BOARD MINUTES

WWLHIN Board of Directors
Special Open Session – October 5, 2017

The following are the minutes of the WWLHIN Board of Directors Special Meeting held at 2:30 p.m. on October 5, 2017 at the WWLHIN Waterloo office, 141 Weber St. S Waterloo, ON and via electronic participation.

Members Present:	M. Delisle (Chair), J. Nesbitt, J. Varner, J. Harper, R. Westbrook, P. Sweeney, J. Kopinak, K. Scian, B. Larkin
Regrets:	
Staff Present:	B. Lauckner, Z. Danis, G. Cardoso, T. Lemon, A. Davidson, K. Lumsden, M. Alarakhia, K. Rhee, R. Forbes
Recording Secretary:	D. Ruprecht

1.0 Call to Order & Recognition of Quorum

Called the meeting to order at 2:30 p.m.

2.0 Approval of the Agenda

Motion No. 42 -17/18 — Moved by R. Westbrook, seconded by J. Varner and unanimously approved:

THAT the agenda be approved as circulated.

3.0 Declaration of Conflict of Interest

All Board of Directors confirmed that there were no declarations of conflict of interest made in relation to the matters to be dealt with on the agenda.

4.0 Investments in Mental Health and Addictions: $1.65M Base for Opioids and $531,800 Base for system improvements and addressing risk

The Board reviewed the material with a recommendation for base investment of $1,650,000 base allocation under the Opioid Strategy, as well as $531,800 in base to improve addictions and mental health services. The investments were presented in tandem as there are interdependencies between the two to realize our overall system plan for addictions and mental health.

Motion No. 43 -17/18

Moved by J. Harper, seconded by B. Larkin and unanimously approved:

THAT the WWLHIN Board of Directors approve the base investment of $1,650,000 base allocation under the Opioid Strategy, as well as $531,800 in base to improve addictions and mental health services as outlined below:

Base Investment in 2017/18 of $713,300 increasing to $1,650,000 in 2018/19 of Opioid funding as follows:

- $273,300 in 2017/18 (increasing to $645,000 in 2018/19) for three Rapid Addictions Clinics, each open 2 days/week, in Guelph, Kitchener, and Cambridge.
- $190,000 in 2017/18 (increasing to $424,000 in 2018/19) for enhanced community management supports directly attached to the RAACs for follow-up care
- $60,000 (increasing to $181,000 in 2018/19) to integrate addictions support workers with police services
- $90,000 (increasing to $270,000 in 2018/19) to build addictions concurrent flexible Assertive Community Treatment teams to serve highly complex clients
- $100,000 (increasing to $130,000 in 2018/19) for peer follow-up post-overdose, and;

One-time investments in 2017/18 of $936,700 of Opioid funding as follows:

- $75,000 in Opioid Prescribing toolbar in primary care EMR
- $180,000 for enhancement of 24hr men's residential addictions services in Kitchener and Cambridge

- $100,000 for time-limited residential addictions treatment

capacity
- $175,000 for Crisis Stabilization pilot
- $60,000 for specialized youth withdrawal management
- $120,000 for addictions supports on WWLHIN campuses
- $85,000 in enhanced Rural support across continuum of care
- $59,900 for Withdrawal Management Centre enhancements
- $81,800 for enhanced Day Treatment options

Base investment of $226,667 in 2017/18 increasing to $531,800 in 2018/19 in Mental Health and Addictions enhancements as follows:

- $226,667 in 2017/18 (increasing to $340,000 in 2018/19) for expanded flexible Assertive Community Treatment Teams to serve highly complex clients
- $191,800 starting in 2018/19 for integrated primary care MH&A (RAIT) teams

One-time investment in 2017/18 of $305,133 in Mental Health and Addictions enhancements as follows:

- $230,133 to reduce counselling and treatment waitlist through time limited walk-in clinics
- $75,000 to expand pilot placing tablets in primary care so patients can complete depression screener, linked to EMR

5.0 Hospital Accountability Planning Submissions (HAPS) Planning Assumptions

The Board reviewed the material with a recommendation to approve the key planning assumptions to guide the 2018-2019 Hospital Service Accountability Agreements (H-SAAs) process.

Motion No. 44 – 17/18

Moved by J. Harper, seconded by K. Scian and unanimously approved.

THAT the WWLHIN Board of Directors direct WWLHIN staff to use the following Hospital Accountability Planning Submissions (HAPS) planning assumptions to form the basis for the

2018/2019 Hospital Service Accountability Agreements (H-SAAs).

1. The WWLHIN retains the authority, as defined under the Local Health System Integration Act (LHSIA), to reallocate system resources to achieve local priorities
2. Ensure alignment with the WWLHIN's Integrated Health Service Plan, Annual Business Plan and Ontario's Patient's First: Action Plan for Health Care
3. All hospitals should plan with the expectation of a zero percent (0%) increase to their global budgets in 2017/18. Other adjustments to funding will be tied to the HSFR (HBAM & QBP) calculations for the new fiscal year
4. Transfer of volumes related to integration initiatives should be clearly identified by both the sending and receiving hospitals
5. All hospitals are expected to achieve and maintain a balanced budget and the WWLHIN will not be providing any waivers to this requirement
6. Hospitals are required to continue to meet the Performance Standards outlined in their H-SAA both during the current planning cycle and beyond
7. Current service volumes must be maintained, unless there is a planned and approved transition of service from one provider to another
8. Hospitals are required to notify the WWLHIN regarding any proposed volume re-allocations between their existing services. The WWLHIN should be notified of any such changes before the November 24th submission deadline so that the required discussions can occur in a timely manner
9. Proposed volume changes will need to be outlined and submitted to the WWLHIN using a service change form, which will be made available on the WWLHIN web site
10. Ministry-LHIN Accountability Agreement (MLAA) targets and associated targets for each hospital will be maintained (i.e. wait time targets, access to care etc.)
11. Any initiatives being considered over the next year that meet the definition of an integration under the Local Health System Integration Act (LHSIA) should be identified to the WWLHIN as soon as possible
12. Other local performance obligations will be included to advance system integration, with additional details provided by the WWLHIN through the HAPS process

6.0 Service Accountability Agreements (SAA) Local Obligations

The Board reviewed the material with a recommendation to approve Local Obligations for the 2018-19 Service Accountability Agreements (SAA), Hospitals (H-SAA), Private Hospital (PH-SAA) and Multi-Sector (Community) (M-SAA) and Long-Term Care Home Service Accountability Agreements (L-SAA) for the 2018-19 fiscal year.

Motion No. 45 – 17/18 — Moved by J. Harper, seconded by K. Scian and unanimously approved.

THAT the Waterloo Wellington LHIN Board of Directors approve the Local Obligations as per Table 1 in Appendix A, for the 2018-19 H-SAA, PH-SAA, M-SAA and L-SAA contracts.

APPENDIX A – Proposed Local Obligations 2018-19

No.	Contract Type	Obligation Description	Target and Reporting Requirements
1.	H-SAA PH-SAA	Carry-over from 2017-18. Hospitals will provide admission, discharge and emergency department notifications and summaries, preferably in electronic format, to primary care within 48 hours of discharge in order to improve patient follow-up with a family doctor after leaving hospital.	100% on target Quarterly reporting, as part of contract.
2.	H-SAA PH-SAA	Carry-over from 2017-18. Hospitals will provide the provide the client, community-based health care provider/ primary care provider, and community pharmacy (as appropriate) with a BPMDP (Best Possible Medication Discharge Plan) complete patient medication list upon discharge.	100% on target Quarterly reporting, as part of contract.
3.	H-SAA PH-SAA M-SAA	Carry-over from 2017-18. Hospitals will participate in System Coordinated Access (SCA) for the following streams: Diabetes, Orthopaedics/ Musculoskeletal (MSK), Mental Health and Addictions (MHA), Chronic Disease Prevention and Management (CDPM), Diagnostic Imaging (DI), Specialized Geriatric Services (SGS), and cataract surgery, with clinical teams being part of the design and development of the system.[1]	Hospital sign-off on SCA system stream projects as per overall SCA program timelines for WWLHIN. Notification through the WWLHIN SCA program.

No.	Contract Type	Obligation Description	Target and Reporting Requirements
4.	H-SAA PH-SAA M-SAA	Carry-over from 2017-18. All Health Service Providers (HSPs) have a process to identify individuals who meet the Health Links definition/ criteria and/or who would benefit from a coordinated care approach. HSPs will initiate, participate in and share coordinated care plans. It is expected that HSPs will update and communicate changes to care plans as a patient's condition and situation changes.	Define percentage of complex residents per sub-region care community. Determine baseline current state of number of Coordinated Care Plans per sub-region care community. Quarterly reporting via the Health Links sub-region care community Steering Committee.
5.	H-SAA PH-SAA	Carry-over from 2017-18. Hospitals seeking to implement a new Hospital Information System will use the Principles of Digital Health Strategy 2.0, Digital Health Investment and Sustainment Board, Hospital Information System (HIS) Renewal, HIS Clustering Guidebook for Hospitals and LHINs, and the EHR Connectivity Strategy to guide their decisions.	Obligation as per MOHLTC Digital Health policy. Notification per HSP.
6.	H-SAA PH-SAA	Carry-over from 2017-18. Hospitals will adopt the principles and practices of senior friendly care and senior friendly hospitals (SFH) through the adoption of SFH principles, patient experience feedback, and participate in local planning related to senior services.	Each hospital to identify a set of performance indicators that highlight areas of focus, potentially including the following: - % of hospital patients (65 and over) receiving assessments of Activities of Daily Living functions with validated tool at both admission and discharge (acute only). -% of hospital patients (65 and over) receiving delirium screening with a validated tool at admission and discharge. -Incidence of delirium patients (65 and over) acquired over the course of hospital admission. Quarterly reporting, through the Health Links sub-region care community Steering Committee.
7.	M-SAA	New for 2018-19. Wait times for all funded services are publicly posted with the regional access centre at Canadian Mental Health Association Waterloo Wellington (CMHAWW) Here 24/7. Each provider to reduce, or eliminate duplication of referral, intake and assessment through to placement of service through integration and optimization of business processes with the	As per Explanatory Indicators as per 2017-18 M-SAA: - Repeat Unplanned Emergency Visits within 30 days for Mental Health conditions - Repeat Unplanned Emergency Visits within 30 days for Substance Abuse conditions

No.	Contract Type	Obligation Description	Target and Reporting Requirements
		regional access centre. Providers use provincially adopted staged screening and assessment tools through Centre for Addiction and Mental Health (CAMH) Provincial System Support Program.[2]	- Average Number of Days Waited from Referral/Application to Initial Assessment Complete -Average number of days waited from Initial Assessment Complete to Service Initiation Submit integration and optimization plan for centralization of referral, intake and service placement processes with regional access centre. Quarterly report, as part of contract.
8.	H-SAA PH-SAA M-SAA L-SAA	New for 2018-19. HSPs will implement the Quality Standards as released by Health Quality Ontario (HQO).[3]	Gap analysis of services in meeting the Quality Standards and work plan in achieving the standard. Annual plan and status report.

7.0 Next Meeting

Wednesday, November 15, 2017
12:00-5:00 p.m. (WW LHIN Office)

8.0 Adjourn

On a motion by J. Nesbitt, seconded by K. Scian and there being no further business, the meeting concluded at 3:15 p.m.

M. Delisle Chair	J. Varner Secretary	D. Ruprecht Recording Secretary