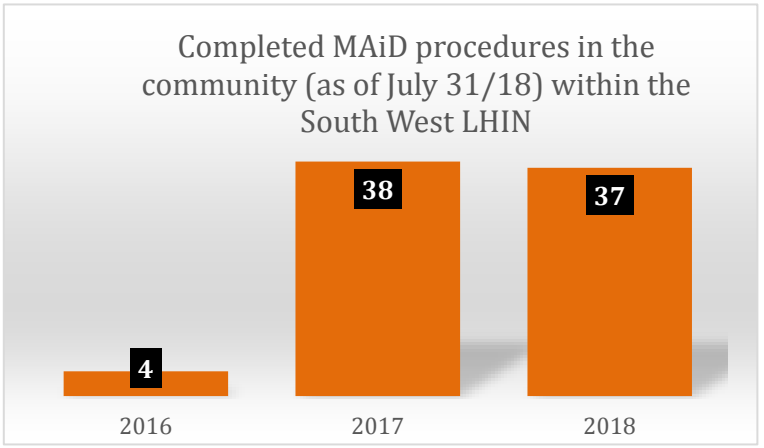


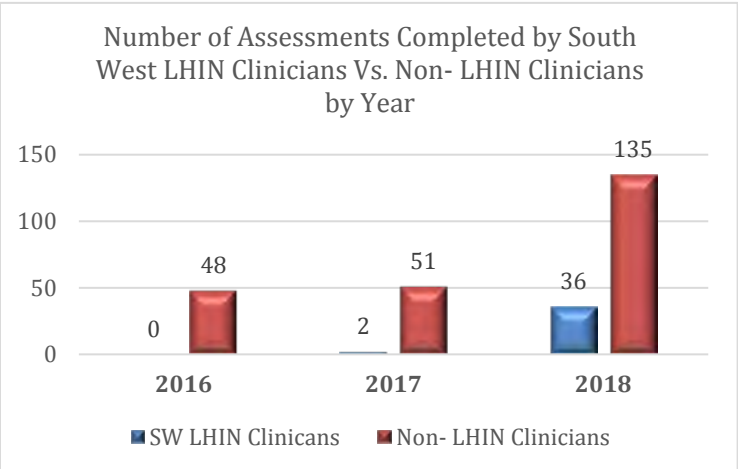


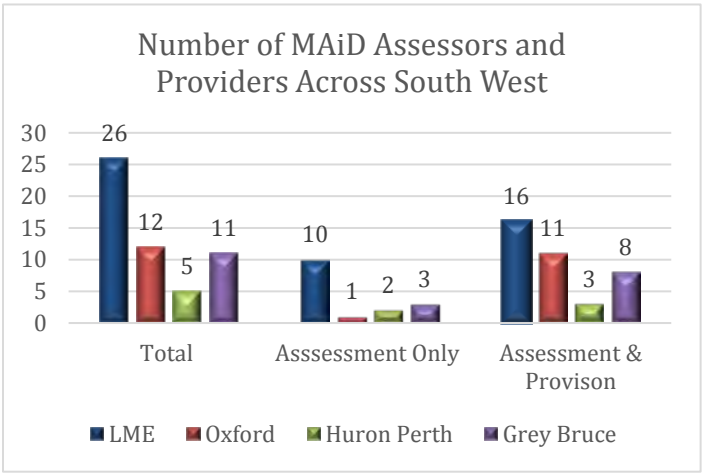
Of the 500 requests for MAiD within the South West LHIN across all health care sectors, 272 of those requests have been in the community. Of the 272 requests, there have been 79 procedures completed in the community within the South West LHIN as of July 31, 2018.

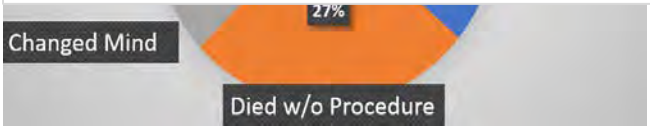
Of the 272 referrals received within the South West LHIN, the graph below outlines of the number of assessments that were completed by the South West LHIN Home and Community Care clinicians (Nurse Practitioners) as well as those completed by non-LHIN clinicians. Within the South West, to date, approximately one third of assessments lead to a completed MAiD procedure.

Across the South West, there are MAiD assessors and providers in each Sub Region. Some individuals elect to only complete assessments, while some elect to do assessments and provisions. This number continues to grow as MAiD becomes increasingly more accepted within the healthcare community, and the general public.









Due to an increasing demand for MAiD, and in response to the Ministry of Health Long Term Care's mandate related to

LHIN's responsibilities for MAiD coordination, the role of a South West LHIN MAiD Navigator was created. The MAiD Navigator's role is to help:

- Facilitate the Ministry of Health and Long Term Care's mandate (MOHLTC)
- Develop and maintain smooth pathways for patients seeking MAiD
- Build a comprehensive clinical registry, create linkages between clinicians for mentorship and shared experience
- Develop support systems though the LHIN, including a single point of contact for MAiD referrals, requests for education, consultation
- Construct communication channels internally and externally to ensure patient centered, comprehensive care and appropriate feedback loops.

With the role of the MAiD Navigator now in place, the LHIN is better equipped to not only deliver the navigation /coordination and assessment of MAiD, but also to deliver the provision of MAiD procedures through the use of Nurse Practitioners (NPs) employed by the South West LHIN.

Development to Date

Based on the scope of the current legislation, the ever increasing number of requests for MAiD assessments and provisions, and the opportunity for continuity of care for community based palliative patients, the South West LHIN wishes to support their Nurse Practitioners (NP's) in providing the legislated full scope of practice, including the Provision of MAiD. The South West LHIN will not take on the sole responsibility of MAiD provisions and will continue to work with community physicians and the newly added NP's to deliver the full mandate of MAiD.

The South West LHIN had previously established an organizational policy and supporting documents in order to support staff within their respective roles to provide navigation/ coordination and assessment. To support the provision of MAiD by NP's employed by the South West LHIN, a revised MAiD policy has been developed to support NP's to work to their full legislated scope of practice with respect to MAiD. Below are the steps that were taken in order to develop the newly defined MAiD policy to ensure the South West LHIN is equipped to deliver the full scope of MAiD.

1. Collaboration and Engagement

Collaboration amongst the MAiD Navigator, the Professional Practice Lead, Director of Home and Community Care and the Director of Quality to ensure all standards put forth within the policy are based on best practice guidelines and are in compliance with college standards. A thorough review of The Ontario College of Nurses practice standards, Canadian Nurses Association framework for MAiD, Centre for Effective Practice Clinical Practice Guideline and a discussion with the Canadian Nurses Protective Society was performed to ensure that supporting guidelines within the South West LHIN were in line with provincial and national standards of practice and regulatory requirements. Engagement with the Provincial LHIN's Professional Practice group was essential to learn for other LHIN's who are currently providing the provision of MAiD. Of the fourteen LHINS's the following three LHIN'S Toronto Central, Champlain and the North East LHIN currently have NP's acting as MAiD providers.

2. Conscientiously Objection

The South West LHIN supports and acknowledges the right of individual staff and community partners to conscientiously object to participating in the navigation/coordination, assessment and or provision of MAiD.

3. Risk Identification

To ensure the delivery of both the assessment and provision of MAiD falls within the South West LHIN'S current insurance policy HIROC was contacted and confirmed the delivery of MAiD is covered under the insurance policy with a liability of $20 million per occurrence. LHIN legal was also consulted for the development of this MAiD policy.

The identification and assessment of residual risks associated with the implementation of the delivery of MAiD was closely examined and rated both on likelihood and impact

Risk	Impact	Likelihood
Care Delivery		Possible (16%-40%)
System Performance		Rare
Reputation		Possible (16%-40%)
Financials		Rare

Based on the completed risk assessment, mitigation strategies were put in place such as:

- The provision of MAiD medication will be via parenteral route only as the South West LHIN does not support oral protocols at this time.
- Two IV's will always be established in the absence of central access
- A nurse from a contracted Service Provider Organization must be present during all provisions of MAiD completed by South West LHIN Nurse Practitioners.
- The South West LHIN will not have two Nurse Practitioners support an individual patient in MAID. Specifically, when a Nurse Practitioner from the South West LHIN is acting as a MAID assessor and/or provider, the second assessment for eligibility and/or the provision of MAID for a patient will not be conducted by another Nurse Practitioner from the South West LHIN.
- Medication administration will be based on the " Alberta Protocol" and consistent with the list of medications funded by the MOHLTC
- Regular documentation and practice audits will be conducted to ensure knowledge, skills and abilities for Nurse Practitioners.

3. Supporting Documents

In order to support South West LHIN employees in the delivery of MAiD and the South West LHIN's policy on MAiD, additional supporting documents have been created to ensure staff have access to the tools required to deliver safe, effective and quality care. Below is a list of documents created and a brief outline of each purpose.

- Clinical Practice Policy: Applies to Nurse Practitioners employed by the South West LHIN who are providing the assessment/ provision of MAiD
- MAiD Administration Clinical Practice Guideline: Is an evidence based guideline that provided an depth step by step approach that NP's must utilize when performing a MAiD provision
- Audit Tool Guideline: A tool to ensure all documentation related to MAiD coordination/ assessment and provision is completed
- Community Order for MAiD Form: A form to standardize ordering of medications used in the provision of MAiD and nursing support for IV insertion.
- MAiD Procedure Flow Sheet: A form to act as a clinical note and record of the MAiD provision
- MAiD Checklist: The MAiD Checklist is a supporting document that in combination with the MAiD SOP outlines a set of steps that must be completed by clinicians/supporting staff in the MAiD process.
- MAiD Procedure Planning Checklist: A checklist to help Nurse Practitioners each key activity is completed when planning a MAiD Provision
- MAiD Guided Conversation: The MAiD guided conversation is a document that provides probing questions for when clinicians are discussing MAiD
- MAiD Standard Operating Procedure: A document that outlines the MAiD process pertaining the coordination, assessment and provision of MAiD

Medical Assistance in Dying

Purpose

The following policy will ensure the South West LHIN is following the ethical principles of accountability, collaboration, dignity, equity, respect, transparency, fidelity and compassion while supporting patient choice at end-of-life.

The term Medical Assistance in Dying (MAiD), describes:

- the administering by a physician or nurse practitioner of a substance to a person, at their request, that causes their death; or
- the prescribing or providing by a physician or nurse practitioner of a substance to a person at their request, so that they may self-administer the substance and in doing so cause their own death.

Scope

This policy applies to the navigation, assessment and provision of MAiD by Home and Community Care staff, management and contracted service providers in the South West LHIN.

Policy Statements

1. The South West LHIN recognizes the provision of MAiD to a patient meeting established **eligibility criteria** (as outlined by the Ministry of Health and Long-Term Care from Bill C-14) as a legal option within a patient's palliative care journey.
2. The South West LHIN supports and acknowledges the right of individual staff (regulated and non-regulated) to **conscientiously object** (see definition) to participating in the navigation, assessment and/or provision of MAiD in accordance with any requirements outlined in law, professional regulatory, and college standards.
3. The South West LHIN supports the right of individual healthcare practitioners that **support** the navigation, assessment and/or provision of MAiD to do so in accordance with the law, professional regulatory, and college standards. Both participating and conscientiously objecting healthcare practitioners and staff must be treated in accordance with the South West LHIN's policies and procedures.
4. The South West LHIN has an expectation that its contracted Home and Community Care service providers will adhere to this policy and support MAiD in the community (including acknowledging the rights of individuals and organizations to participate and/or conscientiously object).
5. Service Providers Organizations who choose not to participate in MAiD in the community will have a patient transferred to a supporting organization.
6. The South West LHIN's Home and Community Care team will support patients in exploring and receiving MAiD in the community, specifically by:
    a Providing system ***navigation and coordination***
    b Conducting ***assessments*** for eligibility
    c Administering (***provision***) substances to an eligible person that causes their death

Navigation and Coordination

7. Care Coordinators, Nurse Practitioners and MAiD Navigators (and supporting management) will support patients to **access** MAiD in the South West geography, specifically by:
    a Providing information on availability and eligibility, and on the resources and process required to obtain MAiD;
    b Facilitate the connection of clinicians and other health providers with one another, and with patients or their caregivers directly seeking to access MAiD
    c Coordinate and facilitate a MAiD procedure

Assessments

8. Within an employee's role, the South West LHIN will support Nurse Practitioners and MAiD Navigators to evaluate a patient against legislative criteria for the purposes of determining eligibility for MAiD.
9. Employees of the LHIN acting as assessors for MAiD must:
    a Be in good standing with the College of Nurses of Ontario (in the extended class)
    b Have the knowledge, skills and judgement
10. The South West LHIN will not have two South West LHIN employed Nurse Practitioners support an individual patient in MAID. Specifically, when a Nurse Practitioner from the South West LHIN is acting as a MAID assessor and/or provider, the second assessment for eligibility and/or the provision of MAID for a patient will not be conducted by another Nurse Practitioner employed by the South West LHIN.
11. Should support from two Nurse Practitioners be required to support a patient in receiving MAiD, approval shall be obtained from the Director, Home and Community Care (Complex/Palliative).

Provision

12. Within an employee role, the South West LHIN will support Nurse Practitioners and MAiD Navigator in administering an eligible substance to a person, at their request, that causes their death.
13. All employees providing substances for the purpose of MAiD must follow the organization's internal Clinical Practice Policy.
14. Nurse Practitioners who provide MAiD must follow the legislative documentation and notification requirements.
15. Employees of the LHIN acting as providers for MAiD must:
    a Must be in good standing with the College of Nurses of Ontario (in the extended class); and
    b Have completed the Controlled Drugs and Substances certification; and
    c Have the knowledge, skills and judgement
16. The South West LHIN will partner with participating community physicians and nurse practitioners in the community to support patients in the provision of MAiD. The South West LHIN will not act or intend to be the sole provider in the community.

Eligibility Criteria

Federal and provincial legislation creates a framework for medical assistance in dying across Canada and in Ontario. The South West LHIN will follow the established legislative criteria.

Definitions

Conscientious Objection:

The South West LHIN acknowledges the right of individuals to conscientiously object to participating in the provision of MAiD in accordance with law and professional regulatory policies or guidelines. Correspondingly, the South West LHIN acknowledges the right of LHIN employees to conscientiously object to supporting the provision of MAiD in accordance with the law. Any member of the interprofessional team may exercise their right to conscientious objection to involvement in MAiD. Objecting employees must make an effective referral (see below) to another LHIN employee. All LHIN employees must act with discretion and compassion, and without discrimination. LHIN employees cannot object to involvement in the usual care of patients requesting MAiD.

Objecting employees may voluntarily disclose conscientious objection to their manager. Early disclosure by an objecting LHIN employee will help to ensure continuity of care and effective referrals.

Effective Referrals

A LHIN employee makes an effective referral when he or she takes positive action to ensure that another LHIN employee is available and willing to take over their role and responsibilities with respect to MAiD in a timely manner.

All effective referrals by LHIN employees involve the following steps:

- The objecting LHIN employee takes positive action to have another LHIN employee take over their responsibilities with respect to the patient requesting MAiD;
- Referrals must be made to non-objecting LHIN employees that are accessible and available to take over the objecting LHIN employee's responsibilities; and
- Referrals must be made in a timely manner to avoid any delay in the provision of MAiD to the patient.

Related Documents

- Medical Assistance in Dying – Standard Operating Procedure (Coordination/Assessment & Provision)
- Medical Assistance in Dying- Clinical Practice Policy
- Medical Assistance in Dying- Clinical Practice Guideline
- Medical Assistance in Dying- Chart Audit Tool
- Medical Assistance in Dying – Checklist (Procedure Planning)
- Medical Assistance in Dying – Checklist (SOP)
- Medical Assistance in Dying – Guided Conversation (Coordination and Navigation)
- Medical Assistance in Dying – Procedure Flow Sheet
- Medical Assistance in Dying - Community Orders for MAID

Agenda item 6.2

Report to the Board of Directors
Revised Purchase Service Budget

Meeting Date: **September 25, 2018**

Submitted By: **Hilary Anderson, VP Corporate Services and Human Resources**

Submitted To: ☒ **Board of Directors** ☐ **Board Committee**

Purpose: ☐ **Information Only** ☒ **Decision**

Suggested Motion: ***That the South West LHIN Board of Directors approve the revised Purchase Service Budget as presented.***

Purpose

The purpose of the briefing note is to provide the Board with an update on the organization's plans to manage, monitor and prioritize items with the Home and Community Care budget for the fiscal year 2018-2019. If approved, the budget will be revised and we will work to implement these items and will keep the Board updated in our reporting starting with the September Q2 report.

Background

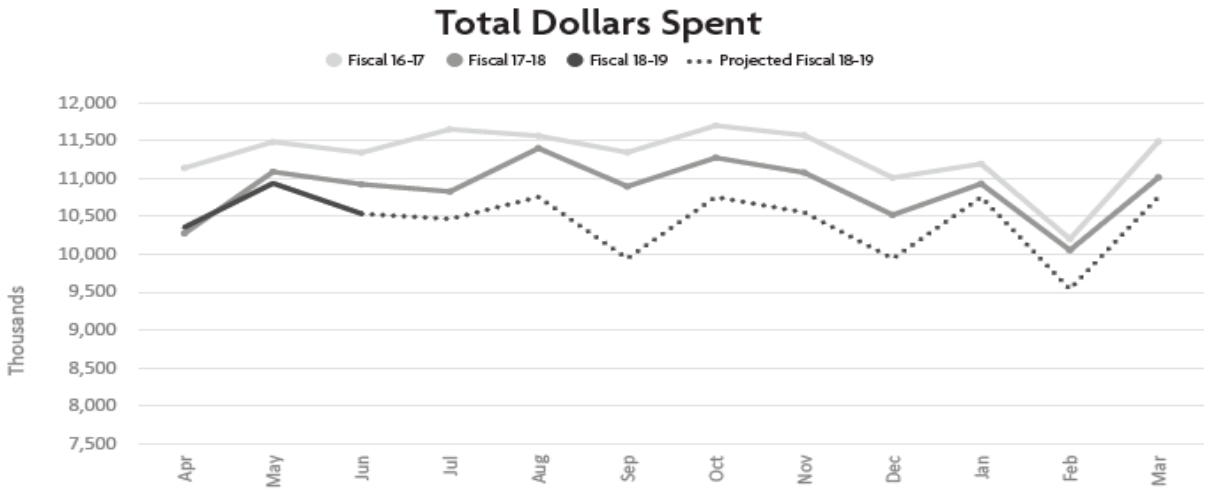
On February 20, 2018, the Board of Directors approved the 2018/2019 budget.

At the time of the report, the purchased services portion of the Home and Community Care budget was projected as follows:

	Consolidated 2018-19 Draft Budget
Purchased Services	-
Complex	41,042,712
Chronic	52,075,609
Community Independence	7,717,734
Short Stay	21,383,458
Others	8,745,560
Purchased Services- In-Home/Clinic	130,965,073
Purchased Services - Schools	4,410,956
Purchased Services - Hospice	3,990,000
PSW increase	1,716,000
Total Purchased Services	**141,082,029**

As you know from our regular updates we are projecting a surplus in Purchase Services. The decreases first observed in the fall of 2017 have continued into the first half of this fiscal. This is due to a lack of human resource capacity in the service provider workforce as well as temporarily reduced care provision capacity with one of our largest service providers following a significant cyber-security incident that affected their ability to provide service for several weeks as systems were restored.

The chart below shows the decreasing level of purchased services spend the last half of last fiscal and continuing this fiscal.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	11,139	11,482	11,342	11,650	11,563	11,346	11,699	11,570	11,011	11,193	10,203	11,490	135,687
Fiscal 17-18	10,277	11,088	10,925	10,828	11,400	10,895	11,274	11,078	10,520	10,932	10,054	11,016	130,288
Fiscal 18-19	10,357	10,937	10,535	*10,468*	*10,756*	*9,944*	*10,756*	*10,553*	*9,944*	*10,756*	*9,538*	*10,756*	31,829

Dollars In Thousands
Projected numbers

Since February we have received additional funding of $15.6M as outlined below which, given our inability to spend our original purchased services budget, has further increased our projected surplus.

- $11.5M increase in revenue due to new Community Investment Funding to expand home care services. A working group is in the process of preparing a proposal for the most appropriate and ethical allocation of the new funding.
  - $15.4M in new Community Investment Funding had been announced for 2018/2019
    - $11.5M to expand home care services;
    - $2.5M to increase contract rates for home care services (currently on hold until we hear more from the Ministry); and,
    - $1.4M funding to support sustainability of community services which flows through transfer payments to the agencies. 60% of the funding has received approval from the Ontario Legislature and the remaining 40% has not yet been released to the LHIN.

As a result of the downward trend and the increased revenue received for purchased services, we are now showing a projected $15M year-end surplus as at Q1.

As indicated at our last Board meeting a committee has been established to come up with alternative solutions on how to get care to patients.

The decisions around how to manage the Home and Community Care budget is being managed through an ethical decision-making approach, specifically with six principles of decision-making.

- **Priority 1** - Enhance the amount of care provided to patients through purchased services from our Home and Community Care contracted providers;
- **Priority 2** - Fund community services that offset the need for purchased services (to support capacity challenges);
- **Priority 3** - Increase the health human resources capacity in the Home and Community Care sector;
- **Priority 4** - Increase the knowledge, skills or experience of existing healthcare professionals (Care Coordinators, Direct Nurses and Service Provider staff);
- **Priority 5** - Introduce additional specialties or disciplines in the delivery of care that will improve patient safety and outcomes;
- **Priority 6** - Address underserved Home And Community Care patients/caregivers including but not limited to:
    - Medically fragile / Technology dependent patients;
    - Patients receiving care with mental health and/or addictions challenges;
    - Patients at end of life;
    - Caregivers experiencing high stress/burden;

After a review with the Home and Community Care Team, the following recommendations for allocation of the Home and Community Care Budget are being made. The items in the list below are in no particular order.

Item	Annualized Amount	Fiscal Amount	Priority	Base / One-Time	Comments
PSW Wage Enhancement – Provide individual PSWs with a wage enhancement. Further discussion and decisions required on how to proceed (hourly increase, retention/recruitment bonus etc.). Note this would be in addition to (or in replacement of) the MOHLTC funding, currently on hold.	$1,789,000	$1,789,000	3	Base	range of changes, fixed $, recommend they be applied retroactively to April 1, 2018
Nursing Wage Enhancement - Provide individual Nurses with a wage enhancement. Further discussion and decisions required on how to proceed (hourly increase, retention/recruitment bonus etc.). Note this would be in addition to (or in replacement of) the MOHLTC funding, currently on hold.	$2,346,000	$2,346,000	3	Base	range of changes, fixed $, recommend they be applied retroactively to April 1, 2018
Therapy Wage Enhancement - Provide individual Therapies with a wage enhancement. Further discussion and decisions required on how to proceed (hourly increase, retention/recruitment bonus etc.). Note this would be in addition to (or in replacement of) the MOHLTC funding, currently on hold.	$114,000	$114,000	3	Base	range of changes, fixed $, recommend they be applied retroactively to April 1, 2018
Enhance Nursing Service Guidelines – Increase the amount of nursing services provided to complex patients (existing and new) to align with new legislative maximums.	$1,700,000 to $4,326,000	$467,000 to $1,402,000	1	Base	It will be a gradual growth over a period of time, we assumed a start date of October 1, 2018 and go up from there. We assumed 20% growth per month (so 100% by March 2019)
Enhanced Personal Support Worker (PSW) Service Guidelines – Increase the amount of PSW services provided to chronic/complex patients (existing and new) to align with new legislative maximums.	$359,000 to $1,797,000	$90,000 to $449,000	1	Base	same as above
Enhance Therapy Service Guidelines - Increase the amount of therapy services provided to all patients (existing and new). Therapy utilization has decreased significantly over the past number of years.	$1,781,000 to $4,323,000	$419,000 to $1,258,000	1	Base	same as above
Reduce Assisted Living Waitlist – Directly fund Assisted Living providers to reduce waitlist. These patients are on LHIN HCC services, and would be more appropriate to receive Assisted Living services.	$3,220,000	$1,610,000	2	Base and One-time	More analysis being done to determine how many pateints we should fund Assisited Living for.
Participation Developmental Service Worker (DSW) Pilot Expansion – Expand the LHIN's current DSW Pilot for medically complex children	$396,000 to $595,000	$198,000 to $297,000	2	Base	
Participation House Residential Beds– Investigate the potential of funding additional residential beds. 2 beds per home	$137,000 to $687,000	$69,000 to $343,000	2	Base	
Community Para-Medicine – Invest in Community Para-Medicine programs in the community.	$950,000.00	$396,000.00	5	Base	
Additional Adult Day Program (ADP) Spaces – Fund additional ADP capacity in the community to increase respite for HCC patients.	$1,136,000	$658,000	2	Base and One-time	
Canadian Vascular Access Association (CVAA) Certification for Home & Community Care Nursing Providers – Fund LHIN Service Provider Organizations (SPO) with CVAA certification, which promotes excellence and best practices for vascular access care and infusion therapy (in progress)	$26,000	$26,000	4	One Time	
Health Human Resources Recruitment Strategy – SPO – Direct funding to support recruitment of Health Human Resources in the community. May include job fairs, advertising, etc.	$250,000	$250,000	3	One Time	
Wound Care Education – Additional Wound Care Education for LHIN SPOs and LHIN Care Coordinators	$120,000	$120,000	4	One Time	
SPO Project Funding – Provide SPOs with the opportunity for 1-time project funding (in progress).	$1,250,000	$1,250,000	TBD	One Time	There is a group deciding which ones will go forward, Initiatives will need to meet the priorities noted above.
Huron Perth PSW Strategy Huron - Perth Health Alliance (HPHA) – Aligned with the Huron Perth Sub Region Integration Table (SRIT), partner to develop pilot to support more effective use of PSWs in the community. Partnership between LHIN, HPHA, OneCare and Long Term Care.	$125,000	$125,000	3	One Time	
PSW Education Partnership - Fanshawe College – Work directly with Fanshawe College to develop a program aimed at providing information and incentive for PSWs to work in the community setting.	$50,000	$50,000	3	One Time	
Mental Health Training – Develop a program for LHIN Care Coordinators, Patient Care Assistants and Managers on appropriately dealing with patients with mental health issues (including suicide, etc.)	$50,000	$50,000	4	One Time	
Long Term Care Home (LTCH) videos - update all 78 LTCH videos to support patients and families with their decision making.	$80,000	$80,000	4	One Time	
Flex Clinic Rate Increase (10% increase in Flex Clinic Rate)	$195,000 to $488,000	$97,000 to 244,000	3	Base	currently Flex clinic rate is 75% to 80% of in home rate, cost out if we went to 85% or 90%
London Hospice Outreach	$941,000	$471,000		TBD	assumed Oct 1 start date
Participation House Residential Beds– additional 2 beds per home or 4 bed home, re: Rick McEllistrum proposal	$580,000 to $645,000	$290,000 to $326,000		Base	assumed Oct 1 start date
Flex Fund- time limited resources availalble to CSS to meet unexpected needs	$75,000.00	$75,000.00		One Time	This is a time-limited and flexible pool of annualized funding resources to meet unexpected and/or transitional needs of clients of CSS LHIN-funded organizations in the SW LHIN to assist individuals to remain in their homes, to prevent hospitalization and/or prevent premature admission to a Long Term Care Facility. Once depleted, the dollars are not available until a new allocation is received for the following fiscal year. These dollars will help support increased demand for the fund in the current fiscal year.
TOTAL	**$17,670,000 to $25,583,000**	**$11,030,000 to $13,729,000**			

As you can see by the chart above, there are 22 items that we are looking for the Board to approve so that we can proceed. You can see which items are one time (only impact the budget in this fiscal - 2018/2019) and base (are an ongoing commitment). Some items relate to funding for Community Support agencies so the dollars would be permanently moved from the home and community care budget. We will also need to seek Ministry approval for these to proceed. The chart provides a brief description of each of the items we are proposing and more detail can be provided by the staff at the Board meeting.

The costs identified for each of the items listed are estimates and if approved will be costed in more detail and then will be monitored closely.

If all items listed above are approved, we believe we can reduce the surplus by $11M-$14M (we won't exceed the available surplus amount) while increasing the care provided to patients and attempting to support providers with attracting and retaining our critical human resources.

As you can see from this list, we are focusing on the patients who need service the most and we are supporting our service providers and community partners to make best use of the available resources.

Agenda Item 6.3

Report to the Board of Directors

Canadian Mental Health Association Elgin Branch – Appointment of a Supervisor

Meeting Date: **September 25, 2018**

Submitted By: **Mark Brintnell, Vice President, Quality, Performance and Accountability**

Submitted To: ☒ **Board of Directors** ☐ **Board Committee**

Purpose: ☐ **Information** ☒ **Decision**

Purpose

The purpose of the report is to seek LHIN Board approval of an extension of the appointment of the current Supervisor at Canadian Mental Health Association (CMHA) Elgin Branch.

Suggested Motion:

Whereas *further to a motion that the board of directors of the South West Local Health Integration Network (the "LHIN") passed on April 17, 2018, attached as Schedule A (Notice of Intention) to this motion, the Chair of the LHIN board of directors gave written notice to the governing body of Canadian Mental Health Association Elgin Branch and to the Minister of Health and Long-Term Care (the "Minister"), in accordance with subsection 21.2(3) of the Local Health System Integration Act, 2006 ("LHSIA"), that the LHIN intends to appoint a health service provider supervisor for Canadian Mental Health Association Elgin Branch, on or after a date which is at least 14 days from the date that the Minister and the governing body of Canadian Mental Health Association Elgin Branch receive the notice;*

And Whereas *the Chair of the LHIN Board gave the required written notices to the Minister and the governing body of Canadian Mental Health Association Elgin Branch on April 18, 2018 via electronic mail delivery;*

And Whereas *the LHIN board of directors, having duly considered any responses to those notices and other relevant information, considers it to be in the public interest to appoint a health service provider supervisor for Canadian Mental Health Association Elgin Branch in accordance with subsection 21.2(1) of the Local Health System Integration Act, 2006;*

Whereas *further to a motion that the board of directors of the LHIN passed on May 3, 2018, attached as Schedule B (Appointment) to this motion, the LHIN board of directors appointed Ms. Sandy Whittall as a health service provider supervisor for Canadian Mental Health Association Elgin Branch pursuant to subsection 21.2(1) of LHSIA, effective May 7, 2018, and directed the Chief Executive Officer of the LHIN to enter into an agreement with Ms. Sandy Whittall for that purpose (the "Supervisor Agreement");*

Whereas *the LHIN board of directors considers it to be in the public interest to extend the term of the appointment of Ms. Sandy Whittall;*

Resolved that the LHIN board of directors:

- *hereby directs the Chief Executive Officer of the South West LHIN to extend the Supervisor Agreement with Ms. Sandy Whittall to continue to be effective up to and including March 31, 2019.*

Current Status

At its May 3, 2018 meeting, the South West LHIN Board of Directors passed the motion to appoint Sandy Whittall as the Health Service Provider Supervisor for the CMHA Elgin Branch effective May 7, 2018.

Since Ms. Whittall's appointment, the organization has stabilized and improved in terms of governance, leadership, communications and staff engagement. Steps take to-date include:

- The members of the Board were retained in an advisory capacity.
- The Executive Director is no longer with the organization.
- Responsibilities for the clinical case managers have been shifted to a Regulated Health Professional (RHP) within the leadership group.
- Regular engagement and communications with all staff established.
- An ''accreditation-like" review of both clinical services and housing services with the intention of identifying opportunities to strengthen services.
- HR specialist engaged to assist with revising critical policies and procedures, including engagement of local union representatives.
- All outstanding grievances have been discussed and resolved.
- At the suggestion of the Union Stewards, organization embarked on trauma de-brief sessions for all of the staff using an outside consultant.
- A comprehensive 'Workplace Harassment' Policy was created by the OH&S committee with the assistance of OPSEU central. The policy has been approved and the committee has taken responsibility for the roll out.
- Working closely with accountant (contract) in overseeing the year-end financial audit as well as our regular submissions to the LHIN. Focus on educating the leaders on budget preparation and monitoring. Working on a zero based approved for new 2018-19 budget.
- Relationship building with provider partners to examine opportunities to strengthen the continuum of mental health and addictions services.

Next Steps

South West LHIN staff initiated a dialogue with the Elgin Mental Health and Addictions Network, Elgin Sub-Region Integration Table and area leaders regarding how best to strengthen local mental health and addictions services. The intention is to work with local leaders to identify options on how best to achieve this goal. Recommendations will be tabled with the LHIN for review and consideration with a recommendation coming to the LHIN Board for approval prior to the end of the calendar year.

SCHEDULE A – BOARD MOTION NOTICE OF INTENTION
APPENDIX A – BOARD MOTION

Whereas on February 20, 2018, Mr. Ron McRae (the "Investigator") was appointed as an investigator under subsection 21.1(1) of the *Local Health System Integration Act, 2006* ("LHSIA") in respect of Canadian Mental Health Association (CMHA) Elgin Branch;

And Whereas the Investigator, submitted a final report to the South West Local Health Integration Network (the "LHIN") on April 9, 2018 (the "Investigator's Report");

And Whereas the Investigator's Report was provided to CMHA Elgin in accordance with subsection 21.1(14) of LHSIA;

And Whereas the Investigator's Report is available to the public at the South West LHIN office and electronically by request, in accordance with subsection 21.1(15) of LHSIA;

And Whereas the Investigator's Report identifies significant concerns regarding governance, management, operations and the workplace environment of CMHA Elgin;

And Whereas the LHIN Board of Directors has accepted the findings and recommendations in the Investigator's Report and considers it to be in the public interest to appoint a health service provider supervisor for CMHA Elgin in accordance with subsection 21.2(1) of the *Local Health System Integration Act, 2006.*

Resolved that the LHIN board of directors:

direct the Chair of the LHIN Board of Directors to give written notice to the governing body of CMHA Elgin and to the Minister of Health and Long-Term Care (the "Minister"), in accordance with subsection 21.2(3) LHSIA, that the LHIN intends to appoint a health service provider supervisor for CMHA Elgin, on or after a date which is 14 days from the date that the Minister and the governing body of CMHA Elgin receive the notice.

SCHEDULE B – BOARD MOTION APPOINTMENT

LHIN Board Motion – Appoint Supervisor following Investigation

Whereas further to a motion that the board of directors of the South West Local Health Integration Network (the "LHIN") passed on April 17, 2018, attached as Appendix A to this motion, the Chair of the LHIN board of directors gave written notice to the governing body of Canadian Mental Health Association Elgin Branch and to the Minister of Health and Long-Term Care (the "Minister"), in accordance with subsection 21.2(3) of the *Local Health System Integration Act, 2006* ("LHSIA"), that the LHIN intends to appoint a health service provider supervisor for Canadian Mental Health Association Elgin Branch, on or after a date which is 14 days from the date that the Minister and the governing body of Canadian Mental Health Association Elgin Branch receive the notice;

And Whereas the Chair gave the required written notices to the Minister and the governing body of Canadian Mental Health Association Elgin Branch on April 18, 2018 via electronic mail delivery;

And Whereas the LHIN Board of Directors, having duly considered any responses to those notices and other relevant information, considers it to be in the public interest to appoint a health service provider supervisor for Canadian Mental Health Association Elgin Branch in accordance with subsection 21.2(1) of the *Local Health System Integration Act, 2006*;

Resolved that the LHIN board of directors:

- hereby appoints Ms. Sandy Whittall as a health service provider supervisor for Canadian Mental Health Association Elgin Branch pursuant to subsection 21.2(1) of LHSIA, effective May 7, 2018; and

- directs the Chief Executive Officer of the South West LHIN to enter into an agreement with Ms. Sandy Whittall, consistent with the terms of reference attached as Appendix B.

APPENDIX B – TERMS OF REFERENCE

TERMS OF REFERENCE
Health Service Provider Supervisor for
Canadian Mental Health Association (CMHA) Elgin

1. The Supervisor shall exercise all of the powers of the Board of the Canadian Mental Health Association (CMHA) Elgin (the “HSP”), the corporation, its Executive Director in governing the HSP in accordance with all applicable legislation.

2. The Supervisor will address the governance, management and operations issues at HSP and take actions that are appropriate and necessary for the proper functioning of the HSP.

3. The Supervisor will address the HSP's financial operating position and work to implement a realistic, sustainable Performance Improvement Plan to restore the organization's financial health and achieve a balanced operating position.

4. The Supervisor will provide direction to the senior management team of the HSP during the term of the involvement of the Supervisor, as appropriate.

5. The Supervisor will develop and oversee the implementation of policies and procedures to ensure the HSP’s operations provide safe, high quality care within the HSP’s resource allocation.

6. The Supervisor may create an advisory body and retain external resources, as appropriate.

7. The Supervisor will report to the South West LHIN as required by the LHIN.

8. The Supervisor will provide scheduled updates to the Vice President, Quality, Performance and Accountability of the South West LHIN.

9. The Supervisor will provide a written report to the South West LHIN upon completion of the Supervisor's appointment.

Report to the South West LHIN Board of Directors

Sub-region Board-to-Board Reference Groups

Meeting Date: **September 25, 2018**

Submitted By: **Leslie Showers, Chair, Board-to-Board Reference Group**
Cynthia St. John, Board Member, Board-to-Board Reference Group

Purpose: ☐ **Information Only** ☒ **Decision**

Proposed Motion

THAT the South West LHIN Board of Directors approves the slate of members for the Board-to-Board Reference Groups in the sub-regions of Huron Perth and London Middlesex as endorsed by the South West LHIN Board-to-Board Reference Group. Membership will also include local representatives from the South West Board-to-Board Reference Group.

Further that the South West LHIN Board of Directors supports the launch of the Huron Perth and London Middlesex Board-to-Board Reference Groups in the fall of 2018 with the others to launch in early fiscal year 2019/20.

Recommended Slate of Members:

Huron Perth

Maureen Cole
Maureen has extensive experience in governance and is currently involved in governance in public health and hospice palliative care in Huron Perth. Much of her health care experience stems from work in municipal politics. Maureen sees sub-regional governance as an opportunity to begin to work closer together to improve the patient journey and ensure a sustainable system.

Kim Lang
Kim is both an operational leader and governor in primary care in Huron Perth. She is excited about the possibilities of another level of governance to help break down the silos in patient care, improve access to care, increase knowledge in improving patient care and building understanding about the services that are available across Huron Perth. Integrating primary care with the rest of the health care system is a priority.

Barb Major-McEwan
Barb has extensive governance experience in primary care, acute care, a regulated health professional college, and health care leadership at the local, provincial and national levels. She is interested in supporting a collaborative approach to care in Huron Perth and suggested innovative ways of governors contributing to improvements in this sub-region.

John McNeilly
John has served on a number of local Boards and is currently involved in acute care governance. John is an advocate for collaborative governance and sees our health care system as being blessed to have abundance. He is interested in change and working with other groups who will be free to be more creative in how we meet ongoing and future challenges. John sees building leadership in operations, governance and system thinking as a priority.

Delbert Shewfelt
Deb has extensive governance experience in health care including public health, long-term care and currently in community support services. Much of his health care experience stems from previous work in municipal politics. Deb sees sub-regional governance as an opportunity to begin to work closer together, integrate better, and pool resources for improved governance.

Rena Spevack
Rena has been involved in acute care governance in Huron Perth for a long time as well as being involved in local governance with the YMCA, and in provincial Trillium Foundation grant decision making. She stated that we should invest in sub-regions as health care was not sustainable if we stay the same. Rena thought we could find ways to work better with each other and find more opportunities for change, including further integration at the sub-region level.

Potential gaps in membership are: mental health and addictions, long-term care

London Middlesex
Joy Bevan
Joy has experience in health care at the staff and governance level. She worked in many capacities as a Registered Nurse and is currently involved in governance in the community support service sector. She states that she is a system thinker that is passionate about improving the patient experience and is interested in doing something about it. She sees the opportunity for governors at the sub-region level to impact patient care.

Trish Fulton
Trish has been engaged in health care governance for a long time and is currently involved in governance in public health and long-term care. Other governance experience includes acute care and a not-for profit organization. Over this time, Trish has observed that the blockages for significant patient care improvements continue to occur and the strategies we employ remain the same, so is very open to looking at a new approach. She feels there is an urgent need to move these broad discussions forward.

Lynn Humfress-Trute
Lynn has extensive governance experience with health care organizations in community support services and has recently expanded into Long-Term Care in the rural area of London Middlesex. She has governance experience in other fields such as libraries (provincial) and Military Family Resources Centres (national and international). Lynn has observed that care happens in silos and at a governance level we need to determine where we should be in 5 years in working together so that we can implement change, sharing risks and responsibilities across organizations along the way.

Jan Devereux
Jan has extensive operations and now governance experience in health care. Her most recent experience is with community support services as a governor. She is really interested in this work and believes that opportunities for integration could be identified by this group as this is very difficult for staff to do. Having Boards talk to each other is an important function that does not occur naturally in the current environment.

Dennis Lunau
Dennis has experience with governance at the school board and with a local agency that offers services for people with addictions. He got interested in governance due to the many youth he saw in schools with mental health and addictions challenges. He would be interested in supporting Boards to work better together to coordinate care with patients and their families.

Potential gaps in membership: primary care

Purpose

To provide background information on the development of Sub-region Board-to-Board Reference Groups and an overview of the candidates deemed to meet the criteria set out for membership.

Background

Terms of Reference for Sub-region Board-to-Board Reference Groups (see Appendix A) were approved at the December 2017 meeting of the South West LHIN Board of Directors. An Expression of Interest was distributed in February 2018 with 22 people making application. Due to low numbers, the Board held a webinar in May 2018 to broaden the knowledge and interest in this work. Three more applications were received. In June 2018, the South West LHIN Board-to-Board Reference Group agreed to move forward with interviews for the candidates in the London Middlesex, Huron Perth and Grey Bruce sub-regions as there were sufficient candidates to form a group if most or all candidates met the criteria.

Candidates were deemed to be ideal if they had the courage to explore and innovate, a belief in continuous improvement, the willingness to evolve, a commitment to collaboration, the discipline to demand high quality, and a focus on ensuring value for money. Over August and September, candidates were asked to join a phone call with Leslie Showers, a local member of the Board-to-Board Reference Group (Brian Orr in London Middlesex, Philip McMillan in Huron Perth, John Haggarty in Grey Bruce), and Sue McCutcheon. Consistent questions were used to guide the discussion. Overall, interviewers were encouraged by the enthusiasm for local patient care improvement through collaborative sub-region governance, regardless of decision making authority.

TIMELINE	ENGAGEMENT
September 20, 2018	South West LHIN Board-to-Board Reference Group endorses slate of members for groups in London Middlesex and Huron Perth.
September 25, 2018	South West LHIN Board of Director deliberates on slate of members for Huron Perth and London Middlesex Board-to-Board Reference Groups.
September 26 – October 5, 2018	Notify all Sub-region candidates of Board decision.
November 2018	Sub-region Board-to-Board Reference Groups are launched in Huron Perth and London Middlesex with 2 key agenda items: local governance educational needs and implementation of the Integrated Health Services Plan.
October to December 2018	Interview the candidates that have expressed interest in the Sub-region Board-to-Board Reference Groups for each of Oxford and Elgin (currently 3 in each county). Further recruitment planning: 1) identify barriers to interest, 2) develop strategies to address utilizing communication strategies brainstormed by the South West LHIN Board-to-Board Reference Group
January to March 2019	Deploy tactics in Grey Bruce, Oxford, and Elgin in order to recruit members. Further communication in Huron Perth, and London Middlesex if it is determined that there are gaps in membership.
April to June 2019	Launch Grey Bruce, Oxford and Elgin Board-to-Board Reference Groups.
Spring 2020	Evaluate progress and set work plans for 2020/21.

Appendix A

Terms of Reference

South West LHIN Sub-region Board-to-Board Reference Group

September 26, 2017 – draft reviewed by the Board-to-Board Reference Group
October 31, 2017 – revised draft reviewed by the Board-to-Board Reference Group
December 19, 2017 – approved by the Board of Directors

1. Background/Context

In keeping with our commitment to work in partnership, the South West LHIN Board of Directors is committed to building effective working relationships with Health Service Provider governing bodies to collectively advance the health system goals identified for the South West LHIN and to ensure ongoing support for a high quality, accessible and sustainable system of health care services within our LHIN.

The South West LHIN continues to move forward with health system renewal plans as part of the Patients First directions. A key focus of this work is on the development of five sub-regions across the South West LHIN. Sub-regions are smaller geographic areas that follow recognized care patterns. They have been created as part of a vision for seamless, consistent, high-quality care, and will be a focal point for integrated service planning and delivery. The South West LHIN has identified five sub-regions: Grey Bruce, Huron Perth, London Middlesex, Oxford, and Elgin.

Sub-region integration tables have been established to provide operational leadership in the identified sub-regions. They will identify, plan and make recommendations on local priorities, while driving change through a population-based planning approach, innovation and collaboration.

The South West LHIN recognizes the important role of local board members in providing guidance and leadership that ensures the delivery of high quality sustainable care that ensures a seamless patient journey for individuals and families relying on our local services. To reach our goal of an integrated system of care, the LHIN believes that a system-level governance view is imperative.

The South West LHIN is establishing 5 Sub-region Board-to-Board Reference Groups to ensure proactive consideration of board-related issues associated with the work of the sub-region integration tables and to promote a system view at the board level within each sub-region.

2. Mandate

2.1. Role of the South West LHIN Sub-region Board-to-Board Reference Groups

The South West LHIN Sub-region Board-to-Board Reference Groups will be available as needed to provide board perspectives to the sub-region integration tables representing Grey Bruce, London Middlesex, Huron Perth, Elgin, and Oxford. The key responsibility will be to facilitate broader board and community engagement in their respective local sub-region areas to promote patient-centred, inter-organization coordination while honouring member's obligations to their respective health service provider organization.

Specific issues that will be considered by the Sub-region Board-to-Board Reference Groups will include but will not be limited to:

- Strategies to promote a system view amongst health service provider board members
- Board perspectives on the current and future state of health care within the sub-region and broader South West LHIN and the role and expectations of board members; and
- Support for focused board and community engagement in the local sub-region areas to advance sub-region objectives related to improved population health, experience of care and value for money.

Sub-Region Board-to-Board Reference Groups are not governing bodies and will not alleviate the governance responsibilities of individual Boards of Directors.

3. Membership

3.1. Membership

Membership of the South West LHIN Sub-region Board-to-Board Reference Groups will be comprised of:

- Community Support Services
- Mental Health and Addiction Agencies
- Community Health Centres
- Hospitals
- Long-Term Care Homes
- Primary Care
- Public Health
- Residential Hospice
- South West LHIN *(2 board members, one local and one from outside the sub-region as available)*

The Sub-region Board-to-Board Reference Groups will be co-chaired by a South West LHIN Board Member and another member as elected by the group.

3.2. Accountability

The South West LHIN Sub-region Board-to-Board Reference Groups are convened by the South West LHIN Board of Directors to:

- Engage at least annually with their respective local Sub-region Integration Table to discuss the SRIT work plan, accomplishments to date, and potential governance implications.

- Establish a sub-region level board engagement and communication plan to help enhance system-level governance and ensure awareness of sub-region improvement and integration activities through a governance lens

- Work with Sub-region Integration Tables to identify mechanisms to support broader public engagement and awareness of advancements within their respective sub-regions as appropriate.

The Terms of Reference for the Sub-region Board-to-Board Reference Groups will be reviewed annually by the regional South West LHIN Board to Board Reference Group with any recommended changes to be approved by the Board of Directors of the South West LHIN.

3.3. Individual Roles

Individual members will:

- Provide governance level input and advice to the rollout of the Health System Design Blueprint – Vision 2022, the Integrated Health Service Plan, and Sub-region plans
- Participate fully in the exchange of information and identification of issues of relevance.
- Consider ideas and issues raised and provide guidance and input as appropriate.
- Consider system level and organizational implications and impacts of issues under consideration.

4. Logistics and Processes

4.1. Role of the Co-Chairs

The Co-Chairs will be responsible for coordinating the development of the meeting agenda and leading the meeting in a way that ensures advancement of the agenda within the timelines allocated for specific agenda items. The Co-Chairs will ensure that input is solicited from all table members when establishing objectives and meeting agendas. The Co-Chairs will ensure that an annual work plan is established by the group.

4.2. Secretariat and Administrative Support

Secretariat and administrative support will be provided by the South West LHIN Sub-Region Lead and administrative staff respectively.

4.3. Delegates

It is expected that members will regularly attend meetings, however, it is recognized that on occasion individual members may need to send a delegate to the meeting due to unavoidable scheduling conflicts. If members are sending a delegate, it is important to ensure consistency in terms of the individual selected to attend as a delegate and the use of delegates should be kept to a minimum to ensure continuity. Permission should be sought from the Co-Chairs in advance of sending delegates to a meeting. It is the responsibility of members to ensure that delegates are appropriately briefed and debriefed prior to and following any meetings that they attend.

4.4. Frequency of Meetings

Each Sub-region Board-to-Board Reference Group will meet a minimum of two times per year. Additional meetings may be scheduled at the call of the Co-Chairs.

Agenda item 6.5

Report to the Board of Directors

Chippewa of the Thames First Nation – MSAA Approval

Meeting Date: **September 25, 2018**

Submitted By: Sue McCutcheon, Interim Vice President, Strategy, System Design and Integration
Kristy McQueen, Director, System Design & Integration, and Digital Health

Submitted To: ☒ **Board of Directors** ☐ **Board Committee**

Purpose: ☐ **Information Only** ☒ **Decision**

Suggested Motion

THAT the South West Local Health Integration Network (LHIN) Board of Directors authorizes the Board Chair and Chief Executive Officer to approve and sign the new 2018/19 Multi-Sector Service Accountability Agreement covering the period September 25, 2018 to March 31, 2019 with Chippewa of the Thames First Nation (COTTFN) for $69,178.00 annualized base funding and $1,337,800 in one-time multi-year funding spread over 2018/19, 2019/20 and 2020/21 to support direct delivery of care to Indigenous clients seeking community support services and community mental health and addictions services.

Purpose

To provide a brief overview on the development of a formal funding relationship between Chippewa of the Thames First Nation (COTTFN) and the South West Local Health Integration Network (LHIN), to provide the LHIN Board with sufficient information to consider approval to authorize the Board Chair and Chief Executive Officer to approve and sign the 2018-19 Multi-Sector Service Accountability Agreement (M-SAA) between the South West LHIN and Chippewas of the Thames First Nation (COTTFN). The effective date will be September 25, 2018.

Background

The Chippewa of the Thames First Nation (COTTFN) Health Centre acknowledges that all people have a right to holistic and community care, and is guided through the leadership of Chief and Council. In 2016, the COTTFN Health Centre successfully underwent a formal accreditation of their healthcare services and supports. By providing services from nurses, traditional healers, community health representatives, allied health care professionals, support service workers, volunteers and family, the health centre is committed to preserving and maximizing each community member's ability to remain independent and in

control of their lives. The leadership is committed to working together with others to restore the culture and traditional values required to continue to rejuvenate the growth of the Nation and to govern themselves, creating a self-reliant, safe, healthy and environmentally sound community for all the descendants of Desh-kan-Ziibi.

The South West LHIN board and staff have been engaged with Chippewa of the Thames First Nation (COTTFN) Health Centre's leadership over the past seven months to create a service plan and M-SAA agreement that will enable the First Nation's community to manage the base funding for their Community Support Service (CSS) resources (currently being flowed through Southwest Ontario Aboriginal Health Access Centre and Oneida Nation of the Thames), along with the new multi-year funding for Mental Health and Addictions (MHA), retained through a recent proposal funded through the MOHLTC. COTTFN has identified that since they have undergone a successful accreditation, they have rebuilt their financial and healthcare service structures to accommodate a higher standard of operations, and in keeping with their mandate as both a First Nation and healthcare provider, they are seeking to integrate and manage these financial resources through their centre.

In the summer of 2017, COTTFN Health Centre submitted a proposal to the Ministry of Health and Long-term Care's The Journey Together call for proposals, to create new services to support the opioid crisis within the First Nations communities including Harm Reduction/Mental Health and Addictions Case management and Cultural Outreach Workers. These new supports will enhance their existing Native Alcohol and Drug Abuse Prevention Program (NADAPP) funded through Health Canada, by creating wrap-around services for community members living with addictions, through a culture-based harm reduction program. This proposal was approved for up to $1,337,800 in one-time multi-year funding for the 2018-19, 2019-20, and 2020-21 funding years. Funding will be distributed within those years as follows: up to $450,000 in 2018-19, up to $443,900 in 2019-20, and up to $443,900 in 2020-21. This funding is flowed from the LHIN directly to Chippewas of the Thames First Nation Health Centre as the lead organization to deliver an Indigenous mental health and addictions programs.

The MOHLTC has determined that funding through *The Journey Together* will flow through each LHIN organization, this means that the COTTFN community would be required to either carry an active M-SAA with the South West LHIN, or seek to flow this funding through an organization that does. Based on engagement with the First Nations, it has become clear that self-governing nations seek to carry the responsibility for their own funding whenever possible.

In keeping with this knowledge, the MOHLTC has honoured their relationships with the First Nations to find ways to support flowing the funding from the last Request for Proposal (RFP) through the LHIN to each community directly, whenever possible. While this funding is only one-time in nature, with the opportunity to be renewed after the three years, it is not possible to build an M-SAA on these new resources alone. It is the reallocation of the CSS base funding from the LHIN, which currently flows through Southwest Ontario Aboriginal Health Access Centre (SOAHAC) and Oneida Nation of the Thames, to the COTTFN Health Centre that will create a sustainable foundation for an active M-SAA agreement. All parties involved are in agreement to this approach.

Previously, the LHIN board have expressed a strong commitment for re-establishing a productive relationship with the First Nations communities to improve equitable access to health services and ultimately health outcomes for the communities. By establishing an M-SAA with COTTFN, the Board is signaling a broader commitment between COTTFN and the LHIN to work through an enhanced and formal relationship process starting with reallocating the CSS funding and creating a financial framework

to support enhanced mental health and addictions services that address the direct needs of the community.

Current Status

The LHIN has been actively working together with the leadership from the COTTFN Health Centre to develop and finalize the necessary agreements, service plan, Community Accountability Planning Submission (CAPS) plan and M-SAA documentation required to fulfill the requirements for this process.

In September, 2018, the COTTFN Leadership brought forward the Community Accountability Planning submission to Chief and Council for approval. On September 10, 2018, the Chippewas of the Thames First Nation Chief and Council gave their full support of the Community Accountability Planning submission being submitted to the South West LHIN and passed a resolution that supports entering into an agreement with the LHIN.

Summary of Proposed Funding Allocation

Type of Funding	**Amount**	**Utilization**
Annualized Base Funding	**$69,178.00**	Seniors Program Coordinator
	$47,000	Salaries and Benefits
	$2,428	Equipment Expenses
	$4,000	Supplies & Sundry Expenses
	$15,750	Contracted Out Expense
One Time 2018-19	**$450,000.00**	Total One Time Funding 2018-19
	$226,643	Salaries and Benefits
	$155,000	Med/Surgical Supplies & Drugs
	$57,255	Supplies & Sundry Expenses
	$6,102	Community One Time Expense
	$5,000	Contracted Out Expense
Total	**$519,178.00**	**Total 2018-19 Funding**

Next Steps:

- LHIN staff will continue to work in partnership with COTTFN Health Centre to fully develop the details of the M-SAA and Service Plan.
- Board Chair and CEO will approve and sign the proposed M-SAA
- Once the M-SAA is approved, the LHIN staff will work with COTTFN Health Centre to ensure that reporting training and mechanisms are in place to guide the implementation and sustainability of these services

Agenda item 7.1

Report to the Board of Directors

June 2018 Financial Update

Meeting Date: **September 25, 2018**

Submitted By: **Hilary Anderson, Vice President Corporate Services**
Ron Hoogkamp, Director Finance and Health Records

Submitted To: ☒ **Board of Directors** ☐ **Board Committee**

Purpose: ☒ **Information Only** ☐ **Decision**

Below is the 2018/2019 fiscal year reporting for the period ending LE03 June 30, 2018. The report consists of the Financial Narrative Report (below), the Financial Report (Appendix A), the Referrals, Admissions & Discharges Chart (Appendix B), and the Purchased Service by Population Charts (Appendix C). The Financial Narrative Report provides explanations for the Financial Report (Appendix A). The Financial Report (Appendix A) consists of 2 statements. The Statement of Operations – Year to Date compares the Budget Latest Estimate (LE) for the Year to Date (YTD) compared to the Actuals YTD. The LE vs LE – Total Year compares the adjustments to the full year LE made after the last report. The Referrals, Admits, & Discharges Chart (Appendix B) details the average referrals, admits, and discharges per working day. The Purchased Service by Population Charts (Appendix C) consists of YTD dollars spent in total and by population for in-home services and school services. The YTD dollar spent in total for in-home services also includes the projection for the remainder of the year as a dotted trend line in the Total Dollars Spent chart.

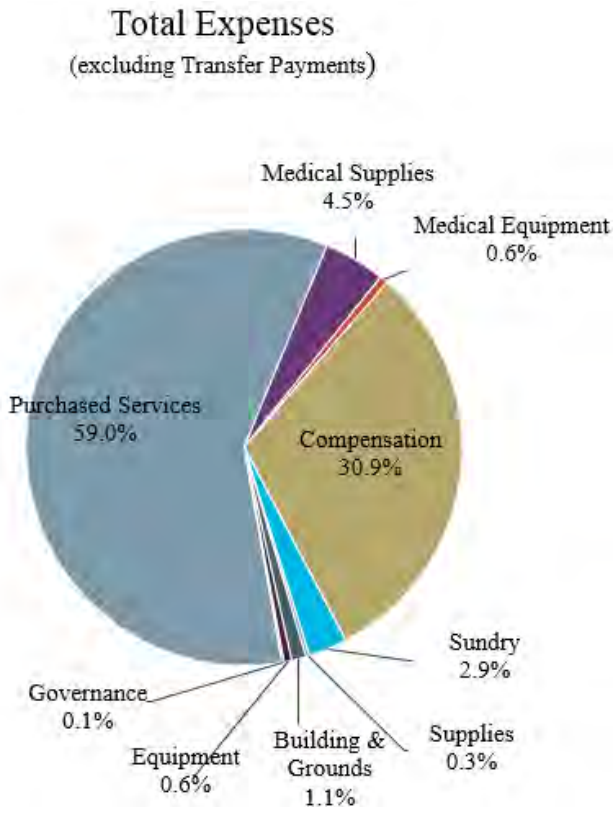
Purpose

The South West LHIN finance team is accountable for accurate, timely and transparent financial reporting and for evaluating the impact of changing assumptions on projected financial results. The purpose of this report is to provide a summary of financial results year to date and significant changes to the 2018/19 projections as at LE03 (June 30, 2018).

LE03 Actuals

Refer to the Statement of Operations – Year to Date (Appendix A) for Actuals and Budget LE YTD as of LE03. Below is a chart showing each expense line, excluding transfer payments, as a percentage of the total. Surplus (revenue over expenses) to LE03 is $4.0M or 0.7% as a percentage of total revenues and 6.3% as a total of operational funding (MoHLTC Funding and Other Income). This is mainly due to new funding of $11.5M for Home Care/LHIN delivered services that was partially recognized in the first quarter. Related expenses are expected to be realized beginning in fall 2018 as plans to use these funds are initialized. In the expense section of the statement the top portion shows all payments made to

external Health Service Providers, including contracted in-home health services, medical supplies and medical equipment rental. The bottom section includes all LHIN operational activities, including planning and integration, quality and performance, administration and front line patient service delivery activities such as, care coordination, mental health nurses, rapid response nurses, palliative care outreach teams.



Purchased Services

The Purchased Service decreases first observed in 2017-18 have continued into the first quarter of this year. This is due to a lack of human resource capacity in the service provider workforce as well as reduced care provision with one of our largest service providers following a cyber-security incident.

Compensation

Increased casual and overtime usage is having an unfavourable effect on compensation expenses which is offset in part with higher than average vacancies. The current deficit in compensation is due to timing and is expected to align by year end.

Other Lines

Sundry and Supplies expenses are trending lower than expected in part due to timing and in part due to imposed spending and travel restrictions.
Building and Grounds expenses are in line with budgeted amounts.
Equipment expenses are trending as expected. Historically the majority of spending in this line will occur in the last quarter of the fiscal year.
Governance expenses are less than budgeted due to timing and are expected to align at year end.

LE03 Year End Projection

In this section, we will detail the changes to assumptions when compared with opening 2018-19 balanced budget (LE00). The projected surplus is $14.9M as at LE03.

Projected Revenue

Revenue is forecasted to increase $33.5M due to the following:

- $17.9M increase in Transfer Payment revenues and payments to Health Service Providers in the first quarter of 2018-19.
- $11.5M increase in revenue due to new Community Investment Funding to expand home care services. A working group is in the process of preparing a proposal for the most appropriate and ethical allocation of the new funding.
    - As previously reported, $15.4M in new Community Investment Funding had been announced for 2018/19, allocated $11.5M to expand home care services, $2.5M to increase contract rates for home care services, and $1.4M to support sustainability of community services (this will flow through transfer payments). The original funding letter had indicated that 40% was subject to appropriation from the Ontario Legislature. A portion of the new funding that was on hold has now been released to the LHIN, as detailed below.
    - The full $11.5M has received the approval from the Ontario Legislature.
    - The full $2.5M funding for home care service contract increases is currently on hold and no revenue or expenses are included for the year as of LE03.
    - The $1.4M funding to support sustainability of community services flows through transfer payments. 60% of the funding has received approval from the Ontario Legislature and the remaining 40% has not yet been released to the LHIN.

- $4.3M increase due to the delay in transitioning the Special Needs Strategy (SNS) program to the Ministry of Children and Youth Services (MCYS). Originally, the opening balanced budget had not included the SNS program as the expectation was it would be transferred to the Children's Treatment Centre effective April 1, 2018. It will now remain with the South West LHIN for the time being until the Ministry decides the best course of action. Until such time the related revenues and expenses have been added back into our Latest Estimate. Subsequent to the preparation of the Q1 financial report we have received instruction from the Ministry to proceed with the transfer SNS program to the Thames Valley Children's Treatment Centre (TVCC). The Ministry has given us a window from November 2018 to January 2019 to complete the transfer. We are working with TVCC to meet that timeframe. The adjusted funding and related expense will be reflected on your Q2 financial report.
- $555K decrease in revenue due to Priorities for Investment (PFI) funding no longer being received, with the expectation that base funding will be reallocated to cover the related expenses.
- $500K decrease in revenue due to Chronic Kidney Disease (CKD) funding from Cancer Care Ontario funding transferring to London Health Sciences Centre (LHSC), with the expectation that base funding will be reallocated to cover the related expenses.
- $420K increase in funding for additional Hospice beds in Grey Bruce.
- $287K increase in funding for prorated portion of Geriatric Resource Nurse funding.

Projected Purchased Services

$2.0M decrease in Purchased Services due to the following:

- $7.1M decrease due to a decrease in projected In-Home/Clinic Purchased Services based on an analysis of current trends and a continuing shortage in the PSW workforce.
- $4.3M increase as a result of the delay in the Special Needs Strategy transition to move school therapy services to Thames Valley Children's Centre. The LE reflects an increase in funding, offset fully with expenses to accommodate for this delay.
- $420K increase due to funding of two Hospice beds in Huron Perth and two Hospice beds in Grey Bruce. No additional funding will be received, instead these will be funded directly from base Home & Community Care funding.
- $420K increase due to funding additional beds in Grey Bruce Hospice. The hospice expansion has not yet taken place. Funds will not be distributed until the beds are operational.

Projected Medical Supplies and Equipment

$206K increase to Medical Supplies projection due to new funding for Wound Care Offloading devices.

Medical Equipment is trending as expected.

Projected Compensation

Increase in Compensation due to the following adjustments:

- $1.25M due to an increase of approximately 20 FTE in the first quarter of 2018-19
- Significant increase in Casual and Overtime usage due to the pressures imposed by increased vacancies
- $275K due to a top up in pay equity accrual, an increase in nurse practitioner compensation as a result of inclusion in ONA, and an increase in the casual and overtime budget.
- $275K due to the delay in transferring Geriatric Resource Nurses to St. Joseph's Health Care London. The transfer had originally been budgeted to be effective April 1, 2018 but will now be effective August 20, 2018. The LE reflects an increase in funding, offset fully with expenses to accommodate for this delay.
- The non-union pay equity analysis has been completed and required salary adjustments have been finalized.

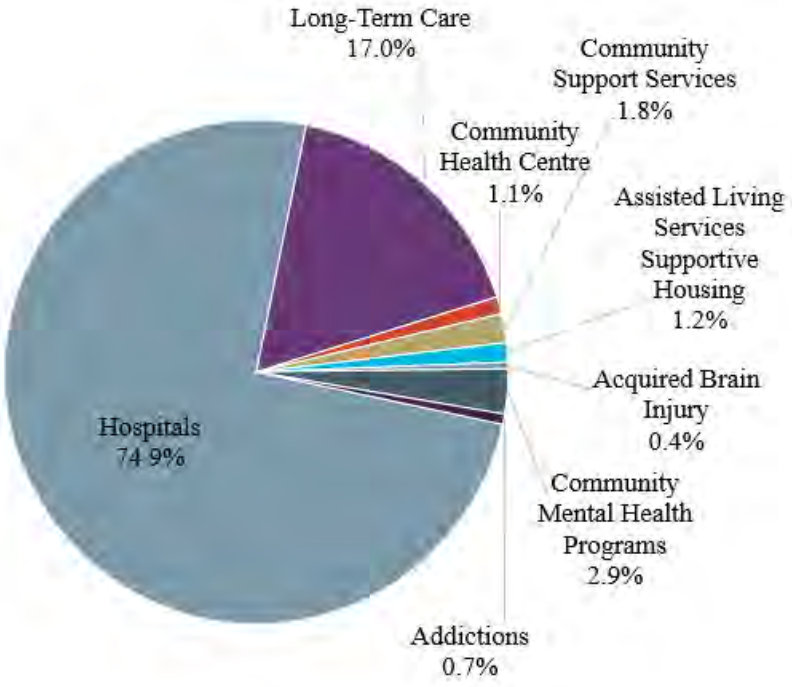
The opening balanced budget included a 1.4% vacancy rate, however we are currently trending at 4%. If vacancy rates continue in this manner we will start to see a surplus develop on this line.

Transfer Payments

Transfer payments paid to health service providers are shown in below. The table below compares Annualized Commitments, Fiscal Commitments, and YTD Actuals. Also below is a chart showing the fiscal percentage of dollars by sector. In total, these funds represent approximately 90% of the Ministry dollars administered by the South West LHIN. Annualized commitments (i.e. 12 months base) is the amount payable to health service providers as per the MLAA and SAA as at June 30, 2018. Fiscal allocations are actual funds payable to health service providers in 2018-19 fiscal year. This includes both base and one-time funding. YTD actuals are the funds allocated to health service providers as on the statement date.

	ANNUALIZED COMMITMENTS	FISCAL ALLOCATIONS	YTD ACTUALS
Hospitals	$ 1,601,442,885	$ 1,603,362,485	$402,008,221
Long-Term Care	361,250,313	364,268,029	89,333,884
Community Health Centre	23,106,663	23,446,663	6,009,689
Community Support Services	39,101,414	39,552,514	9,775,544
Assisted Living Services Supportive Housing	26,761,288	26,761,288	6,690,388
Acquired Brain Injury	9,068,786	9,068,786	2,267,216
Community Mental Health Programs	61,459,182	61,450,475	15,328,723
Addictions	13,090,531	14,090,531	4,198,501
TOTAL	$ 2,135,281,062	$ 2,142,000,771	$535,612,166

FISCAL ALLOCATIONS



South West LHIN

Appendix A

2018-2019 JUNE (LE03) FINANCIAL REPORT

STATEMENT OF OPERATIONS - YEAR TO DATE

	Budget LE YTD (A)	Actuals YTD (B)	Variance	% Variance
Transfer Payment Revenue	$ 535,612,166	$ 535,612,166	-	0%
MoHLTC Funding	62,429,235	63,127,549	698,314	1%
Other Income	251,963	384,932	132,969	53%
Total Revenues	**$ 598,293,364**	**$ 599,124,647**	$ 831,283	
Transfer Payment Expenses	$ 535,612,166	$ 535,612,166	-	0%
Purchased Services	34,777,222	35,684,376	(907,154)	-3%
Medical Supplies	2,681,551	2,517,096	164,455	6%
Medical Equipment	358,587	348,844	9,743	3%
Total External Health Service Provider Expenses	**$ 573,429,526**	**$ 574,162,482**	$ (732,956)	
Compensation	18,228,510	18,618,421	(389,911)	-2%
Sundry	1,697,527	1,387,806	309,721	18%
Supplies	161,876	69,566	92,310	57%
Building & Grounds	627,954	601,191	26,763	4%
Equipment	338,070	234,353	103,717	31%
Governance	85,359	37,788	47,571	56%
Total Operational Expenses	**$ 21,139,296**	**$ 20,949,125**	$ 190,171	
Surplus / (Deficit)	**$ 3,724,543**	**$ 4,013,040**	**$ 288,498**	**8%**

