South West LHIN | RLISS du Sud-Ouest

South West Local Health Integration Network
Board of Directors' Meeting
Tuesday, December 19, 2017, 2:00 to 5:00 pm
South West LHIN London Downtown Office, 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		2:00
1.1	**Approval of Agenda**	Chair	Decision	2:00-2:05
1.2	**Declaration of Conflict of Interest**			
2.0 APPROVAL OF MINUTES				
	2.1 **November 21, 2017 – South West LHIN Board of Directors Meeting***	Chair	Decision	2:05-2:07
3.0 THE PATIENT VOICE				
	3.1 **Patient Care Story**	C Faulds	Information	2:07-2:25
4.0 DELEGATIONS/PRESENTATION				
	4.1 **Interdisciplinary Team-Based Primary Care*** D2D – Data to Decision • Dr. Sean Blaine, Family Physician STAR FHT • Dr. Rob Annis, Family Physician North Perth FHT, President of AFHTO • Monique Hancock, Executive Director STAR FHT • Kimberly Van Wyk, Executive Director Clinton FHT	Guests	Information	2:25-:2:40
	4.2 **Strengthening Primary Care in the South West LHIN**	C Faulds/K Gillis D Ladouceur		2:40-3:10
5.0 APPROVAL OF CONSENT AGENDA				
	Approval of Consent Agenda 5.1 November 23, 2017 – Draft Board Quality Committee Minutes* 5.2 November 28, 2017 – Draft Governance Committee Minutes* 5.3 Service Accountability Agreement Renewal for 2018/19* 5.4 Health Service Provider 2017/18 Quarter 2 Report and Non-Discretionary Funding Provided to the LHIN* 5.5 Board Director Reports* 5.6 Board Committee Reports*	Chair	Decision	3:10-3:15
6.0 AGENDA ITEMS FOR DECISION				
	Agenda Items for Decision			3:15-3:45
	6.1 2018/19 DRAFT South West LHIN Annual Business Plan*	K Gillis	Decision	
	6.2 Specialized Unit Update*	K Gillis	Decision	
	6.3 Proposed Changes to the Capital Review Process*	K Gillis/ D Ladouceur	Decision	
	6.4 South West LHIN Board Committee Composition 2018*	Committee Chair	Decision	

	6.5 Local/Sub-Region Board-to-Board Reference Group Terms of Reference*	K Gillis	Decision	
7.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION				
	Agenda Items for Information/Discussion			3:45-4:30
	7.1 New LHIN Authorities under the *Local Health System Integration Act, 2006* (LHSIA)*	M Brintnell	Information	
	7.2 October 2017 Financial update*	H Anderson	Information	
	7.3 Indigenous Mitigation and Amplification Matrix*	K Gillis	Information	
	7.4 French Language Services Planning*	K Gillis	Information	
	7.5 Access & Flow through the Holiday Season*	D Ladouceur /K Gillis	Information	
	7.6 Board Quality Committee Highlights and Refections *	Committee Chair	Information	
8.0 CLOSED SESSION				
	8.1 **Closed Session**	Chair	Decision	4:30-5:00
9.0 FUTURE MEETINGS/EVENTS				
	South West LHIN Board of Directors Meeting, Tuesday January 16, 2018, Participation House, 193 Clarke Road, London, ON Programme/Common Room			
10.0	**Adjournment**	Chair	Decision	5:00

**** Attachment***

Board Directors are reminded to complete Board meeting evaluation

South West LHIN Board of Directors' Meeting
Tuesday, November 21, 2017 2:00 to 5:00 pm
South West LHIN Seaforth Office, 32 Centennial Drive, Seaforth
Room: Van Egmond/Dunlop Rooms

Minutes

Present: 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
Wilf Riecker, Board Director
Leslie Showers, Board Director
Aniko Varpalotai, Board Director

Regrets: Cynthia St. John, Board Director
Lori Van Opstal, Board Chair

Staff: Hilary Anderson, Vice President, Corporate Services
Maureen Bedek, Vice President, Human Resources
Mark Brintnell, Vice President, Quality, Performance & Accountability
Dr. Cathy Faulds, Chief Clinical Lead
Kelly Gillis, Interim Co-CEO/Vice President, Strategy, System Design & Integration
Donna Ladouceur, Interim Co-CEOI/Vice President, Home & Community Care
Amanda Harper Sevonty, Communications Director
Stacey Griffin, Executive Office Coordinator
Marilyn Robbins, Executive Office Assistant

1.0 Call to Order – Welcome and Introductions
The Acting Board Chair called the meeting to order at 2:00pm. There was quorum and five members of the public, which included health service providers, were in attendance for parts of the meeting.

1.1. Approval of Agenda

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

THAT the Board of Directors' meeting agenda for November 21, 2017, 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 October 17, 2017 South West LHIN Board of Directors Meeting

MOVED BY: Myrna Fisk
SECONDED BY: Linda Ballantyne

THAT the October 17, 2017 South West LHIN Board of Directors' meeting minutes be approved as presented.

CARRIED

2.2 October 17, 2017 Special Meeting of the South West LHIN Board of Directors

MOVED BY: Myrna Fisk
SECONDED BY: Linda Ballantyne

THAT the October 17, 2017 Special Meeting of the South West LHIN Board of Directors' meeting minutes be approved as presented.

CARRIED

2.3 November 3, 2017 South West LHIN Board of Directors Meeting

MOVED BY: Myrna Fisk
SECONDED BY: Linda Ballantyne

THAT the November 3, 2017 South West LHIN Board of Directors' meeting minutes be approved as presented.

CARRIED

3.0 The Patient Voice
3.1 Patient Care Story
The Board heard a patient care story by Donna Ladouceur, Interim Co-CEO and Vice President, Home & Community Care, about a 48 year old male born with cerebral palsy who requires total daily assistance with activities and the positive impact that the 4 additional beds for Participation House approved at the July board meeting has had on the patient and his family. A family member provided an overview of the patient and family experience via videoconference.

4.0 Approval of Consent Agenda

MOVED BY: Glenn Forrest
SECONDED BY: Leslie Showers

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

CARRIED

5.0 Agenda Items for Decision
5.1 South West LHIN Mission, Vision, Values

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

THAT the South West Local Health Integration Network Board of Directors adopts the proposed Mission, Vision and Values to serve as the foundation to set the strategic direction of the organization.

Mission Statement
Working with our communities to deliver quality care and transform the health care system.

Vision Statement
A healthier tomorrow for everyone.

Values & Value Statements
Respect:
We will treat everyone with dignity and kindness, valuing everyone's opinion and perspective.

Integrity:
We will be fair, consistent, and transparent in all that we do and will follow through on our commitments.

Compassion:
We will be empathetic and recognize that our decisions impact people.

Courage:
We will amplify the patient's voice, challenge the status quo, and make the hard decisions.

Innovation:
We will be creative and embrace new ideas to respond to the changing needs of our communities.

CARRIED

5.2 2017/18 – Quarter 2 Financial Statement and Year End projection

MOVED BY: Glenn Forrest
SECONDED BY: Aniko Varpalotai

That the South West LHIN Board of Directors approve as presented the 2017/2018 Quarter 2 Financial Statement and Latest Estimate (revised budget) as attached in the board briefing and report to the ministry a balanced budget as at the end of November 2017.

CARRIED

5.3 Integration - Salvation Army and Home and Community Support Services Grey Bruce

MOVED BY: Myrna Fisk
SECONDED BY: Linda Ballantyne

THAT the South West LHIN Board of Directors approves the termination of the 2014-18 Multi-Sector Service Accountability Amending Agreement between the South West Local Health Integration Network and The Salvation Army Owen Sound Community Church Ministries (Salvation Army) under Article 12.1 effective November 30, 2017.

CARRIED

6.0 Agenda Items for Information/Discussion

6.1 Personal Support Worker (PSW) Capacity Challenge

The Board received an update on the Personal Support Worker (PSW) Capacity Challenges. South West LHIN staff continue to work with our service provider partners to develop short-term & long-term actions to help with the critical shortage of PSW resources in our community.

6.2 Roadmap: Indigenous Inclusion and Reconcili-ACTION

The board received an overview on the South West LHIN Indigenous Health Roadmap including key priority areas and activities.
The Board actioned senior management to work with the Board Chair to schedule meetings with our Indigenous communities.

6.3 2017/18 Priorities for Investment Plan Update

The board received an update on the unallocated base funding under the 2017/18 Priorities for Investment Funding targeted to mental health and addictions crisis services. The funding will be utilized to support the London Middlesex Mental Health and Addictions Crisis Centre (Crisis Center) and enable the implementation of Middlesex London Emergency Medical Services (MLEMS) Protocols.

7.0 Focused Discussion

7.1 2018/19 Annual Business Plan

The Board received a presentation from Kelly Gillis, Interim Co-CEO/Vice President, Strategy, System Design & Integration providing an overview of the South West LHIN approach to the development of the South West LHIN 2018/19 Annual Business Plan (ABP) and requested guidance from the Board of Directors on our draft ABP priorities. LHIN staff will work to draft the 2018/19 ABP engaging across all functional areas of the organization The final draft ABP is targeted to be completed by LHIN staff in November for Board review and approval at the December 19, 2017 board meeting

The board took a break from 3:48 pm to 3:55 pm

8.0 Closed Session

MOVED BY: **Wilf Riecker**
SECONDED BY: **Linda Ballantyne**

THAT the Board of Directors move into a closed session at 3:55 pm pursuant to s. 9(5)(a)(g) of the Local Health System Integration Act, 2006

CARRIED

LHIN staff members Kelly Gillis, Donna Ladouceur, Mark Brintnell, Maureen Bedek, Cathy Faulds and Stacey Griffin were permitted to attend for parts of the meeting and left the meeting at 4:51 pm.

MOVED BY: **Myrna Fisk**
SECONDED BY: **Wilf Riecker**

THAT the South West LHIN Board of Directors rise from closed session at 5:09pm and returned to open session reporting that discussion was held around a Board Chair update, discussion on the Provincial Executive Compensation Framework and LHIN CEO Executive search process.

CARRIED

9.0 Dates and Location of Next Meeting

The next South West LHIN Board of Directors Meeting will be held on Tuesday December 19, 2017, South West LHIN London Downtown Office, 201 Queens Ave, Suite 700, London.

10.0 Adjournment

MOVED BY: Linda Ballantyne
SECONDED BY: Wilf Riecker

THAT the South West LHIN Board of Directors meeting adjourn at 5:10pm.

APPROVED: _____
Andrew Chunilall, Acting Board Chair

Date:_____

INTERDISCIPLINARY TEAM-BASED PRIMARY CARE

EVIDENCE FOR A HIGH QUALITY MODEL OF CARE

Dr. Sean Blaine, Family Physician STAR FHT
Dr. Rob Annis, Family Physician North Perth FHT, President of AFHTO
Monique Hancock, Executive Director STAR FHT
Kimberly Van Wyk, Executive Director Clinton FHT

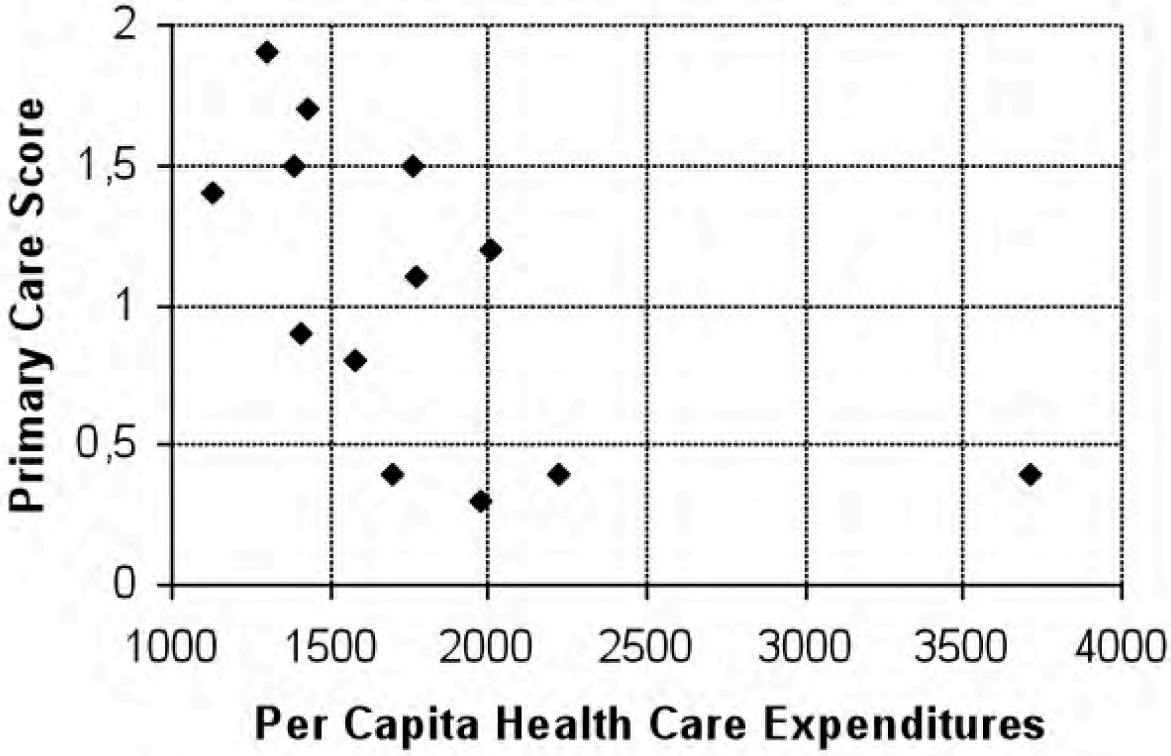
December 19, 2017

afhto | D2D: DATA TO DECISIONS ