South West LHIN | RLISS du Sud-Ouest

South West Local Health Integration Network
Board of Directors' Meeting
Tuesday May 15, 2018, 1:30 pm to 6:00 pm
South West LHIN, 201 Queens Ave, Suite 700, Main Boardroom London

AGENDA				
Item	**Agenda Item**	**Lead**	**Expected Outcome**	**Time**
1.0 COVENING THE MEETING				
1.0	**Call to Order, Recognition of Quorum**	Chair		1:30
1.1	**Approval of Agenda**	Chair	Decision	1:30-1:35
1.2	**Declaration of Conflict of Interest**			
2.0 APPROVAL OF MINUTES				
	2.1 April 17, 2018 – South West LHIN Board of Directors Meeting 2.2 April 23, 2018 – South West LHIN Special Meeting of the Board	Chair Chair	Decision Decision	1:35-1:37
3.0 PATIENT STORY				
	3.1 Patient Story o Kirk Float	D Ladouceur	Information	1:37- 2:05
4.0 PRESENTATIONS				
	4.1 Opioid Strategy	D Brennan	Information	2:05-2:30
5.0 APPROVAL of CONSENT AGENDA				
	Approval of Consent Agenda 5.1 Human Resources, Vice President Recruitment 5.2 Integrated Health Service Plan Update 5.3 Board Committee Reports 5.4 Board Director Reports	Chair	 Information Information Information Information	2:30-2:35
6.0 DECISION ITEMS				
	6.1 South West LHIN Musculoskeletal (MSK) Strategy Implementation Update	Decision	Mark	2:35-2:45
7.0 FOCUSSED DISCUSSION ITEMS				
	7.1 March 2018 Financial Update 7.2 Indigenous and French Language Services	H Anderson/ /M Brintnell D Ladouceur	Discussion Discussion	2:45-3:15
BREAK				3:15-3:30
8.0 CLOSED SESSION				
	8.1 Closed Session	Chair	Decision	3:30-6:00
9.0 FUTURE MEETINGS/EVENTS				
	South West LHIN Board of Directors Meeting, Tuesday June 19, 2018, 1:00 pm to 5:00 pm South West LHIN, Woodstock office, 1147 Dundas Street - Community East/West Rooms			
10.0	**Adjournment**	Chair	Decision	6:00

South West LHIN Board of Directors' Meeting

Board of Directors' Meeting
Tuesday April 17, 2018, 1:30 pm to 5:00 pm
Elgin St. Thomas Public Health – Talbot Boardroom, 1230 Talbot Street, St. Thomas

Minutes

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

Staff:
Hilary Anderson, Vice President, Corporate Services
Dan Brenann, Communications Director
Mark Brintnell, Vice President, Quality, Performance & Accountability
Dr. Cathy Faulds, Vice President Clinical
Kelly Gillis, Interim Co-CEO, VP, Strategy System Design and Integration
Donna Ladouceur, Interim Co-CEO/Vice President, Home & Community Care
Stacey Griffin, Executive Office Coordinator (Recorder)

1.0 Call to Order – Welcome and Introductions

The Acting Board Chair called the meeting to order at 1:30 pm. There was quorum and six members of the public, which included health service providers, were in attendance for parts of the meeting.
The Board welcomed new Board Director Allan MacKay, A Chartered Professional Accountant from Kincardine, Allan is very active in his community and has operated a public accounting practice since 1984. He brings over 40 years of professional experience, with a strong background in community relations and leadership. Allan has held numerous community and board positions over the years. For over 20 years, he was the treasurer of the Kincardine and District Chamber of Commerce and received the Lifetime Achievement Award. Allan served on the Complaints Committee and the Appeals Committee for Certified Management Accountants Ontario between 2000 and 2014 and currently sits on the Appeals Committee of CPA Ontario. He is the former owner and president of the Ainsdale Golf Course and has been a partner of the Somerhill Golf Club since 2005.
The Board also welcomed and thanked Board Chair Lori Van Opstal for her participation in today's meetings.

1.1. Approval of Agenda

MOVED BY: **Glenn Forrest**
SECONDED BY: **Jen-Marc Boisvenue**

THAT the Board of Directors' meeting agenda for April 17, 2018, be approved with the change of agenda item 5.5 **Integrated Health Service Plan (IHSP) Strategic Planning Update and Board Advance** ***being removed from the agenda. 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 March 20, 2018 South West LHIN Board of Directors Meeting

MOVED BY: **Myrna Fisk**
SECONDED BY: **Cynthia St John**

THAT the March 20, 2018 South West LHIN Board of Directors' meeting minutes be approved as presented.

CARRIED

3.0 Patient Care Story
Kelly Gillis provided a patient story on a gentleman who suffered a stroke and was a candidate for the endovascular therapy (EVT) treatment. EMS transported the patient to London Health Sciences Centre, University Hospital where he immediately had the EVT treatment to remove the blood clot from his brain using a retrievable stent. The recovery of this patient is an example of the stroke network of care – from hospitals in Seaforth, Stratford, and London, to telestroke, neurology, radiology and anesthesiology all working seamlessly together to produce the best possible outcomes.

4.0 Approval of Consent Agenda

MOVED BY: **Linda Ballantyne**
SECONDED BY: **Aniko Varpalotai**

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

CARRIED

5.0 Decision Items/ Focused Discussion items
5.1 South West LHIN Accreditation

MOVED BY: **Linda Ballantyne**
SECONDED BY: **Aniko Varpalotai**

THAT the South West Local Health Integration Network Board of Directors approves proceeding with a primer survey for the upcoming accreditation cycle.

CARRIED

5.2 Canadian Mental Health Association, Elgin Branch

The Board was provided with an update on the status of the investigation at Canadian Mental Health Association Elgin Branch.
On January 16, 2018, the South West LHIN Board passed a motion approving its intention to appoint an investigator to investigate CMHA Elgin related to the concerns with the organization. At its February 20, 2018 meeting, the South West LHIN Board passed a motion approving the appointment of Mr. Ron McRae as the Investigator under authority of Section 21.1 of Local Health System Integration Act (LHSIA) to investigate the Canadian Mental Health Association (CMHA) Elgin Branch. The cost of the investigation will be paid by the South West LHIN. Terms of reference were established to guide the work of the investigator. The LHIN Board Chair and senior staff met with CMHA Elgin Board Chair and Executive Director to review the terms of reference and discuss the overall approach to the work.

- A draft report was delivered to the LHIN on March 29, 2018 and a copy was issued to CMHA Elgin for review and comment. CMHA Elgin prepared a written response which the LHIN forwarded to the investigator for review and consideration for the final report. A written copy of the investigator's assessment and response to CMHA Elgin's response was provided to CMHA Elgin.

- The Investigation Final Report was delivered to the LHIN on April 9, 2018 and the LHIN provided CMHA Elgin with a copy the same day. The final report is deemed a public document. The Board Chairs from both organizations held a call on April 9th to confirm a final report was received and would be discussed at the upcoming April 17th Board meeting. A copy of the final report can be requested through the LHIN office.

- The over-riding theme of the findings and recommendations contained in the report is that changes need to be made in all three areas of focus investigated. The findings confirm material limitations in governance, leadership and operations at CMHA Elgin.

CMHA Elgin was advised that the final report would be considered by the South West LHIN Board at its April 17th meeting and that the LHIN would be back in touch with CMHA Elgin to discuss next steps.

5.3 Indigenous Engagement

The Board heard that LHIN staff continue to work with the Indigenous Health Committee and it was identified that 2 proposals have been received regarding the Opioid crisis within Indigenous communities. The Board discussed follow-up regarding the letter of apology to the Chiefs of the 5 First Nations in the South West LHIN. The LHIN Board taskforce on Indigenous engagement will meet to determine next steps and to ensure that there are clear principles on how to engage moving forward.

5.4 2018/19 LHIN Transfer Payment and LHIN- Delivered Services Funding Update

The Board was provided on an update on known information pertaining to new funding allocations in 2018/19. The South West LHIN has not yet received specific details on LHIN home care funding nor funding targeting our community sector partners. The Ontario Budget 2018 included a number of measures that would support LHIN-funded HSPs and LHIN-delivered community programs.
In 2018/19, an additional $822 million will be invested in hospital operations, representing a 4.6% increase over last year. The South West LHIN's hospital sector base funding has been increased by $38,318,400 and new one-time funding totals $6,981,935 (subject to appropriation form the Ontario Legislature). Individual hospital base increases over 2017/18 funding levels range from 2% to 4%. When compared to the funding assumptions used for the recent 2018/19 Hospital Service Accountability Agreements (H-SAA), the new confirmed funding is greater in every case but LHIN staff will be working

with each hospital corporation to confirm material differences and ensure the new funds support maintain and/or enhancing certain services. Once the LHIN has final funding information, we will be working with our hospital partners to amend the H-SAA funding, service and performance schedules to incorporate the impact of the new funding.

Major capital investments include London Health Sciences Centre's expansion of inpatient and outpatient clinics to increase access to the stem cell transplant program. South Bruce Grey Health Centre renovations to expand the emergency department, address aging infrastructure and optimize the use of existing space at the Kincardine site. Grey Bruce Health Services new construction at Markdale site. The South West LHIN has not yet received specific details on South West LTCH funding levels. The Ontario Budget 2018 highlighted an investment of $300 million over three years in new funding, starting with $50 million in 2018–19 to hire a registered nurse for every home, and setting a goal of increasing the provincial average to four hours of daily care per resident by 2022. This will provide residents with more direct, one-on-one patient care, including nursing, personal support and therapeutic care. It will also ensure that every home will have staff with specialized training in behavioural supports and in palliative and end-of-life care.
As the LHIN receives further details on funding impacting LHIN home care and HSP funding allocations, these details will be shared with the LHIN Board.

5.5 Integrated Health Service Plan (IHSP) Strategic Planning Update and Board Advance
The agenda item was removed from the agenda as the Board Advance scheduled for April 23, 2018 has been cancelled. Further information will follow.

5.6 **Talent Management Update**
Maureen Bedek, Vice President Human Resources reviewed slide deck included in the Board package highlighting the work of the Cultural Transformation Committee and spoke to work being done to recognize staff and how we can improve as an organization. We will be looking to send out a Staff Pulse Survey as part of Accreditation. Work being done on a PAN LHIN approach on recruitment and retention. A talent management survey was done with our hospital partners – How do we share with others and set up for success to be an employer of Choice. It was noted that since amalgamation there has been a turnover of staff in the fall. The LHIN s=will be looking at some targeted focused training on French Language Services and Indigenous. (Indigenous Cultural Competency Training)

Andrew Chunilall, Acting Board Chair and Lori Van Opstal, Board Chair left the meeting at 2:30 pm and Vice Chair Linda Ballantyne Chaired the meeting.

**The Board took a short break from 2:38pm to 2:46 pm

6.0 Closed Session

MOVED BY: Myrna Fisk
SECONDED BY: Linda Ballantyne

THAT the Board of Directors move into a closed session at 2:46 pm pursuant to s. 9(5)(a)(g)(h) of the Local Health System Integration Act, 2006

CARRIED

LHIN staff members, Hilary Anderson, Maureen Bedek, Dan Brenann, Mark Brintnell, Cathy Faulds, Kelly Gillis, Stacey Griffin and Donna Ladouceur were permitted to attend for parts of the meeting and left the meeting at 3:31 pm.

MOVED BY: **Leslie Showers**
SECONDED BY: **Wilf Riecker**

THAT the South West LHIN Board of Directors rise from closed session at 3:30 pm and returned to open session. The Vice Chair reported that the Board discussed the Canadian Mental Health Association, Elgin Branch, Investigators Final report and passed the following motion:

MOVED BY: **Glenn Forrest**
SECONDED BY: **Jean-Marc Boisvenue**

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 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.*

CARRIED

**The Board took a break at 3:31 pm and LHIN staff left the meeting.

MOVED BY: **Myrna Fisk**
SECONDED BY: **Aniko Varpalotai**

THAT the Board of Directors move into a closed session at 3:40 pm pursuant to s. 9(5)(a)(g)(h) of the Local Health System Integration Act, 2006

CARRIED

MOVED BY: **Allan MacKay**
SECONDED BY: **Aniko Varpalotai**

THAT the South West LHIN Board of Directors rise from closed session at 5:30 pm and returned to open session and adjourned the meeting.

7.0 Dates and Location of Next Meeting

The next regular meeting of the South West LHIN Board of Directors Meeting will be held on Tuesday May 15, 2018, 1:00 pm to 5:00 pm, South West LHIN, 201 Queens Ave, Suite 700, Main Boardroom London

8.0 Adjournment

THAT the South West LHIN Board of Directors meeting adjourn at 5:30 pm.

APPROVED: ______________________________
Andrew Chunilall, Acting Board Chair

Date:______________________________

South West LHIN Special Meeting of the Board of Directors
Monday, April 23, 2018 2:00 to 5:00 pm
Best Western Lamplighter Inn and Conference Centre,
591 Wellington Road S, London- Cambridge Room

Minutes

Present: Lori Van Opstal, Board Chair
Andrew Chunilall, Vice Chair, Acting Board Chair
Linda Ballantyne, Board Director, Vice Chair
Jean–Marc Boisvenue, Board Director
Myrna Fisk, Board Director
Glenn Forrest, Board Director
Allan Mackay, Board Director
Wilf Riecker, Board Director
Jim Sheppard, Board Director
Leslie Showers, Board Director
Cynthia St. John, Board Director
Aniko Varpalotai, Board Director

Staff: Stacey Griffin, Executive Office Coordinator

1.0 Call to Order – Welcome and Introductions
The Acting Chair called the meeting to order at 2:01 pm. There was quorum and no members of the public were in attendance.

1.1. Approval of Agenda

MOVED BY: **Wilf Riecker**
SECONDED BY: **Cynthia St John**

THAT the Board of Directors' meeting agenda for April 23, 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 Closed Session

MOVED BY: **Glenn Forrest**
SECONDED BY: **Jean-Marc Boisvenue**

THAT the Board of Directors move into a closed session at 2:02pm pursuant to s. 9(5)(a)(g)(h) of the Local Health System Integration Act, 2006

CARRIED

LHIN staff members Stacey Griffin left the meeting at 2:02 pm.

MOVED BY: **Linda Ballantyne**
SECONDED BY: **Jim Sheppard**

THAT the South West LHIN Board of Directors rise from closed session at 4:30 pm and returned to open session.

CARRIED

3.0 Report out in Open Session

The Acting Board Chair reported that the Board of Directors made the decision to recruit for an Interim Chief Executive Officer (CEO) until such time that the Board CEO Search Committee can establish a new process for recruiting a new CEO.

4.0 Dates and Location of Next Meeting

The next South West LHIN Board of Directors Meeting will be held on Tuesday May 15, 2018 at the South West LHIN, 201 Queens Ave, Suite 700, London, Main Boardroom

5.0 Adjournment

MOVED BY: **Wilf Riecker**
SECONDED BY: **Glenn Forrest**

THAT the South West LHIN Board of Directors meeting adjourn at 4:32 pm.

APPROVED: ________________________________
Andrew Chunilall, Acting Board Chair

Date:________________________________

Getting to Zero

Kirk Foat

May 15, 2018

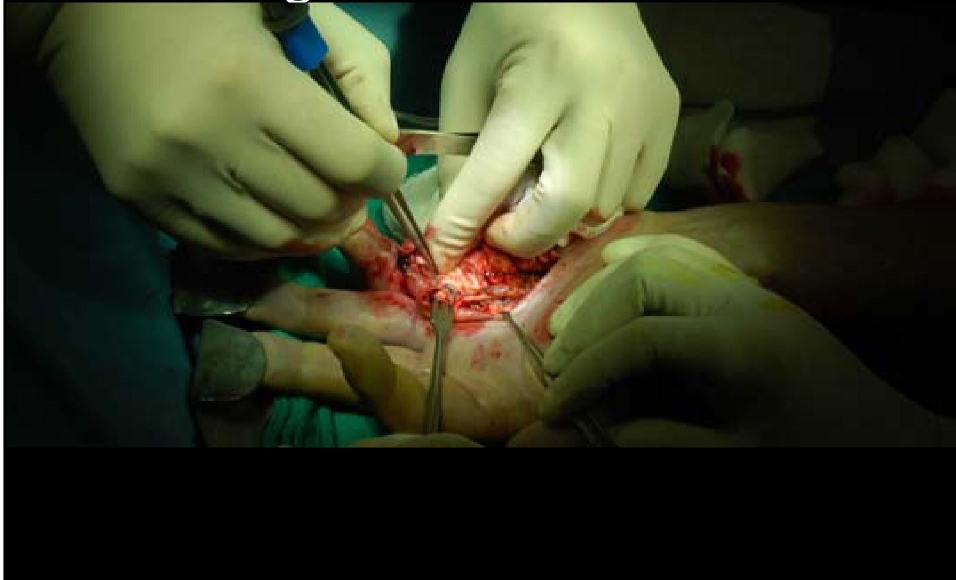
January 25, 2008

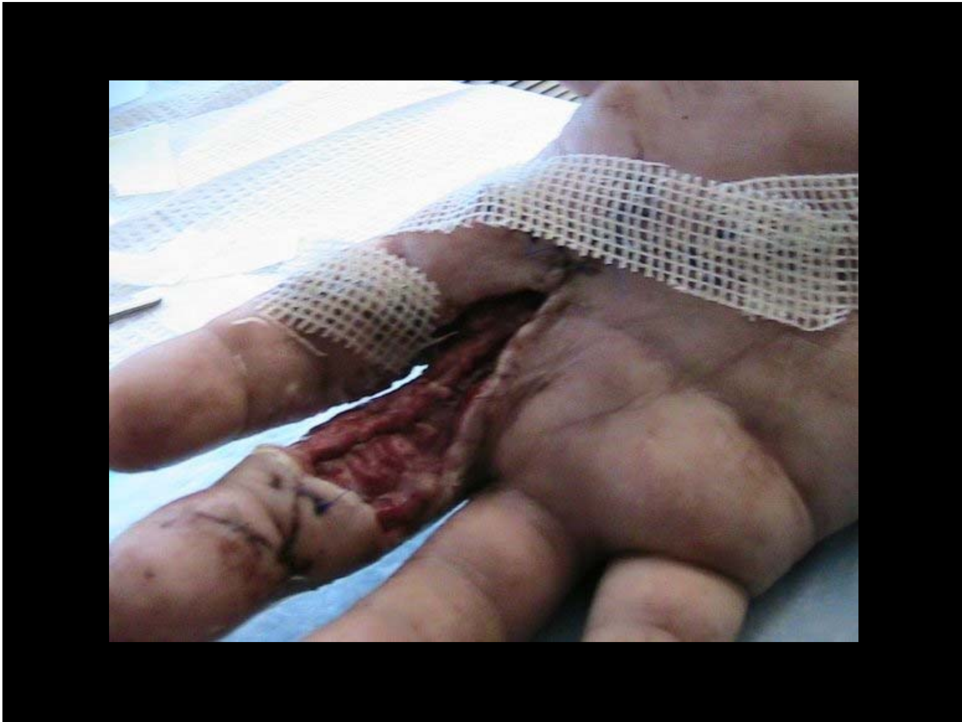
They did not find me.
I win.

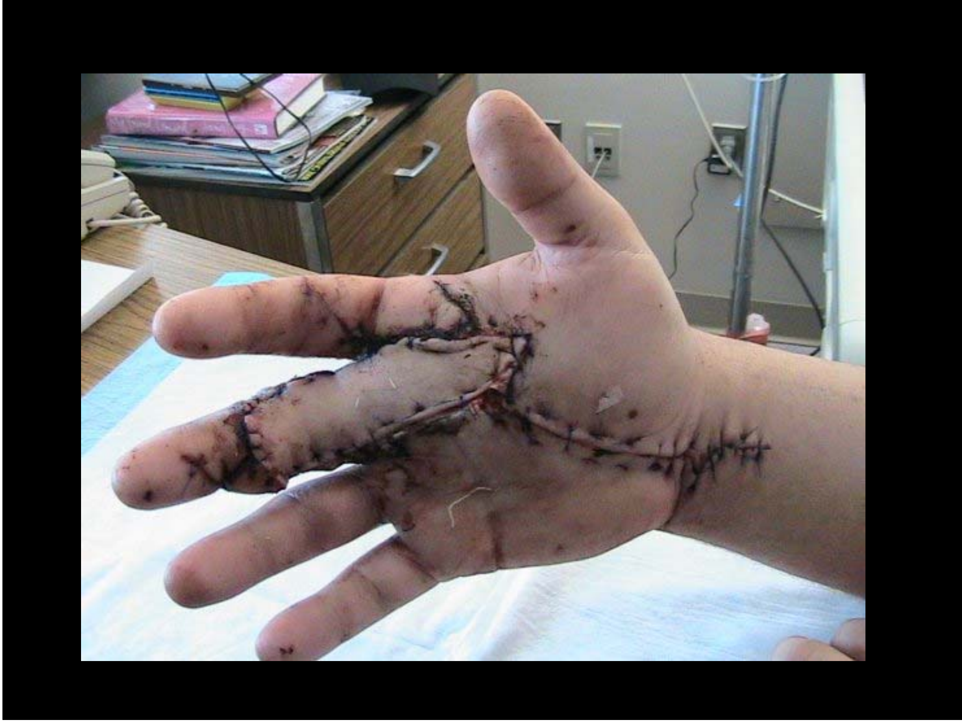
I win.

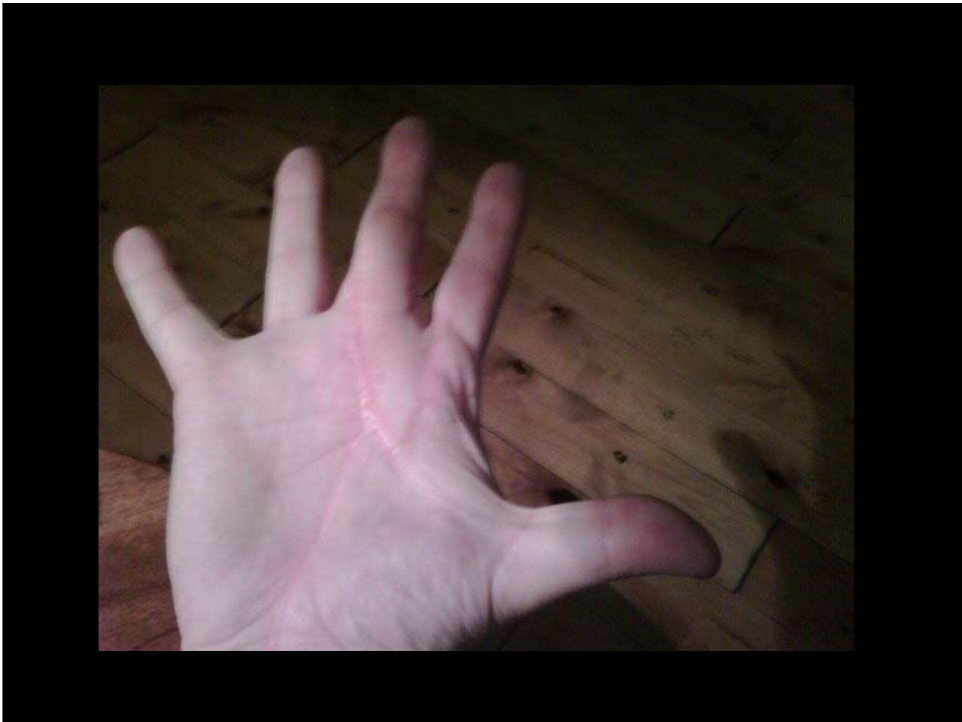
Ambulance
Hospital
Stitches
Leptospirosis

Four surgeries





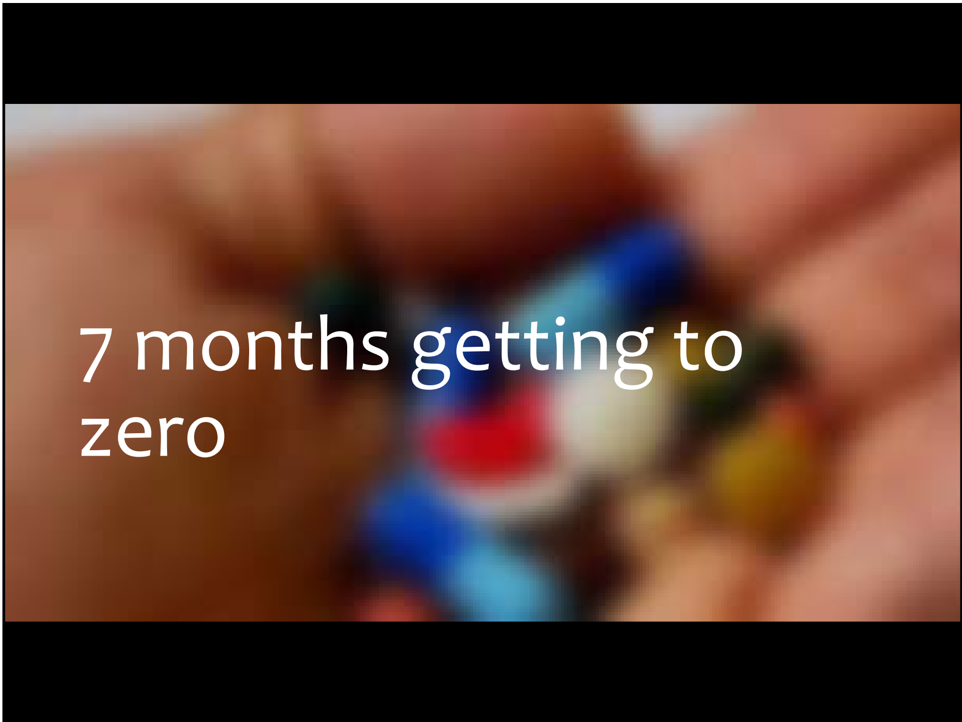




Rehabilitation

8 ½ years

Side effects and quality of life


7 months getting to zero

“I’m so proud of what you achieved and what you have taught me as an MD about getting off opioids”

“Can you help me taper?”

Expose opioid using patients to success stories.

"Unfortunately our funding model cannot support your ideas."

The surgeons gave me back my hand.

Tapering gave me back my life.

We can get people OFF opioids

If I could tell a patient just one thing…

If I could tell a doctor just one thing…

If I could tell the policy makers just one thing…

South West LHIN

Opioid Strategy

May 15, 2018

Ontario
Local Health Integration Network

Jane's Story

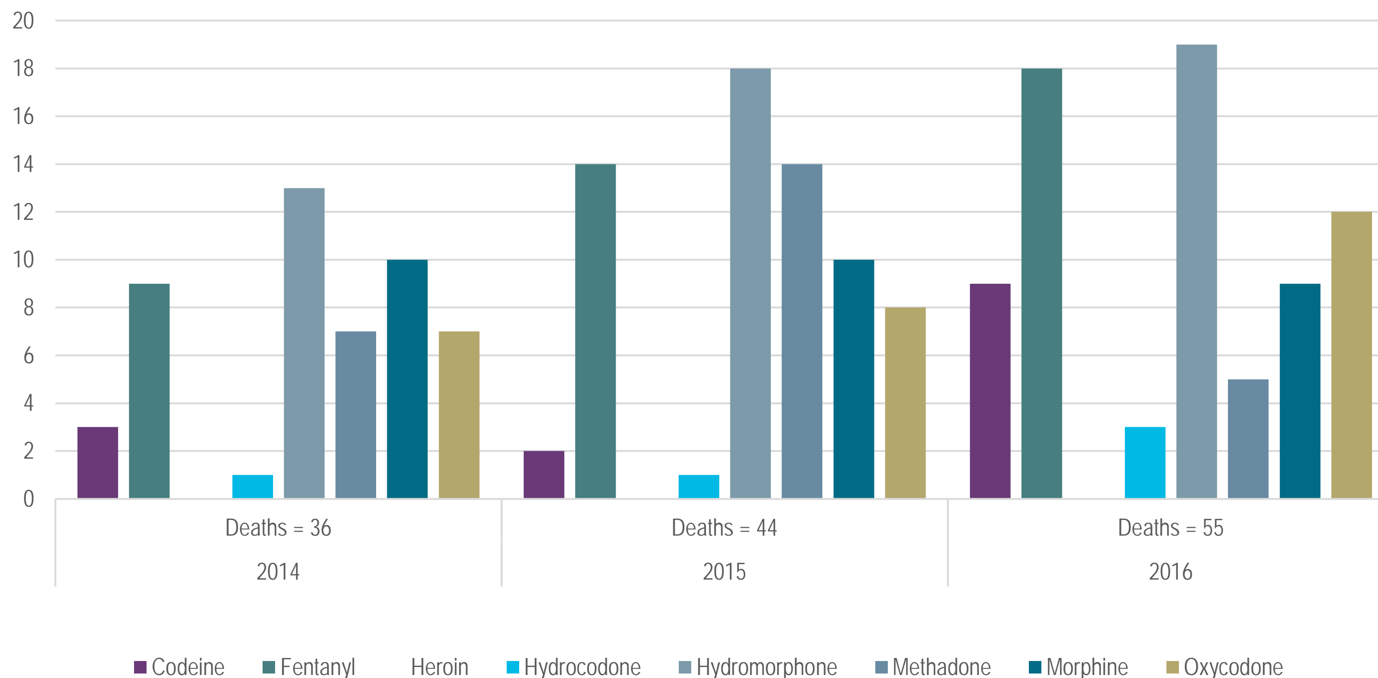
- Jane is a 44-year-old paraplegic, drug user with extensive wounds on her body
- She has received hundreds of hours of care coordination, and thousands of hours from hospital and community service providers
- She is often aggressive, verbally abusive, uncooperative
- She has frequently lived on the street, while alternating between use of crash beds, hostels, supportive housing, emergency departments and hospitals
- Jane requires daily assistance from a PSW for washing, dressing and other needs, but often refuses care, sometimes because it interferes with her drug habit
- Jane's family can no longer cope with her behavior and the family's lack of support contributes to Jane's distress

Government Plan – 3 Years, $222 million

- Expand **Rapid Access Addiction Medicine Clinics**
- Improve access to **withdrawal management services and addictions programs**
- Expand **harm reduction services**
- Expand **addictions treatment and care provided in family health teams**
- **Mentor health care providers** on appropriate prescribing
- Enhance **culturally appropriate mental health and wellness programs**
- Develop treatment and services targeted to the **unique needs of youth**

Complex Issue

- Many different opioids: Codeine, Fentanyl, Heroin, Hydrocodone, Hydromorphone, Methadone, Morphine, Oxycodone, Tramadol, etc.



Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2017) Interactive Opioid Tool.

Complex Issue

- Many faces: medical use of prescription opioids, recreational use of prescription opioids, recreational use of illicit opioids, accidental use/contamination
- In 2016, one in seven Ontarians received an opioid prescription
  - New starts accounted for about 15% of all opioid prescriptions in 2016
- 74% of opioid related deaths in 2017 involved synthetic opioids, such as fentanyl
  - ED physicians feel spikes often coincide with “bad products” on the streets

Heavy Burden

- 4,000 Canadians died as a result of opioid overdoses in 2017
- From 2014 to 2016, opioid related deaths in the South West LHIN increased by approximately 50% compared to 20% for the rest of Ontario
- In 2016, the South West was among the top five opioid prescribers for new starts by family doctors and surgeons
- Opioid related ED visits have increased by 101% in the South West since 2013
- London Middlesex hospitals accounted for over 50% of all the South West opioid related visits and have seen an increase of 132% since 2013

Prevention Strategies

- Primary care practice reports
- Membership in the Opioid Crisis Working Group
- Supervised consumption facilities
- Quality standards
- Academic detailing
- Chronic Pain Network
- Surgery Safe
- ER education

Treatment Strategies

- $1 million in funding from South West LHIN to support addictions treatment: RAAM Clinics, Community Withdrawal and Crisis Support, SOAHAC, etc.
- Socializing clinical protocol for Schedule 1 mental health inpatient beds
- MSK Strategy with specific strategies for pain management and opioid prescribing
- Investment opportunities for supportive housing
- Seeking additional stabilization beds at the CMHA Crisis Centre
- Working with EMS to establish protocols that direct patients to the Crisis Centre
- Project Hope, which provides additional support when prescribing suboxone

Harm Reduction Strategies

- Safe consumption sites
- Naloxone kits
- Discharge planning for patients with Endocarditis
- Overdose education
- Community Opioid Addiction Programs, including assessment, treatment planning, case management, as well as withdrawal management support and treatment

Enforcement Strategies

- Ministry Accountability – e.g. limits on pills dispensed, exceptional access program
- Distribution of Primary Care Practice Reports from Health Quality Ontario
- Leverage Methadone Clinics – a treatment wrap-around
- Fund Suboxone Regional Champions
- Inventory of Pain and Addiction Resources – e.g. through Primary Care Alliance
- Policies and Procedures for Prescribing – Close ties with CPSO and CMPA
- Business Case for Rehab and Pain Management Resources – OHIP coverage

QUESTION &
ANSWER

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SOUTH WEST LHIN OPIOID STRATEGY

Improving the quality of lives across communities

Dr. Cathy Faulds
Vice President, Clinical, South West LHIN

Dan Brennan
Director of Communications, South West LHIN

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South West LHIN Opioid Strategy

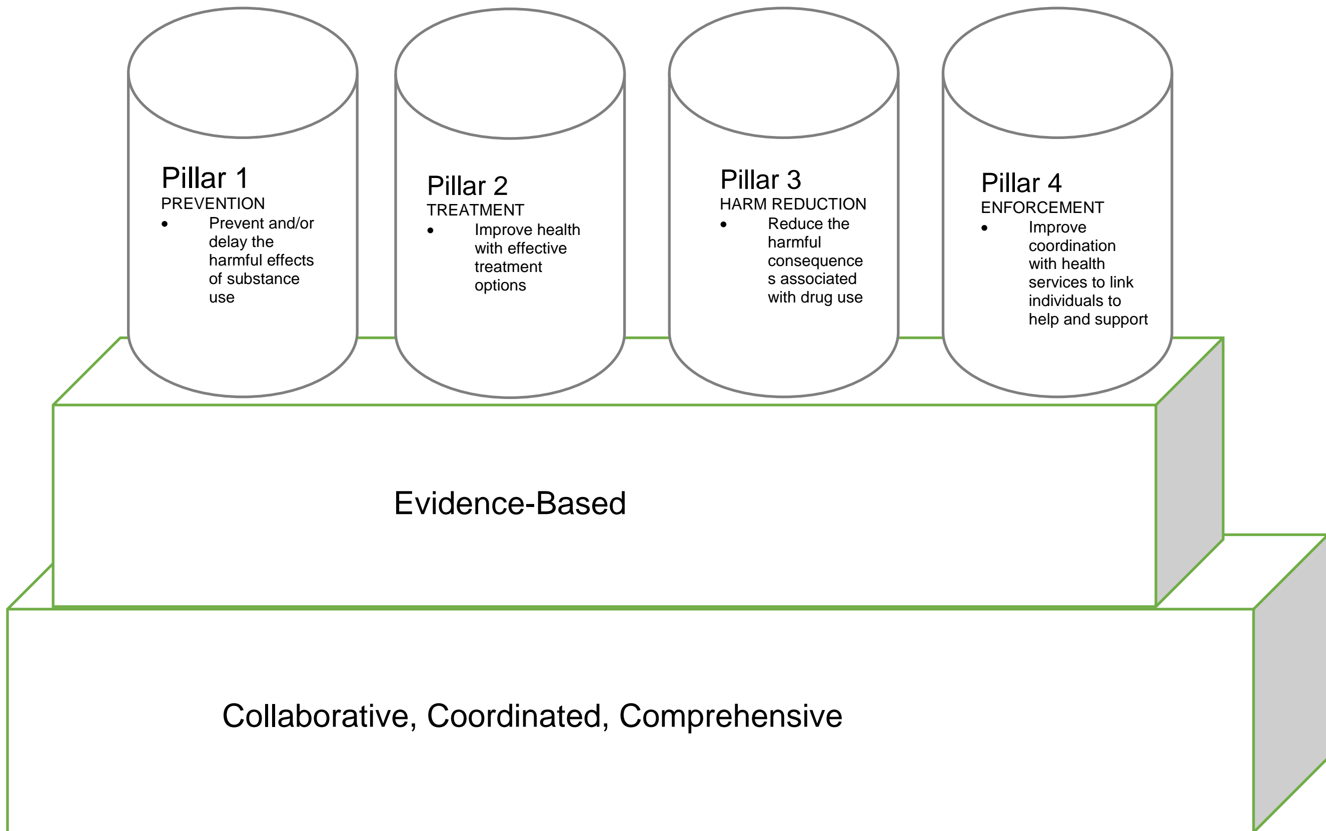
On October 12, 2016, Dr. Eric Hoskins, Minister of Health and Long-Term Care, announced the government's plan to address the rise in opioid addiction and overdose. On August 29, 2017, the government announced an additional $222M over three years to ensure a coordinated and holistic approach, including:

- Expanding **Rapid Access Addiction Medicine Clinics** across Ontario, low barrier clinics that provide people with immediate and ongoing addiction treatment, counselling and other mental health supports.
- Boosting access to **community-based withdrawal management services and addictions programs** across the province to ensure people with opioid addictions have access to holistic supports that address the underlying factors leading to addiction.
- Expanding proven **harm reduction services**, such as needle exchange programs, as well as hiring more harm reduction outreach workers.
- Partnering with the Centre for Addiction and Mental Health to expand **addictions treatment and care provided in family health teams** across the province.
- Collaborating with the Ontario College of Family Physicians to **mentor health care providers** on appropriate prescribing of opioids for pain management and treating patients with addiction, including the use of methadone and buprenorphine/naloxone.
- Working with Indigenous communities to enhance **culturally appropriate mental health and wellness programs** as well as support new or expanded Indigenous Mental Health and Addictions Treatment and Healing Centres.
- Developing addictions treatment and services targeted to the **unique needs of youth**, as recommended by the Mental Health and Addictions Leadership Advisory Council.

In addition, there are efforts to improve pain management through a coordinated approach that will support clinicians and patients with best practices and improve connections to services and supports to enhance decision making. This will take place through Project ECHO (a lifelong learning model that links experts with primary care in local communities) for pain and addiction services, bolstered by the Ontario College of Family Physicians pain and addiction mentoring network, as well as the implementation of Inter-professional Spine Assessment and Education Clinics (ISAEC) and the MSK (musculoskeletal) Strategy.

Our strategy –Four Pillar Model

In this document, we will take a four pillars approach, focusing on Prevention, Treatment, Harm Reduction and Enforcement. This model has been used in other large-scale overdose and drug strategies.



1. Prevention: interventions that seek to prevent or delay the onset of substance use as well as to avoid problems before they occur. More than education, prevention involves strengthening the health, social and economic factors that can reduce the risk of substance use, including access to health care, stable housing, education and employment. Examples of prevention include mentoring programs, education, and nonpharmacological pain strategies.

2. Treatment: the programming provided to people already dealing with a substance use issue, with services ranging from a philosophy of total abstinence to one that focuses on managing use. Examples of treatment include residential withdrawal management ("detox") and outpatient treatment, counselling, and medication-assisted therapies (e.g. buprenorphine/naloxone).

3. Harm Reduction: a range of pragmatic and evidence-based public health policies designed to reduce the harmful consequences associated with drug use. Harm reduction includes naloxone distribution, safe injection equipment, counselling and referrals.

4. **Enforcement:** interventions that seek to strengthen community safety by responding to the crimes and community disorder issues associated with legal and illegal substances.
(Source: Peterborough Drug Strategy)

Through the four pillar model, we hope to address the following goals:

- Reduce opioid-related morbidity and mortality
- Reduce ED visits and revisits
- Expand and increase access to opioid replacement and supportive therapies
- Improve access and coordination of addiction treatment and services
- Streamline a patient navigation system to increase patient access to the full continuum of addiction care
- Implement clinical quality standards to improve patient outcomes in chronic pain management and acute opioid prescribing
- Improve geographical and cultural equities in access to care
- Integrate care delivery and communication between providers
- Implement standard evidence-based opioid prescribing and dispensing practices
- Enhance HR services
- Improve surveillance and research of fatal and non-fatal opioid-related overdose data
- Enhance and integrate cross-sector opioid-related data collection and reporting
- Increase education and awareness within both healthcare and the community

Heavy Burden of Disease

Canada is experiencing a national public health crisis. Over the past several years there has been a sharp increase in the number of people who have overdosed and/or died because of the harms associated with both prescription and non-prescription opioid use. The Public Health Agency of Canada has estimated that approximately 4,000 Canadians lost their lives due to opioid-related overdoses in 2017, a 30% increase since 2016. The opioid crisis is also having a significant impact on the healthcare system as there has been a 53% increase in the number of Canadians who seek emergency hospital care for opioid-related overdoses over the past 10 years.[1]

4,000 Canadians died as a result of opioid overdoses in 2017, 30% more than 2016.

More recently, the opioid crisis has been defined by drug contamination with illicitly manufactured versions of fentanyl - a powerful opioid that is 50 to 100 times more potent than morphine and 30 to 50 times more potent than heroin.[2] In Canada, 74% of apparent opioid-related deaths involved fentanyl or fentanyl analogues, compared to 53% in 2016.[3] The vast majority of people who use opioids are not seeking fentanyl, nor suspecting its presence in their drug supply.

Until recently, opioids such as fentanyl, oxycodone, morphine, heroin and codeine were mainly prescribed to treat acute pain and pain associated with terminal illness such as cancer. However, over the past 20 years, opioids have been commonly prescribed to treat chronic non-cancer pain. The use of opioids for both medical and non-medical reasons can result in physical dependence and put people at risk of overdose or death. Additional harms associated with opioid use include the risk of blood-borne infections such as HIV and hepatitis C from any unsafe injection practices among people who inject and infants born dependent on opioids due to the mother's opioid use.[4]

In 2016, one in seven Ontarians received an opioid prescription. According to Health Quality Ontario, new starts accounted for about 15% of all opioid prescriptions in 2016, or about 1.3 million. This represents a slight decrease of about 25,000 (2%) of new starts from 2013.[5]

From 2014 to 2016, Ontario's opioid related deaths increased by approximately 20%; in the South West LHIN, deaths rose by 51.4% or about 10 per year.[6] This number may be higher as opioid related deaths are not always coded as such, but emergency department physicians have introduced new processes to encourage more accurate coding of deaths and visits.

74% of opioid related deaths in 2017 involved synthetic opioids, such as fentanyl or fentanyl analogues.

In 2016 the South West LHIN was among the top five opioid prescribers for new starts by family doctors and surgeons.[7]

Hospitalization

Provincially, the 12-month average for hospitalization rates for mental health and substance abuse is 12.0/10,000 for adults (18 and over). While the South West LHIN rate has improved since Q1 2016-17, the average is still higher than the provincial average at 15.6/10,000 with Huron Perth (19.7) and Elgin (18.0) having the highest rates.

The South West LHIN emergency department revisit rates for mental health and substance abuse have been better than provincial performance for the past four years, although both rates did rise in the most recent quarters. The South West LHIN had a roughly 10% increase in repeat unscheduled mental health ED visits within 30 days between Q1 2016-17 and Q1 of 2017-18. In Q1 of 2017-18, the percentage of repeat unscheduled substance abuse ED visits was the highest since the end of 2014-15 at 26.6%.

For opioid related emergency department visits, the number of visits has increased by 138% in Ontario since 2013 compared to 101% for the South West. In 2016, London Middlesex hospitals accounted for over 50% of all the South West opioid related visits and have seen an increase of 132% since 2013.[8]

South West opioid overdose ED visit rates have steadily increased from April 2017 (3.55/10,000) to November 2017 (4.47/10,000).[9] Anecdotal and experiential feedback from ED physicians suggests that spikes often coincides with "bad products" being sold on the streets.

The CMHA Middlesex Support line receives 1700 calls per month on average but this number has been increasing by approximately 200 per month in the last quarter.

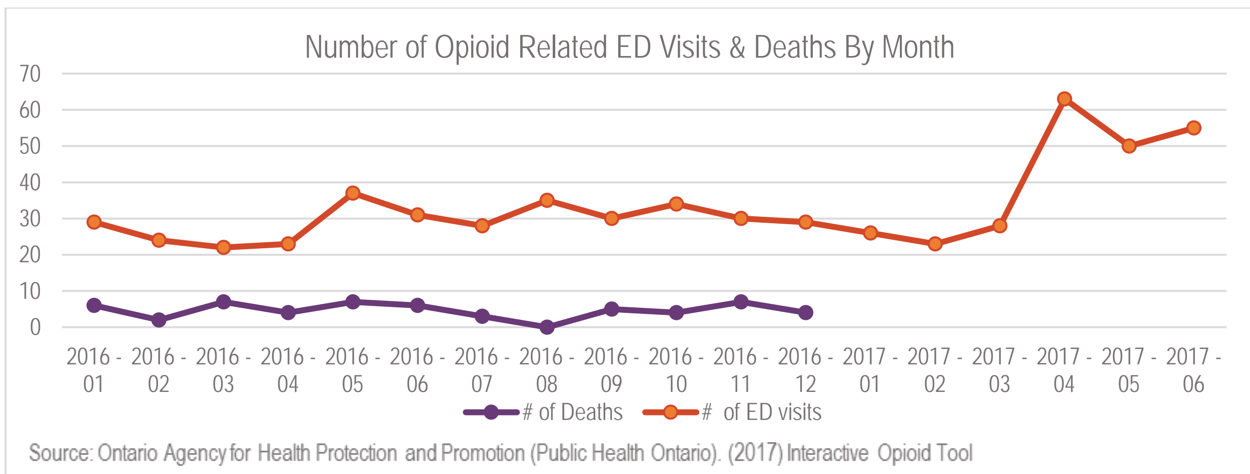
Community resources

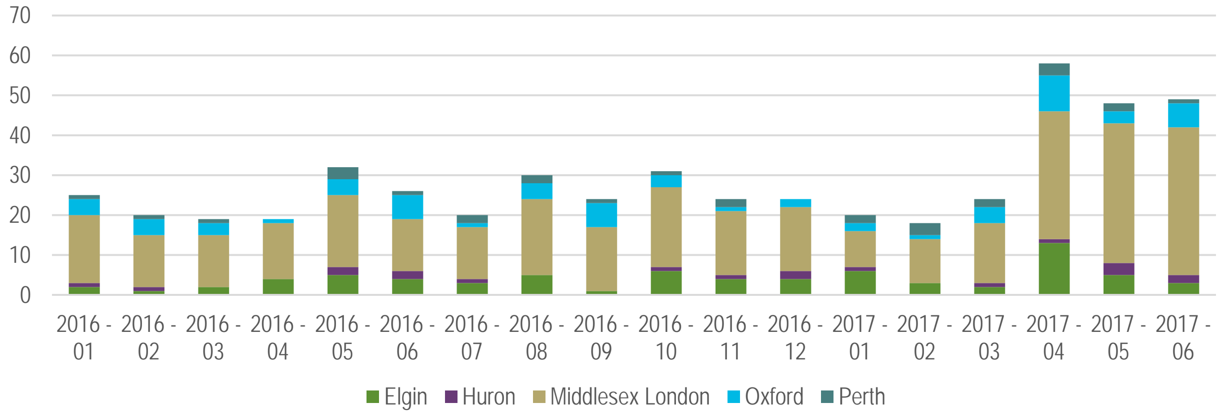
The CMHA Middlesex Support line receives 1700 calls per month on average but this number has been increasing by approximately 200 per month in the last quarter. An average of 700 calls per month are received through Reach Out.

The London Middlesex Crisis Centres are reporting over 300 visits per month. The London Middlesex Mobile Response Teams average over 340 interventions per month – 1/3 of these are face-to-face visits.

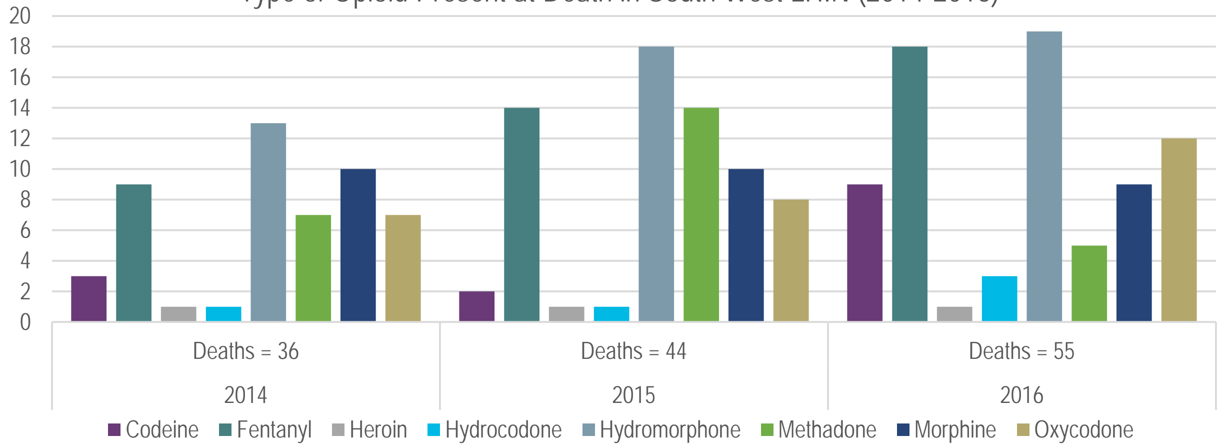
ED visits (all ages) for opioid overdose based on patient residence (April to November 2017)	
HNHB	871
Toronto Central	788
Central East	474
South West	344
Central	343
Champlain	305
Waterloo Wellington	294
North Simcoe Muskoka	270
North East	232
Mississauga Halton	224
Central West	207
Erie St. Clair	188
North West	76

Source: National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health (CIHI)





Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2017) Interactive Opioid Tool



Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2017) Interactive Opioid

Jane's Story – Real Story, Fictitious Name

Jane is a 44-year-old patient at University Hospital, whose current state of health can be traced back to complications of pain management resulting from a spinal injury. She is a paraplegic, incontinent, with an in-situ catheter to drain urine, and a person who injects drugs and frequents methadone clinics. She has extensive wounds on her body and has a Peripherally Inserted Central Catheter (PICC line) for antibiotics, as she often contracts very serious infections. Unfortunately, the PICC line has also enabled her illicit drug use.

In 2011, she was a patient at the Parkwood Hospital Spinal Cord Injury Unit and started receiving care coordination that year. Her illicit drug use has often made her aggressive, verbally abusive and unwilling to cooperate and unwilling to consent to service, which has frequently caused her to live on the street, while alternating between use of crash beds, hostels, supportive housing, emergency departments and hospitals. Unsurprisingly, Jane suffers from PTSD.

Jane requires daily assistance from a personal support worker (PSW) for help with washing, dressing and other personal needs, but often refuses care, sometimes because it interferes with her drug habit. Jane's family can no longer cope with her behavior and the family's lack of support contributes to Jane's distress. The London Police Service had been checking on her from time to time in recent months.

She has been in hospital for 1.5 months now. The goal is to heal her pressure sores and other wounds before she is discharged from hospital to what might be an unsupportive and possibly unsanitary environment.

She has received hundreds of hours of care coordination since 2011, as well as thousands of hours of support from hospital and community service providers combined. While a sad case of drug addiction, disability and life on the streets, Jane's situation is becoming more common as she is but one of the many opioid users who require extensive care from the South West LHIN.

Pillar I – Prevention Strategy

While prescription opioids have proven therapeutic benefits, they also have a high potential for harm such as addiction, overdose and death. One of the factors contributing to the current crisis in the use of prescription opioids is insufficient knowledge and skills on the part of health practitioners in the assessment and management of pain. This knowledge gap includes skills in choosing and monitoring non-pharmaceutical and pharmaceutical treatments for pain, and in preventing, recognizing and managing the harms associated with opioids.

This strategy addresses the need for effective and accessible educational programming for overall pain management, beyond just opioid stewardship. The target audiences are:

- Medical residents
- Practitioners who prescribe opioids within parameters consistent with guidelines
- Practitioners whose opioid prescribing is inconsistent with guidelines
- Practitioners who care for particular populations
- Practitioners include: family physicians, nurse practitioners and specialist physicians

> *Pain is poorly managed in Canada because there is a lack of education and training for pain assessment and treatment, especially about alternatives to opioids.*

The release of the new *Recommendations for Use of Opioids in Chronic Non-Cancer Pain* in early 2017 is challenging Canadian clinicians to re-examine their prescribing practices and seek opportunities to learn. Several clear areas of need have already emerged:

1. A de-prescribing protocol for opioids – aimed at primary care teams and involving patients – that will support achievement of lower dosing thresholds in the new guidelines.
2. An academic detailing initiative (one-on-one educational outreach), conducted by the Centre for Effective Practice (CEP), aimed at high prescribers of opioids identified by provincial regulatory authorities.
3. Development of a protocol for physicians and teams to acquire the knowledge and skills to initiate and sustain opioid substitution treatment with suboxone. The protocol would be supported with online learning and other resources to guide its implementation.
4. Implementation of a network of expert colleagues equipped and supported to provide advice to practitioners struggling with difficult pain management and prescribing issues. The network, based on Project ECHO (lifelong learning model) and Medical Mentorship initiatives that already exist in several provinces, would be extended to practitioners across Canada.
5. Development and implementation of a platform to guide clinicians and practice teams through practice quality improvement (QI) initiatives around multiple aspects of optimal pain management, opioid prescribing, and handling substance use disorders.

The Pan-Canadian Collaborative on Opioid Prescribing has in fact commissioned a task group to assess the learning needs and gaps of prescriber in order to create or change Continuing Professional Development (CPD) programming. The goal is to develop the programming required to help prescribers address this crisis immediately and in the longer term.

Note that there is a need for more timely data related to opioid usage, overdoses and related deaths to support prevention and the other pillars of our opioid strategy. It is difficult to assess the impact of opioid abuse in a timely way when data is often six months to two years old. Investigation and coordination between public health, hospitals and the Ministry could help improve consistency in reporting and make comparisons easier.

Physician-based scorecards are being developed and implemented in many hospitals (London Health Sciences Centre, St. Thomas, Woodstock and others) and may include opioid prescribing information by physician. Knowledge sharing and partnership opportunities exist and must be capitalized on.

Below you will find some of the prevention strategies underway.

Primary care

- **Primary care practice reports:** Education of family physicians on their opioid prescribing through the MyPractice Opioid Report Webinar, also available on iTunes.
- **Membership in the Opioid Crisis Working Group (OCWG):** Middlesex London Health Unit, City of London, Police, London Health Sciences Centre, InterCommunity Health Centre, HIV/AIDS Connection, Chippewas of the Thames First Nation, South West LHIN, Patient representative.
- **Supervised Consumption Facilities (aka injection sites)**: Site opened with public health and the support of the primary health care sector (InterCommunity Health Centre, sub-region clinical lead), civic leadership and other social sectors.
- **Quality Standards:** Defining what quality care looks like for people with acute or chronic pain considering opioid therapy and for people with opioid use disorder. This is based on the *2017 Canadian Guideline for Opioids for Chronic Pain*.
- **One-on-one Educational Outreach (aka Academic Detailing)**: The South West LHIN will have 70 spots available for family doctors to receive this education as well as access to clinical tools and supports focused on delivering providers with objective, balanced, evidence-informed information on best practice. This will be made available through the Centre for Effective Practice.
- **Primary Care Alliance Outreach:** The Primary Care Alliance, in coordination with public health, will increase awareness of available supports and programs, and investments to increase access to addiction services.
- **Various Conferences:** The South West LHIN will share what it learns at a host of conferences, such as the Medical Mentoring for Addictions and Pain conference and at the Every Step conference, where the South West LHIN will present, to help doctors use EMR tools and QI initiatives to improve adherence.
- **Other Supports:** The South West LHIN will provide access to: the Safer Opioid Prescribing webinars and workshops (University of Toronto Faculty of Medicine); Quality Improvement Decision Support Specialists (QIDSS); analytics available through the Association of Family Health Teams of Ontario; the National Narcotics Monitoring Network, which shows whether a patient is obtaining drugs from multiple providers; and

DHDR through Clinical Connect, which the sub-region clinical leads and Primary Care Alliance are promoting.

Public health

- **Clinical Leadership:** Providing a strong clinical voice on the Opioid Crisis Working Group (OCWG) and support for education days, such as the Narcotics education day held on November 15, 2017.
- **Direct Education:** Public health has provided direct education to physicians in the Health Unit in response to the awareness created around opioids, pain management and addiction through media coverage of Fentanyl-laced drugs and the need to make naloxone more available.
- **Newsletter:** The public health newsletter has been distributed to local media.

Pain clinics

- **Chronic Pain Network:** Working closely with the government to roll out its $20 million annual investment in Ontario's Chronic Pain Network.
- **Mentoring in Pain and Addiction:** The South West LHIN will support the Ontario College of Family Physicians as it expands this network to family physicians and nurse practitioners.

Surgeons

- **Surgery Safe:** This prescribing education is currently underway and encourages a maximum seven day prescription for acute pain.

ER departments

- Our prevention strategy for ER departments includes educational material on prescribing standards and prevention resources. For example, suboxone (a combination of buprenorphine and naloxone) is currently underutilized in emergency departments, despite its clinical effectiveness for opioid use disorder.

Pillar II – Treatment Strategy

In terms of planning and initiating a treatment strategy for opioid addiction and overdoses, the South West LHIN is currently socializing a clinical protocol for adults and adolescents to facilitate timely access to Schedule 1 Mental Health inpatient beds and engaging with stakeholders to develop recommendations for optimizing existing mental health and addictions resources.

We have also developed a strategy to reduce wait times for hip and knee surgery that has specific strategies for pain management and conservative pain management treatment. We need to reduce unnecessary or excessive opioid prescribing, while prescribing opioids confidently to those who truly need them.

We need to reduce unnecessary or excessive opioid prescribing, while prescribing opioids confidently to those who truly need them.

Working collaboratively with housing service advisors and municipalities, the South West LHIN is also evaluating investment opportunities for supportive housing for people with mental health and addictions conditions as well as identifying other potential housing opportunities. Supportive housing is a critical social determinant of health with 25-50% of homeless people struggling with mental health issues. Note that supportive housing is approximately seven times less expensive than keeping someone in a psychiatric hospital.[10]

We are also pursuing capital funds to co-locate five additional stabilization beds at the Crisis Centre managed by Canadian Mental Health Association (CMHA) Middlesex. As mentioned earlier, we have experienced challenges with active addiction use requiring long term IV antibiotic use in the community and are now working with the InterCommunity Health Centre on discharge planning and housing for patients with IV therapy for endocarditis secondary to IV drug use.

Coordination is at the heart of the South West LHIN's mission. That's why we're proud that approximately 1000 calls received per month result in individuals being provided with community supports and facilitated bookings directly with community providers. This coordination is exemplified in our partnerships with police and public health to understand what is happening at the street level and through our work with EMS to establish protocols that would divert transports away from the emergency department to the Crisis Centre for London Middlesex.

Of course, family physicians and primary care are fundamental to quality health outcomes. The South West LHIN is providing health care providers with prescribing standards and alternatives to opioids, as discussed in the previous section on prevention. This primary care support includes Project Hope, an initiative from the Thames Valley Family Health Team, which provides additional support when prescribing suboxone. The South West LHIN will provide similar support to specialists such as surgeons and dentists in partnership with hospital quality leads, Chiefs of Staff and Medical Advisory Committees.

Funding

The South West LHIN approved $1,000,000 in funding to support addictions treatment as part of the Strategy to Prevent Opioid Addictions and Overdose. This included $200,000 to Grey Bruce Health Services to expand the Rapid Access Addiction Medicine (RAAM) Clinic in Grey Bruce; $454,380 to Addiction Services of Thames Valley to expand the RAAM Clinic, the Community Withdrawal and Crisis Support Program, the Community Opioid Addiction Program (COAP) in London Middlesex and the COAP program in Elgin and Oxford; $168,000 to Choices for Change Alcohol, Drug & Gambling Counselling Centre to expand the Opioid Outreach program in Huron Perth; and $177,620 to Southwest Ontario Aboriginal Health Access Centre for outreach workers to provide access to needles, syringes and naloxone in London and the surrounding reserves.

Rapid Access Addiction Medicine (RAAM) Clinics

The Rapid Access Addiction Medicine (RAAM) These low barrier clinics help individuals looking for substance abuse support find specialized addiction care, including counselling, anti-craving medications for alcohol use disorders, and buprenorphine or methadone for opioid use disorders. Doctors assess each individual and develop a treatment plan, including referrals to community organizations for further support, if needed. RAAM clinics have been shown to significantly reduce opioid-related emergency department visits and repeat visits.

RAAM clinics have been shown to significantly reduce opioid-related emergency department visits and repeat visits.

Community Withdrawal and Crisis Support Program

Treating addiction means supporting patients through withdrawal and over the longer term. The Community Withdrawal and Crisis Support Program provides comprehensive community withdrawal management, addiction and mental health crisis care. The program will develop individualized plans, increase access to informal and formal supports and primary care during periods of withdrawal, and provide an entry point into the addictions continuum of service providing options for ongoing treatment plans and referrals. This program aligns with the provincial standards for Community Withdrawal Management.

Emergency departments

Despite the clinical effectiveness of suboxone (a combination of buprenorphine and naloxone) for opioid use disorder, it is currently underutilized in emergency departments. Suboxone inductions, used to suppress opioid withdrawal, have been facilitated in the emergency department through the mentorship of family physicians who have a focus or strong expertise in addiction care. Acute prescribing education has also been implemented.

Despite the clinical effectiveness of suboxone for opioid use disorder, it is currently underutilized in emergency departments.

Pillar III – Harm Reduction Strategy

Many of the harm reduction strategies were discussed in the section on Prevention, such as safe consumption sites, distribution of naloxone kits, discharge planning for patients with Endocarditis, including a pilot for the use of the Baxter pump. Overdose education is also quite effective, increasing a person's ability to recognize an opioid overdose and take action.

Overdose education works, increasing a person's ability to recognize an opioid overdose and take action.

The Community Opioid Addiction Programs (COAP) is another great example of our confidential, harm reduction, community-based strategy for working with individuals who have significant current or historic use of opioids and/or opioid substitution therapies such as methadone and suboxone. The program can provide direct client services in diverse community spaces, including assessment, treatment planning, case management, as well as withdrawal management support and community treatment.

COAP supports individuals with a range of goals including abstinence, moderation and/or harm reduction and assists individuals in any stage of change. The program emphasizes individuals who face barriers to treatment, women who are pregnant or parenting, youth, indigenous people, and people living with HIV/AIDS or Hepatitis C.

The goals and objectives of COAP are, but not limited to, improved health, social outcomes and quality of life, including reduced exposure with the criminal justice system. We have to remain vigilant, because we know substance use disorders are more stigmatized by healthcare providers than any other mental health condition. We need to break down these barriers to care.

Substance use disorders are more stigmatized by healthcare providers than any other mental health condition. We need to break down these barriers to care.

Pillar IV – Enforcement

First responders, emergency medical services, fire services and police are involved in numerous overdose situations, often under challenging circumstances. However, an Ontario study reported that only 46% of those who witnessed a drug overdose actually called 911, and among the barriers included: fear of being arrested for drug possession or for breaching parole.[11] There are countless examples of overdose situations where 911 was not called or that peer-users left the scene before emergency services arrived, leaving the overdose victim at high risk for death.

> *Only 46% of those who witnessed a drug overdose actually called 911 out of fear of being arrested.*

In May 2017, the Good Samaritan Drug Overdose Act received Royal Assent and became law in Canada. The Act applies to anyone seeking emergency support during an overdose, including the person experiencing an overdose. The Act also protects everyone at the scene of an overdose from arrest for drug possession charges. By eliminating the fears associated with calling 911, it will not only save lives but will also provide an entry point to the healthcare system.

Below are other enforcement options being considered by the South West LHIN:

- **Ministry Accountability**
  Stronger levers could be used to top prescribing outside of safe dosing and quantities. The Ministry could place limits on the number of pills dispensed per prescription. Chronic use (beyond two refills per health card) could be required to go through an exceptional access program and meet very strict guidelines and limits on doses. Such changes could be instituted centrally and would remove the need for doctors to police their colleagues. Limits on the number of pills and number of scripts effectively remove the accelerant. Until supply is monitored, any program at the local level will be playing catch up and simply waiting for the next crisis.

- **Distribution of Primary Care Practice Reports from Health Quality Ontario**
  The South West LHIN is discussing ways to best support data collection for these reports, including information on high prescribers. The Centre for Effective Practice (CEP) could then use this information to target academic detailing (one-on-one educational outreach) for those physicians most in need.

- **Leverage Methadone Clinics**
  Methadone clinics should provide addiction treatments or be linked to addiction medicine and mental health. A more robust wrap around program could be developed for methadone clinics. We should stop the stand-alone drug dispensing.

- **Fund Suboxone Regional Champions**
  Intentional development of practice champions in the South West LHIN for suboxone

prescribing. This concept is to fund the CPD and leadership development for each sub-region.

- **Inventory of Pain and Addiction Resources**
  More coordinated education about existing resources in the community. This can be accomplished through the Primary Care Alliance in each sub-region and with the web site. Many of these resources are already on Healthline.ca but are unknown to family physicians.

- **Policies and Procedures for Prescribing**
  Close affiliation with the College of Physicians and Surgeons of Ontario and the Canadian Medical Protective Association for policy and procedures regarding prescribing, in addition to education on best practice.

- **Business Case for Rehab and Pain Management Resources**
  Wait lists for pain clinics are long and referrals are being declined. Use of rehabilitation specialists could be increased for some of these patients. OHIP could cover physiotherapy, massage therapy, occupational therapy, clinical psychology and chiropractic care for patients with no third party coverage and chronic pain diagnosis. Rehabilitation is two tiered in Ontario. Very limited and long waits for those with acute injury and it results in chronic pain development. Patients are perceived to have less chronic pain with more aggressive rehabilitation services.

Conclusion and Next Steps

Combatting the opioid crisis is an urgent public health priority. In learning from other jurisdictions, key experts and evidence-based literature, the South West LHIN Opioid Strategy was developed by a wide range of stakeholders using the four pillar drug strategy model. Implementation of the aforementioned recommendations will require a collaborative, system-wide approach between partners, integrated working groups and people with lived experience.

We have identified several recommendations to be implemented to reduce opioid-related harms and protect the well-being of people living in the South West LHIN region; some of which have already received funding as part of the Ministry's 2017/18 commitment to a three year investment. Other recommendations are deemed high priority, such as the distribution of naloxone in emergency departments, increased buprenorphine/naloxone inductions in emergency departments, implementing standardized care that is both trauma-informed and stigma-free, providing post-withdrawal management addictions treatment, and supporting prescribers in achieving compliance with best-practice medication guidelines.

We believe the South West LHIN is well-positioned to advance this comprehensive Opioid Strategy and in doing so improving the quality of lives across our communities.

Appendix A: Further Reading

College of Physicians and Surgeons of Ontario: Appropriate Opioid Prescribing
http://www.cpso.on.ca/opioids

College of Family Physicians of Canada: Chronic Non-Cancer Pain Management and Opioid Resources:
http://www.cfpc.ca/2017_canadian_guideline_opioids_chronic_non_cancer_pain/

First Nations Health Transformation Agenda, Chapter on Mental Wellness and Addictions, February 2017:
https://www.afn.ca/uploads/files/fnhta_final.pdf

Health Canada's 2016 Joint Statement of Action to Address the Opioid Crisis:
https://www.canada.ca/en/health-canada/services/substance-abuse/opioid-conference/joint-statement-action-address-opioid-crisis.html

Health Canada's Substance Use and Addictions Program:
https://www.canada.ca/en/services/health/campaigns/canadian-drugs-substances-strategy/funding/substance-abuse-addictions-program.html

Health Quality Ontario – Opioid Prescribing in Ontario:
http://www.hqontario.ca/System-Performance/Specialized-Reports/Opioid-Prescribing

House of Commons Standing Committee on Health: Report and Recommendations on the Opioid Crisis in Canada, December 2016:
https://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/report-6/page-27#overview

Appendix B: Performance Indicators

Overall Strategy	Prevention	SIS	HR	Emergency	RAAM
Mortality rate, OD rate, Opioid-related ED visits, 30-day return for OD, Opioid-related hospital admissions, Naloxone dispensed, Naloxone used, % of providers in CELHIN providing substance use care, % of people in treatment, % of health care providers who prescribed opioid agonist therapy (in the last year)	# of people taking prescribed opioids, # of opioid prescriptions, Type and dosage of opioid	Visits (unique, revisits), OD event rate, OD outcome, Visit pattern (weekly, daily, hourly), Treatment referrals	Visits, # of naloxone dispensed, # of needles exchanged, HIV rates, HEP C rates, Treatment referrals,	ED visits, ED revisits, # of Rx suboxone, # of suboxone prescribing physicians RAAM referrals, # of naloxone dispensed	Visits (unique, revisits), Referral source, Outcome (discharge/transfer), Repeat visit following discharge

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[9] National Ambulatory Care Reporting System (NACRS), CIHI, 2017.
[10] Canadian Mental Health Association Web site: http://ontario.cmha.ca/provincial-policy/social-determinants/housing/
[11] Zarkin, G.A., et al., *Lifetime benefits and costs of diverting substance-abusing offenders from state prison.* Crime & Delinquency, 2015. **61**(6): p. 829-850.

Agenda item 5.1

Report to the Board of Directors

Human Resources, Vice President Recruitment

Meeting Date: **May 15, 2018**

Submitted By: **Donna Ladouceur, Interim CEO**

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

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

Background

Maureen Bedek, Vice President, Human Resources retired effective April 30th, 2018. Waterhouse Executive Search is leading the search for her replacement and has been involved since early January 2018.

Current Status

The lead for the recruitment Jon Stungevicius from Waterhouse provided an update on April 30th. Applicants for this role have been quite limited even with numerous reach outs from the recruiter. Reflections of many are they want to know who their CEO will be. He does have a short list of five potential applicants. Jon will be completing a further screening interview with the five and will bring recommendations to the Interim CEO within the next week. The goal will be to set up interviews quickly.

As an interim, Hilary Anderson, Vice President of Corporate Services is taking the Vice President lead for the Human Resources/Organizational Development team.

Agenda item 5.2

Report to the Board of Directors

Integration Heath Services Plan & Strategic Plan Development Update

Meeting Date: **May 15, 2018**

Submitted By: **Sue McCutcheon, Director, Planning and Integration**
Malvin Wright, Manager, Planning and Integration

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

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

Purpose:
To update the Board of Directors on the current state of the 2019-22 Integrated Health Services Plan (IHSP) & Strategic Plan development process.

Background:
In February 2018 the Board approved the recommended Integrated Health Equity approach for the development of the 2019-22 IHSP and the 3 year South West LHIN Strategic Plan; simultaneously. The IHSP is our collective plan that builds on the accomplishments and initiatives from previous plans and identifies new and emerging strategies that will take place over the next 3 years. Like the previous ones, our next IHSP will describe the priorities, approach, strategies, and proposed outcomes for the local health system over the three year period, while reconciling the work achieved over previous IHSPs, identifying successes, gaps and opportunities for the next phase of our health system transformation journey. The Strategic Plan will guide our ongoing systems approach to improving care internally and across the system.

As requested by the Board of Directors, a Request for Proposal (RFP) was developed. Optimus SBR was chosen and will guide the South West LHIN through the development of both the IHSP and Strategic Plan. The draft IHSP is due to the Ministry of Health and Long-Term Care in late October 2018. The work with Optimus SBR was launched in early April.

The Integrated Health Equity (IHE) approach will allow the South West LHIN to set the parameters of engagement and outcomes while ensuring that quality, performance, health equity and strategic alignment are the main drivers. The IHE approach will review what has been undertaken in the past, address today's challenges and adjust for tomorrow's needs while aligning LHIN Board and leadership, staff and stakeholders towards a focused approach to future work.

Since the development of the last IHSP, there have been changes in the health care landscape provincially and locally. With Patients First, Local Health Integration Networks deliver service, plan for

improved health services, and fund many health services providers. A focused approach will be used to ensure that stakeholder engagement will be honoured as well as aligning with provincial priorities and imperatives (both internally and externally).

The measures for success throughout this process are:

- An IHSP that is aligned to provincial policy, South West LHIN's population trends, system drivers and pan-LHIN strategic directions,
- An IHSP that continues to move the South West LHIN from direction to action to meet the needs of the population,
- An internally-focused and informed strategic plan that promotes efficiency and focus that complements the IHSP, and to build
- Buy-in and engagement among stakeholders to build the action plan for South West LHIN services.

Next Steps:

Planned Engagement

The engagement approach will utilize existing South West LHIN groups Board of Directors, Senior Leadership, Health System Renewal Advisory Committee, Clinical Quality Committee, Patient and Family Advisory Committee, French Language Services Entity, Indigenous Health Committee; Sub-Region Integration Tables, and the Cultural Transformation Committee.

The intent is to conduct a robust assessment and prioritization of local issues – identified through analysis and LHIN internal engagement that is aligned with ministry priorities and direction as well as identifying how the LHIN will implement and action these priorities.

The IHSP/Strategic Plan will also engage with external partners (including municipal leadership) in order to reflect on our strengths, gaps and challenges LHIN-wide and in each sub-region:

- Home and Community Care
- Acute Care
- Long-Term Care
- Palliative Care
- Primary Care
- Rehabilitation and Complex Continuing Care (CCC)
- Community Support Services (CSS)
- Mental Health and Addictions

Board Engagement

Optimus SBR will lead the IHSP development session at the upcoming Board of Directors retreat in June 2018 (date to be determined). This workshop will develop a preliminary and high level outline of the IHSP and Organizational Strategic Plan that can be validated with internal and external stakeholders and then refined later in the process based on the current state assessment and stakeholder feedback while setting the direction and establishing the framework for the IHSP and the Strategic Plan.

Agenda item 5.3

Report to the Board of Directors

Board Committee Reports

Meeting Date: **May 15, 2018**

Submitted To: ☒ **Board of Directors**

Purpose: ☒ **Information Only**

Audit Committee

The next meeting of the Audit Committee is scheduled for 3 pm on Thursday, June 14, 2018 to receive and review the 2017/18 annual audit report and letter from Deloitte.

Board-to-Board Reference Group

The next meeting of the Board-to-Board Reference Group is scheduled for 1 pm on Friday, May 25. Draft agenda items include: Sub-region Board-to-Board Reference Groups – review of Expressions of Interest, IHSP Development, and HSP Governance Education Session Planning. A webinar is being held on Tuesday, May 29 for all HSP board governors in the LHIN-area to learn more about the sub-region initiative.

Governance & Nominations Committee

The Governance Committee last met on Friday, April 27, it was a closed session. The next meeting is proposed for Tuesday, May 15 for another closed session, and a regular meeting of the committee is scheduled for Thursday, June 28 to continue with the governance policy review work.

Quality Committee

The Quality Committee last met on Tuesday, April 24. At that meeting they listened to a patient story on Family-Managed Care (previously referred to as Self-Directed Care), heard a brief presentation on Quality Measures and received updates on Accreditation, and Provincial Committee Guidelines. The committee is next scheduled to meet on Tuesday, May 22.

Agenda item 5.4

Report to the Board of Directors

Board Director Reports

Meeting Date: **May 15, 2018**

Submitted To: ☒ **Board of Directors**

Purpose: ☒ **Information Only**

Board Directors reported attending the following events.

Myrna Fisk

Since my last report, I have attended two board meetings and one board teleconference.
I attended both the Quality and Governance Committee meetings.

Wilf Riecker

April 23, 2018

- Meeting of CEO Search Committee – candidate interviews
- Special Meeting of the Board

April 27, 2018 - Meeting of the Governance & Nominations Committee

May 3, 2018 - Special Meeting of the Board

Aniko Varpalotai

- CEO Selection Committee interviews
- Quality Committee Meeting
- Governance Committee meeting

Agenda item 6.1

Report to the Board of Directors

South West LHIN Musculoskeletal (MSK) Strategy Implementation Update

Meeting Date: **May 15, 2018**

Submitted By: **Shirley Koch, Sub-Region Director – Huron Perth**
Andrea McInerney, Manager, Quality Improvement
Mark Brintnell, Vice President, Quality, Performance and Accountability

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

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

Suggested Motion
THAT the South West LHIN Board of Directors approves the allocation of $1,636,280 in base funding in 2018/19 to London Health Sciences Centre as the Regional Lead and host for the Central Intake and Assessment Centre.

Purpose

Further to the April 17, 2018 Board report, the purpose of this report is to provide further information to enable the South West LHIN Board in considering base funding dollars to London Health Sciences Centre (LHSC) as the Regional Lead and host for the Central Intake and Assessment Centre.

Background

The provincial musculoskeletal (MSK) model will see a new standardized pathway for patients with hip and knee osteoarthritis (OA) and low back pain, and involves core mandatory elements including a single central intake office for the South West Region and inter-professional assessment within 2 to 4 weeks of referral from Primary Care.

Over the next three years, $245 million will be invested provincially to expand models of care for highly prevalent conditions and improve specialist access, including new digital solutions to streamline consults and e-referrals. In 2017/18, this included: $17M for expanding MSK intake and assessment across all LHINs (CIAC and ISAEC) plus $10M for digital solutions (such as eReferral and eConsult). In December 2017, the South West LHIN received local funding details outlining ~$1.6M annual base funding to support this new pathway of care.

The MSK Steering Committee, co-chaired by Cathy Vandersluis, Vice President at LHSC and Andrew Williams, CEO of Huron Perth Healthcare Alliance, unanimously supports that the base funding be allocated to LHSC as the regional lead and host for central intake. This funding arrangement will:

- streamline funding and accountability from the LHIN to a single partner;

- expedite the flow of funds to LHSC, thereby enabling LHSC to post in a timely manner the Advanced Practice Lead (APL) clinical roles and central intake (administrative functions) roles;
- provide flexibility for future decisions regarding the employment relationship of the assessors (meaning if the Steering Committee determines a decentralized/multi-employer relationship is preferred for the assessors, LHSC as the host site would draft an MOU with the regional partners, who would invoice LHSC for the Assessment resources); and
- maintains the MSK base funding as one for resource, simplifying the process if planning/adjustments over time are needed – for instance, if allocations and populations grow which would see shift of assessors required to meet demand in a particular area.

Next Steps

Pending the LHIN Board's consideration of this recommendation, LHIN staff will put in place all the necessary accountability requirements for this regional role as part of the program.

Agenda item 7.1

Report to the Board of Directors

March 2018 Financial Update

Meeting Date: **May 15, 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**

Purpose

The Finance team has been hard at work finalizing the fiscal year ending March 31, 2018, ensuring that the accounting records are complete and accurate in advance of the annual audit (started May 7, 2018) and the subsequent Ministry reporting.

The purpose of this financial update is to give you a brief summary of where we are from a financial perspective for the year ending March 31, 2018 and to provide a look forward into 2018/2019.

2017-18 Current State

We have finished the year in a surplus position at March 31, 2018 in the range of $2.5-3.5M. This is subject to change as the year end is finalized.

It has been a challenging year and one full of change. As we have indicated throughout the year, purchased services trended down as compared to the volumes seen in first quarter and lead to an unexpected surplus. A significant portion of this trend was due to the continued shortage of PSW staffing capacity.

As a result of the surplus, we received Ministry approval to transfer $4M from the Home and Community Care envelope to the HSP transfer payment envelope on a one-time basis. This allowed Health Services Providers to undertake many one-time projects. We were also able to undertake additional projects internally such as SW LHIN infrastructure investment and increased program spending.

Unfortunately a planned increase in PSW volumes through the implementation of a respite service strategy did not generate the results we originally anticipated.

Our surplus projection has increased since we updated you in February as a result of the following:

- Release of the HST accrual – The Canada Revenue Agency has ruled that legacy SW LHIN rebate rate (100%) would continue to be applied to the merged SW LHIN and SW CCAC. As a result this accrual was released.
- Additional recovery of Chronic Kidney Disease expenses that were not anticipated
- Additional interest earned on the accumulating surplus throughout the year
- a net underspend on salaries due to the timing of filling vacancies and
- other miscellaneous small variances from our plan

2018-19 Projections

Although we are still very early on in the new fiscal year, we are able to provide some comments on current trends against the previously submitted 2018/19 budget.

- Analysis of Purchased Services trends indicates that although they continue to be impacted by the PSW staffing shortage, they are on track with the amount budgeted for 2018/2019.
- The timing of the transfer of the School Therapy program to the Thames Valley Children's Centre as a result of the special Needs Strategy has been revised, and is currently expected to occur in the second quarter. The related funding continues to be advanced to the SW LHIN.
- A new funding letter has been recently received that allocates an additional $15M to expand home care services, increase contract rates for home care services, support sustainability of community services. This is great news! Additional information on the plans on how we will utilize this funding will be communicated to the Board at a later date through a revised annual budget.

PSW Shortage Update

Current Status:

- PSW Capacity continues to be a concern across the South West, with missed care rates remaining consistent since Q3 (~ 1.3%). In addition to mitigating the current situation, the LHIN is examining:
  - Possibly entering into a formal research project with Ivey (Western) to study the impact of our contracted model on missed visits.
  - Capacity Wait List - when a care plan cannot be filled, Care Coordinators are placing patients on a "wait list" for remaining services
  - Shared Care Plans - currently working with select providers on share care plans to determine options
  - Provider Discussions - working with providers to identify shared recruitment strategies but challenges remain at the education level
  - Changes to Legislated Maximums - in order to better support clients with complex care needs to remain at home and in the community, the government has amended the home care service maximums.