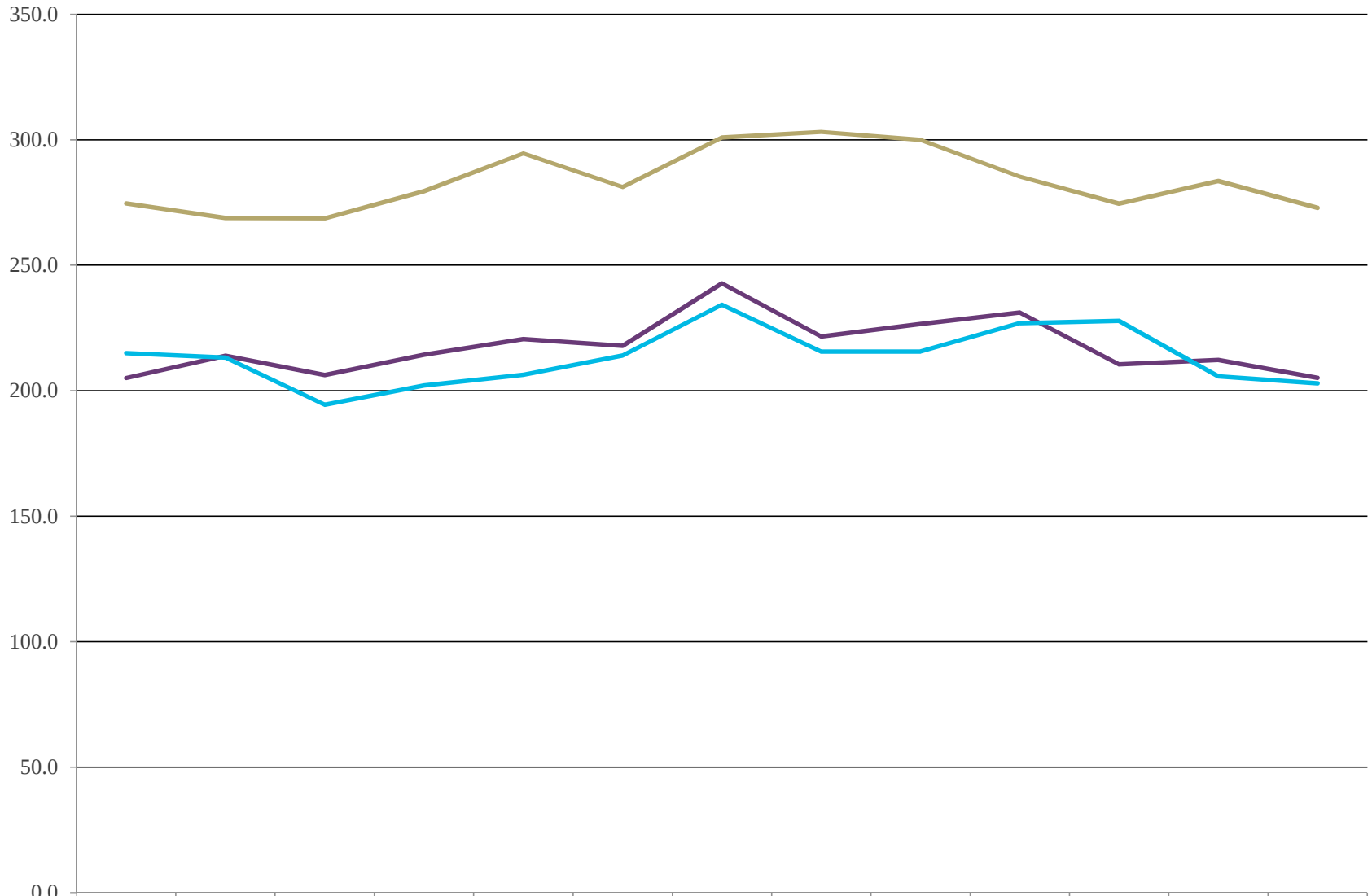
LE vs LE - TOTAL YEAR

	LE00 (C)	LE03 (D)	Variance	% Variance
Transfer Payment Revenue	$ 2,124,064,961	$ 2,142,000,771	17,935,810	1%
MoHLTC Funding	233,687,842	249,716,941	16,029,099	7%
Other Income	1,459,652	1,007,852	(451,800)	-31%
Total Revenues	**$ 2,359,212,455**	**$ 2,392,725,564**	$ 33,513,109	
Transfer Payment Expenses	$ 2,124,064,961	$ 2,142,000,771	(17,935,810)	-1%
Purchased Services	141,082,029	139,108,887	1,973,142	1%
Medical Supplies	10,520,504	10,726,204	(205,700)	-2%
Medical Equipment	1,434,347	1,434,347	-	0%
Total External Health Service Provider Expenses	**$ 2,277,101,841**	**$ 2,293,270,209**	$ (16,168,368)	
Compensation	70,511,883	72,914,040	(2,402,157)	-3%
Sundry	6,919,689	6,929,109	(9,420)	0%
Supplies	647,505	647,505	-	0%
Building & Grounds	2,511,818	2,511,818	-	0%
Equipment	1,317,282	1,352,282	(35,000)	-3%
Governance	202,437	202,437	-	0%
Total Operational Expenses	**$ 82,110,614**	**$ 84,557,191**	$ (2,446,577)	
Surplus / (Deficit)	**$ 0**	**$ 14,898,164**	**$ 14,898,164**	

South West LHIN

Average Home Care Referrals, Admits & Discharges Per Workday
June 1, 2017 to June 30, 2018
As of August 13, 2018

Appendix B

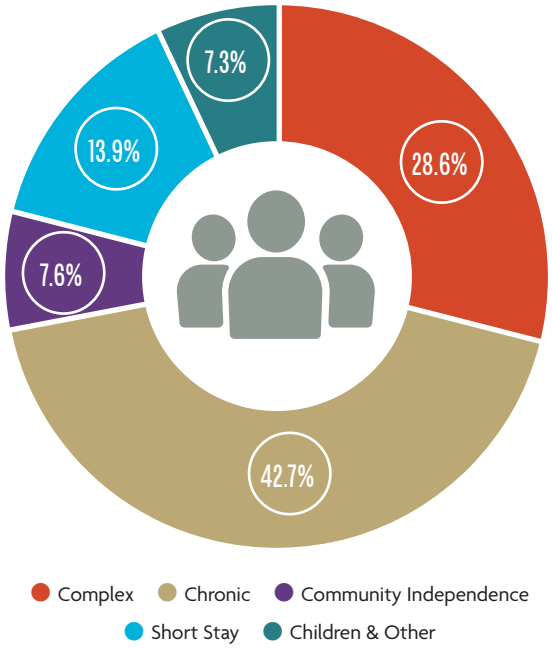


	Jun, 2017-18	Jul, 2017-18	Aug, 2017-18	Sep, 2017-18	Oct, 2017-18	Nov, 2017-18	Dec, 2017-18	Jan, 2017-18	Feb, 2017-18	Mar, 2017-18	Apr, 2018-19	May, 2018-19	June, 2018-19
Avg Admit/Work Day	205.0	214.0	206.2	214.3	220.6	217.9	242.8	221.6	226.6	231.1	210.5	212.3	205.1
Avg Discharges/Work Day	215.0	213.3	194.4	202.1	206.3	214.0	234.3	215.5	215.6	227.0	227.8	205.7	202.9
Avg Referrals/Work Day	274.6	268.9	268.7	279.5	294.6	281.2	300.9	303.1	300.0	285.3	274.6	283.5	272.9

YTD IN-HOME DOLLARS SPENT BY POPULATION

June 2018 | Fiscal 18/19 - April 2018 to June 2018

Dollars by Population

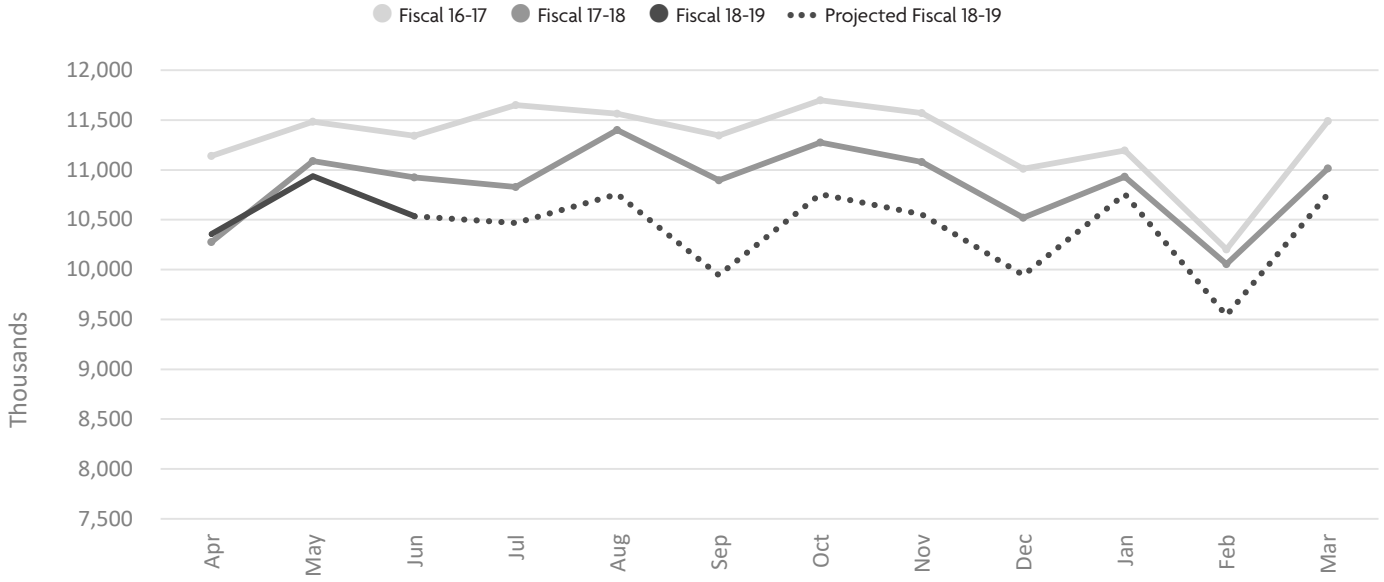


Dollars Spent Change

YTD June 2017 vs YTD June 2018

Complex	-3.60%
Chronic	3.76%
Community Independence	22.14%
Short Stay	-20.08%
Children & Other	2.57%
Total	-1.43%

Total Dollars Spent

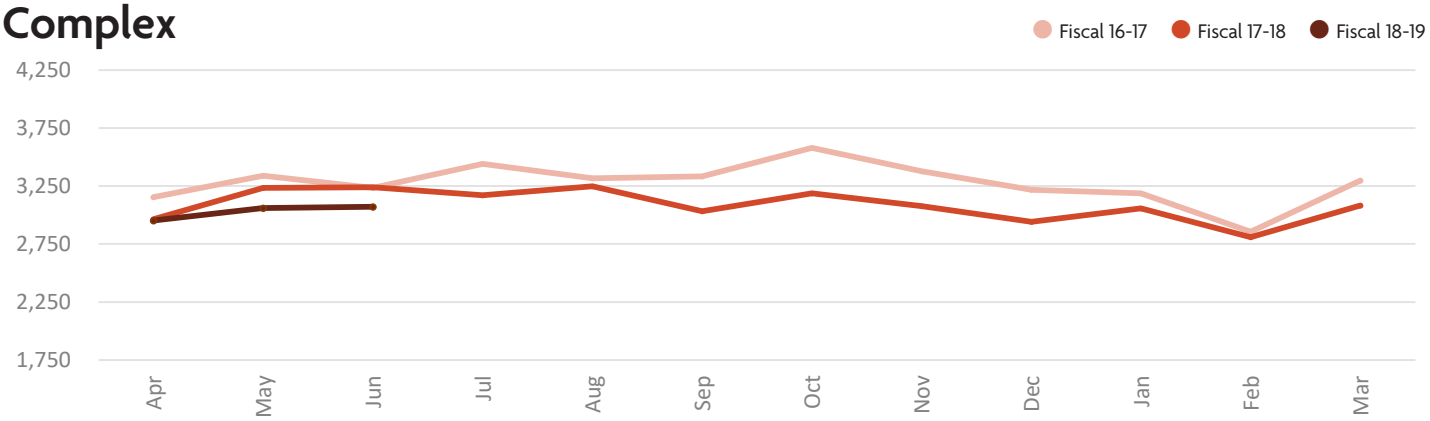


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	11,139	11,482	11,342	11,650	11,563	11,346	11,699	11,570	11,011	11,193	10,203	11,490	135,687
Fiscal 17-18	10,277	11,088	10,925	10,828	11,400	10,895	11,274	11,078	10,520	10,932	10,054	11,016	130,288
Fiscal 18-19	10,357	10,937	10,535	*10,468*	*10,756*	*9,944*	*10,756*	*10,553*	*9,944*	*10,756*	*9,538*	*10,756*	31,829

Dollars In Thousands
Projected numbers

YEAR TO YEAR IN-HOME DOLLARS SPENT BY POPULATION

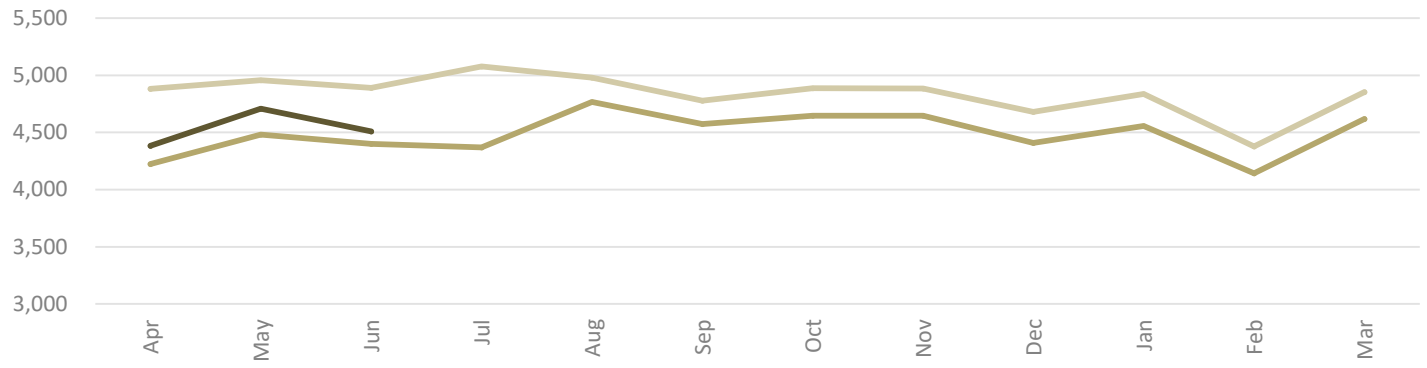
Complex



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	3,154	3,338	3,234	3,441	3,317	3,332	3,578	3,377	3,218	3,186	2,857	3,297	39,330
Fiscal 17-18	2,964	3,233	3,239	3,170	3,247	3,033	3,186	3,075	2,942	3,058	2,809	3,083	37,040
Fiscal 18-19	2,952	3,060	3,072										9,084

Dollars In Thousands

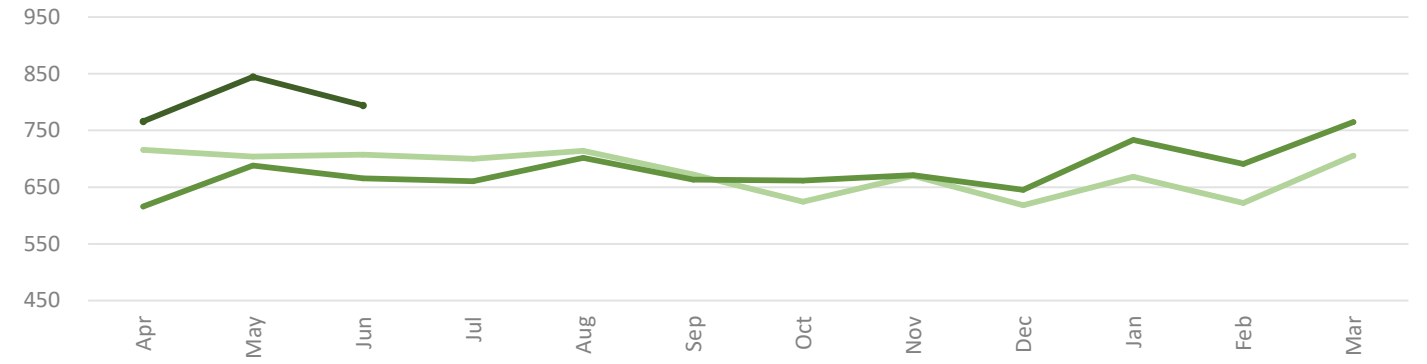
Chronic



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	4,882	4,958	4,889	5,077	4,978	4,778	4,887	4,883	4,679	4,836	4,377	4,854	58,079
Fiscal 17-18	4,224	4,482	4,399	4,368	4,768	4,575	4,647	4,645	4,409	4,556	4,143	4,618	53,833
Fiscal 18-19	4,384	4,707	4,508										13,599

Dollars In Thousands

Community Independence

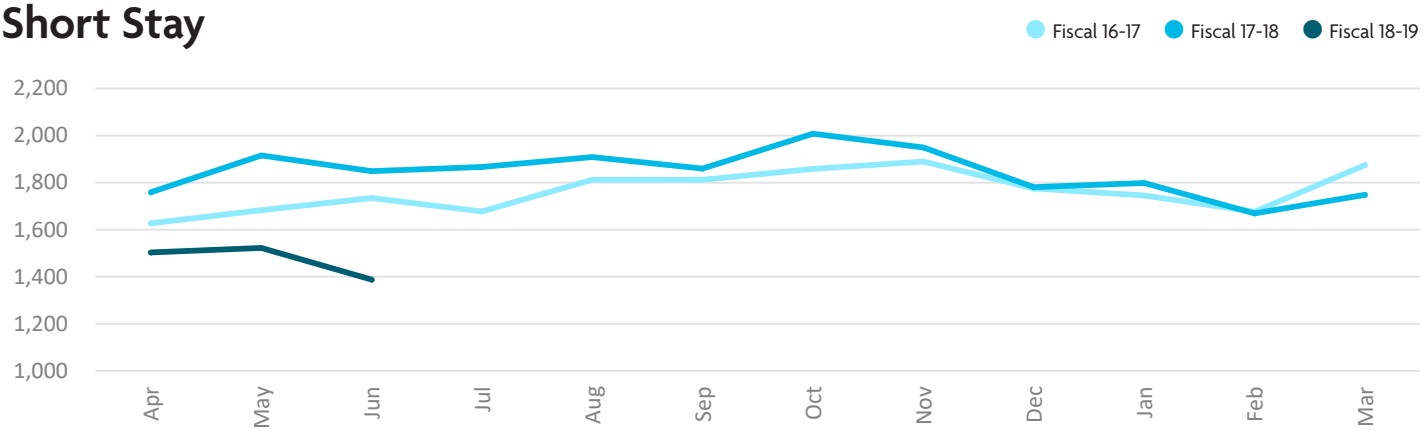


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	716	704	707	700	714	673	624	670	618	668	622	706	8,123
Fiscal 17-18	616	688	665	661	702	663	662	671	645	733	691	765	8,162
Fiscal 18-19	766	844	794										2,405

Dollars In Thousands

YEAR TO YEAR IN-HOME DOLLARS SPENT BY POPULATION

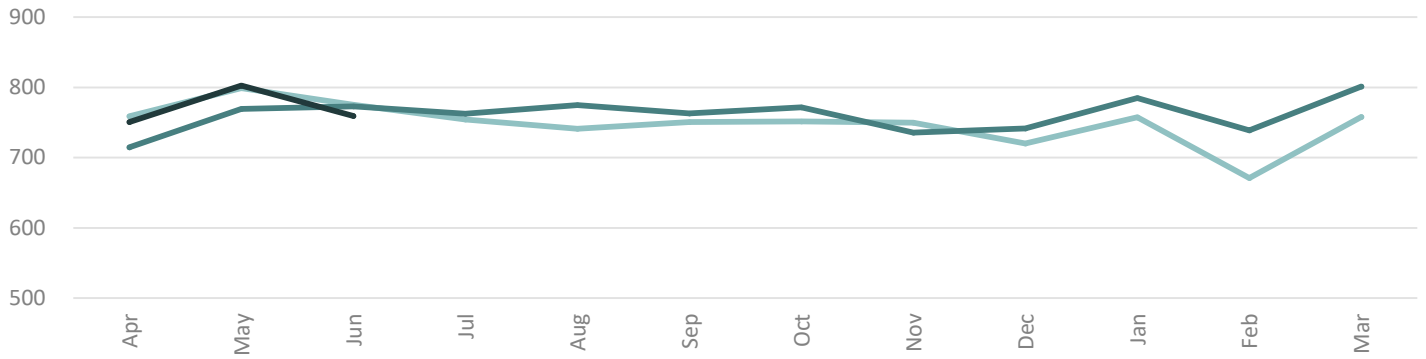
Short Stay



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	1,627	1,684	1,735	1,677	1,812	1,813	1,858	1,890	1,775	1,746	1,676	1,874	21,168
Fiscal 17-18	1,759	1,915	1,849	1,868	1,909	1,861	2,008	1,951	1,782	1,799	1,670	1,748	22,118
Fiscal 18-19	1,504	1,523	1,388										4,414

Dollars In Thousands

Children & Other



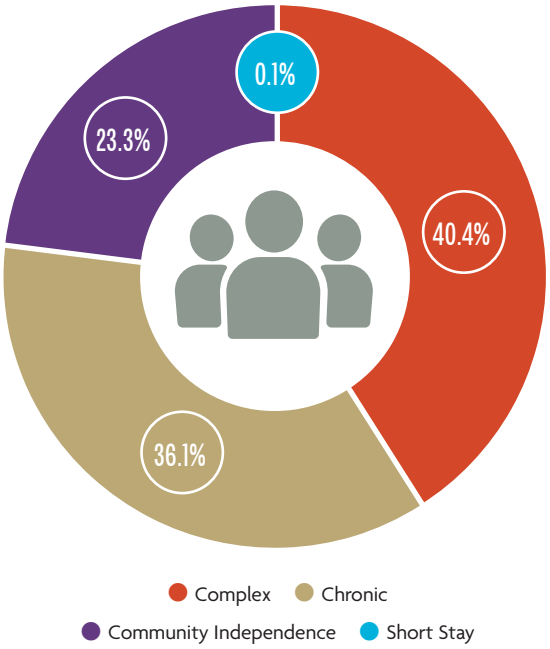
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	759	799	775	754	741	751	752	750	720	757	671	758	8,987
Fiscal 17-18	715	770	773	763	775	763	772	736	742	785	739	801	9,132
Fiscal 18-19	751	803	759										2,313

Dollars In Thousands

YTD SCHOOL DOLLARS SPENT

June 2018 | Fiscal 18/19 - April 2018 to June 2018

Dollars by Population

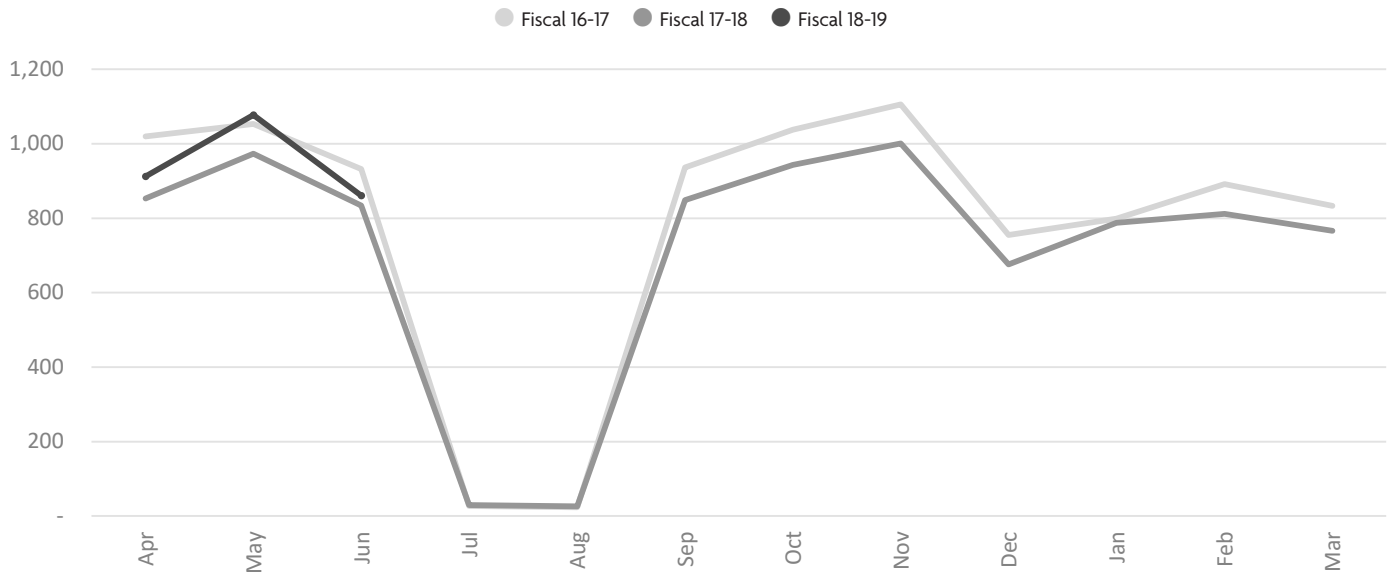


Dollars Spent Change

YTD June 2017 vs YTD June 2018

Complex	18.54%
Chronic	2.32%
Community Independence	-1.79%
Short Stay	38.88%
Total	7.24%

School Dollars

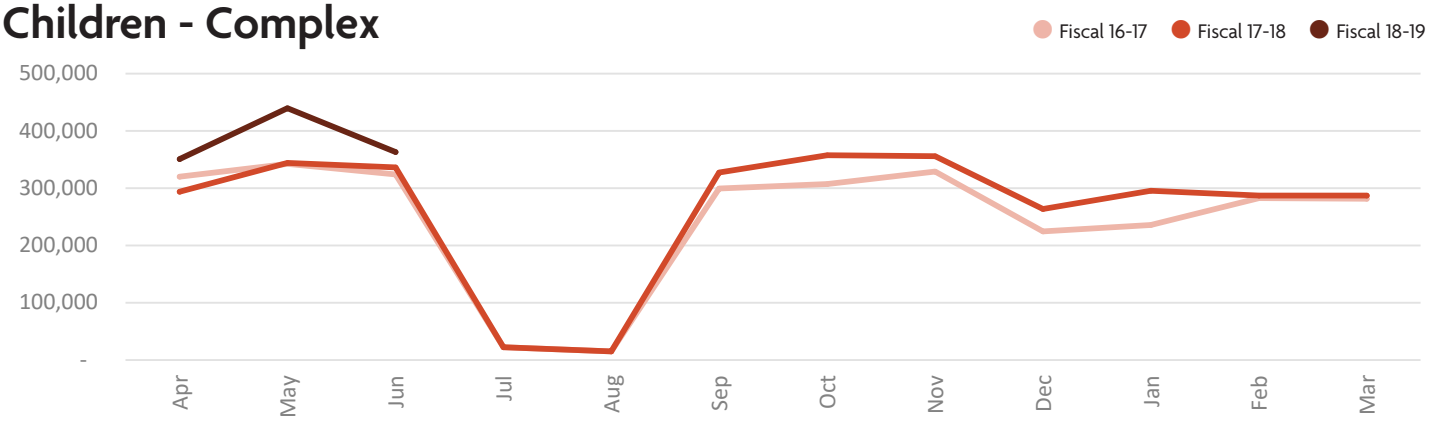


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	1,020	1,053	932	27	24	936	1,038	1,105	755	799	892	834	9,414
Fiscal 17-18	853	974	834	30	26	849	943	1,001	676	787	812	766	8,550
Fiscal 18-19	912	1,078	860										2,850

Dollars In Thousands

YEAR TO YEAR SCHOOL DOLLARS SPENT BY POPULATION

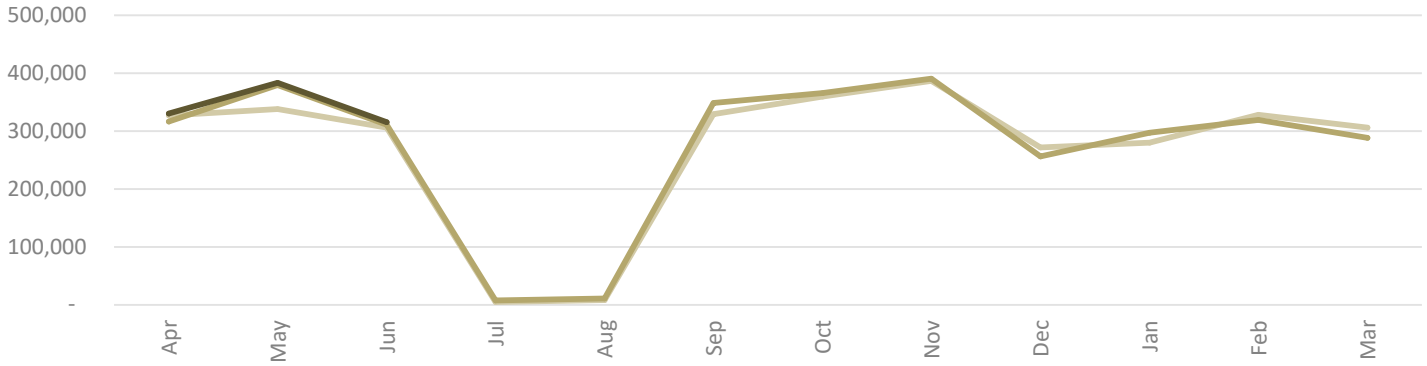
Children - Complex



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	320	342	324	22	15	299	307	329	224	235	282	281	2,981
Fiscal 17-18	293	344	336	22	15	327	358	356	264	295	287	287	3,183
Fiscal 18-19	351	440	363										1,153

Dollars In Thousands

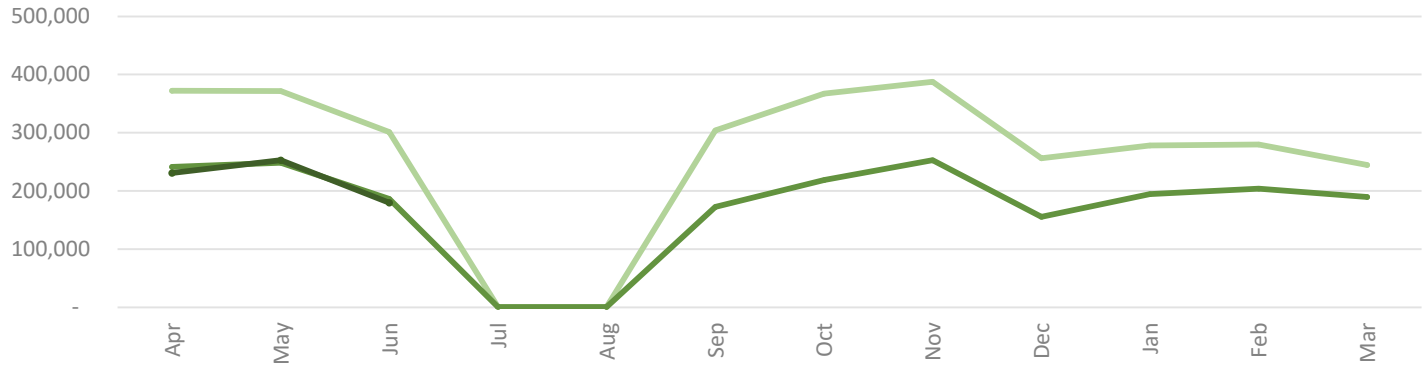
Children - Chronic



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	327	338	306	5	8	329	360	387	272	280	328	306	3,247
Fiscal 17-18	317	380	311	7	11	349	366	391	256	297	320	289	3,294
Fiscal 18-19	330	383	316										1,030

Dollars In Thousands

Children - Community Independence

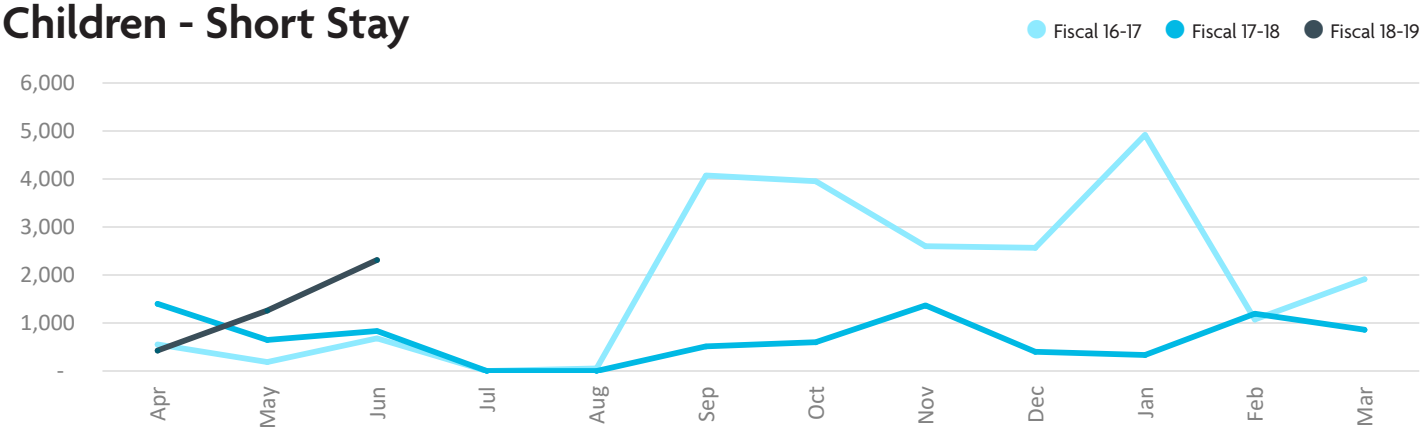


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	372	372	301	.3	1	304	367	387	256	278	280	244	3,163
Fiscal 17-18	241	249	186	.1		173	219	253	156	195	204	190	2,065
Fiscal 18-19	231	253	179										663

Dollars In Thousands

YEAR TO YEAR SCHOOL DOLLARS SPENT BY POPULATION

Children - Short Stay



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Fiscal 16-17	554	185	680	-	51	4,075	3,954	2,603	2,567	4,921	1,074	1,910	22,574
Fiscal 17-18	1,401	647	831	-	-	511	602	1,367	398	334	1,194	858	8,144
Fiscal 18-19	428	1,261	2,311										3,999

Report to the Board of Directors

Sub-Region Evolution

Meeting Date:	**September 25, 2018**
Submitted By:	**Sue McCutcheon, Interim Vice President System Design and Integration**
Submitted To:	☒ **Board of Directors** ☐ **Board Committee**
Purpose:	☒ **Information Only** ☐ **Decision**

Purpose:
To provide the Board of Directors with information on sub-region evolution in the South West.

Background:
Patient's First Act (Bill 41) passed December 7, 2016. The following sections of the Act outline expectations regarding sub-regions in each LHIN.

12. The Act is amended by adding the following section:

Sub-regions

14.1 *(1) Each local health system integration network shall establish geographic sub-regions in its local health system for the purposes of planning, funding and integrating services within those geographic sub-regions.*

Maps

(2) Each network shall make a map of the sub-regions available to the public.

13. (1) Section 15 of the Act is amended by adding the following subsection:

Sub-regions, direction

(2.1) The integrated health service plan shall include strategic directions and plans for the geographic sub-regions of a local health system in order to achieve the purposes of this Act.

Formation of Sub-Regions:
In September 2016, the South West LHIN Board of Directors approved the following motion and a submission was sent to the Ministry for approval of the sub-region geographies.

THAT the South West LHIN Board of Directors approve Grey Bruce, Huron Perth, London Middlesex, Elgin and Oxford as sub-regions of the South West LHIN:; and

THAT the South West LHIN Board of Directors recommends to the Ministry of Health and Long-Term Care that the LHIN is supportive of further dialogue to consider LHIN border changes in Grey and Norfolk Counties to reflect County boundaries, with Grey County changes bringing portions of the Town of Blue Mountains, Grey Highlands, West Grey and all of Southgate to the South West LHIN and the portion of Norfolk County currently in the South West LHIN to move to Hamilton Niagara Haldimand Brant LHIN.
Submission

In January 2017, the Ministry approved the sub-regions as submitted with no mention of the Board's request for further discussion on LHIN border changes. Sub-region information and maps were posted on South West LHIN website.

Sub-Region Integration Tables
In February 2017, the following motion was passed.
THAT the South West LHIN Board of Directors approve the identified directions regarding engagement strategies and structures (Patient and Family Advisory Committee, the Sub-region Integration Tables and the Health System Renewal Advisory Committee) to support implementation of Patients First in the South West LHIN.
Briefing Note

Sub-Region Governance
Under the guidance of the Board, the South West LHIN Board to Board Reference Group considered the role of governors in the sub-regions at 3 meetings between December 2016 and October 2017.

In December 2017, the following motion was passed.
THAT the South West LHIN Board of Directors approve the Terms of Reference for the Sub-Region Board-to-Board Reference Groups as presented.

Following the December meeting of the board a memo from the Acting Board Chair was sent to HSP Board Chairs and System Partners inviting governors to submit an expression of interest with a deadline of March 2. Following further discussion at meetings of both the Board-to-Board Reference Group and the Governance & Nominations Committee it was agreed to extend the deadline and to hold a webinar to further promote the opportunity.

In May 2018, the Acting Board Chair and Vice President Strategy System Design and Integration held a webinar for governors regarding the rationale for sub-regions and the role of governors in moving change forward at the sub-region level.

GENERATIVE DISCUSSION GUIDE

There are three nonjudgmental ways of generative thinking that allow directors to produce good ideas and explore subsequent decisions. They are:

1. Generate a large quantity of ideas to solve a single problem without judgment.
2. Generate a variety of ideas outside of logical, already established approaches.
3. Generate focused and detailed improvement of one idea or solution.

QUESTIONS:

Focusing Collective Attention

1. Why are we talking about this? What do we want to achieve?
2. What's been your/our major learning so far?
3. What assumptions do we need to challenge and test in thinking about this topic?

Connecting Ideas and Finding Deeper Insight

4. What's missing from this issue so far? What is it we're not seeing?
5. What's the next level of thinking we need to do?
6. What will it take to create a change on this issue?

Create Forward Movement

7. What could happen to make us feel engaged and energized?
8. What needs our immediate attention going forward?
9. What challenges might come our way and how might we meet them?

JULY 17, 2018 GENERATIVE DISCUSSION Governance and Sub-Regions – Part 1 SYNOPSIS:
Refer to generative discussion notes.

TOPIC: Governance and Sub-Regions – Part 2

GOAL: Clearly articulate the LHIN Board's vision for local sub-region governance

What is the purpose and role of the sub-region?
Local service providers are responsible for service delivery, program planning and integration, quality improvement, performance management and funding allocation for a geographic area focused on integrated patient care.

If the role of the sub-region is to be realized in a meaningful and impactful way, the following could be a path forward.

VISION OPTION:

WHAT - By 2022, sub-region service providers are responsible for a local health system that is demonstrating better outcomes, improved patient experience, improved provider satisfaction, and lower costs.

HOW – sub-region service providers will have:

- A sub-region collaborative governance model to provide coordinated high-quality care and to lower costs. The collaborative must be ratified by service providers and be based on:
    - Strong joint governance complimentary with current single provider governance model
    - Executive leadership
    - Resources from all partners
    - Data sharing across partners
    - Aligned clinical and operational policies and procedures
    - Mechanism to prioritize investment of existing and new funding allocations
    - Single plan to achieve shared quality aims
    - Single measurement plan (common metrics) focused on quadruple aim in alignment with LHIN framework
- Enter into a contract with the LHIN based on care for a population, including incentives to improve quality and reduce costs

Critical Success Factors:

- The LHIN will enable sub-regions to operate in a win-win, low administrative rules environment.
- The LHIN will need to consider organizational mergers.
- The LHIN will devolve authority accompanied by clear outcomes and accountabilities.
- The LHIN will work with providers through open discussion, conviction and willingness to work differently.
- The LHIN will work within the legislative context in Ontario. Where successful sub-region collaborative governance occurs, the LHIN will continue to delegate authority (planning, funding and integration) in support of integrated patient care.
- The LHIN will work with providers to clarify how regional programs will be considered within the sub-region collaborative model.

Timing:

- Year 1: engagement at governance and leadership levels and education on the goals of sub-regions and vision statement.
- Year 2: Drafting, ratification and implementation of sub-region collaborative model.
- Year 3: Execution to achieve a local health system that is demonstrating better outcomes, improved patient experience, improved provider satisfaction, and lower costs.

South West **LHIN** | **RLISS** du Sud-Ouest

Home & Community Care Review

September 25, 2018

Donna Ladouceur
Vice President, Home and Community Care

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

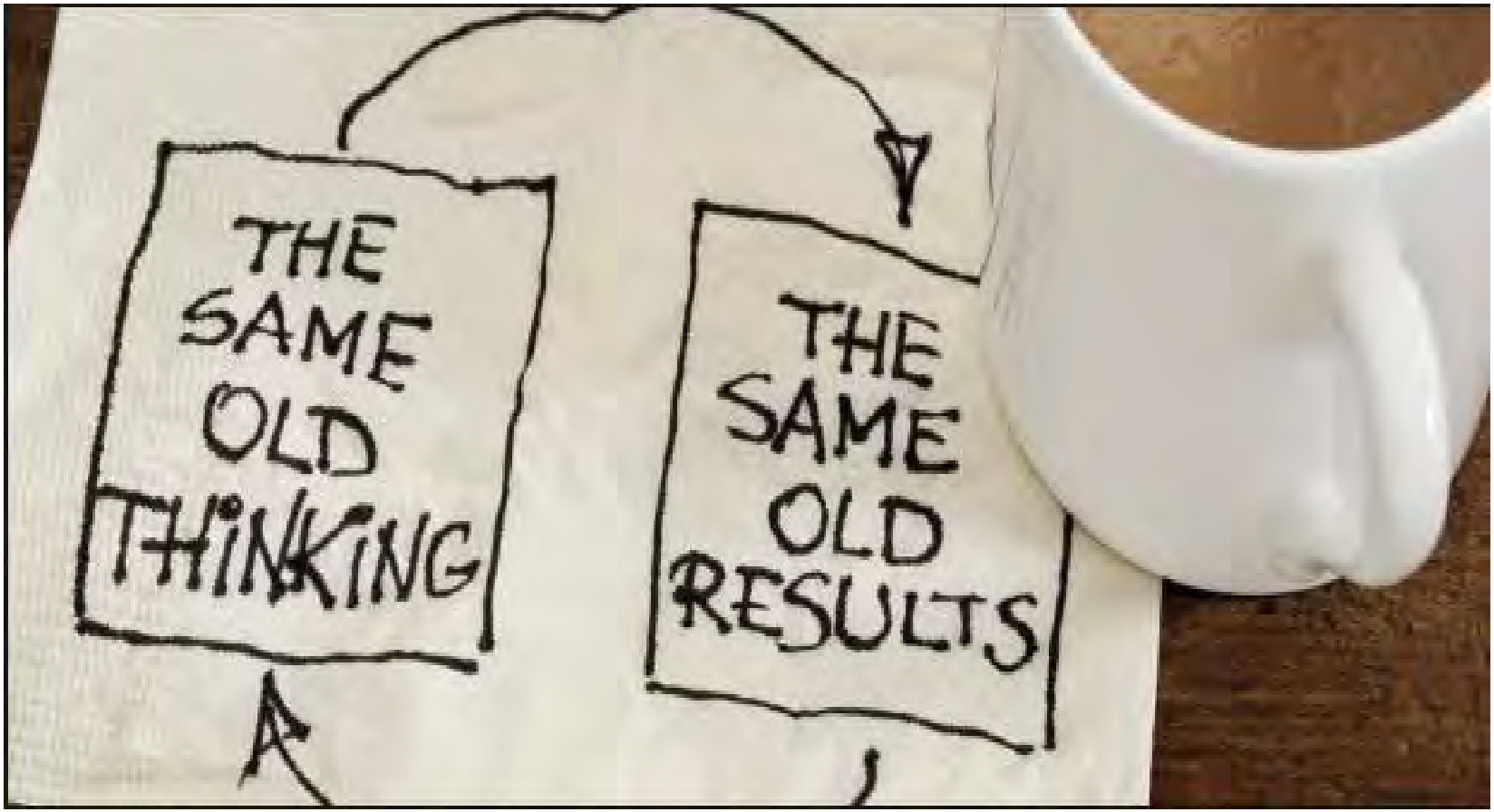
Home and Community Care (HCC) Review

- Feedback from partners, patients, caregivers and staff…what we are doing is not working
- Have seen a number of HCC reviews including the Donner report…minimal execution on recommendations
- Creating a small team to lead this work
- Executive advisor to CEO
- Report and recommendations will be completed by end of November

Why Now?

- Increasing challenges with Human Resource capacity in the community, both for nursing as well as personal support workers
- Growing concerns around quality
- Demonstrated rise in complex patients being supported at home over past several years, both medical complexity as well as complex social needs
- Aging population want to remain in their home and have supports available to them in a responsive way by qualified staff
- “End of hallway medicine “ needs to have a strong foundation in Home and Community Care
- Alignment with primary care is critical for patients to remain at home

Time For Change…we need to be bold



Key Deliverables

- Modernization of Care Cordination role…building on the work that is currently underway
- Modernization of SPO contracts
- RAI tools - what is the value add for care planning
- Health Links - an approach to care
- Alternate care models including using technology differently

Engagement Is Critical

- Patients and caregivers
- Primary care team
- Acute partners
- SRIT
- Provincial leads
- Staff
- Faculty of Nursing UWO
- Service providers

Leave No Stone Unturned

Determine

NO Sacred Cows!!!

DISCUSSION

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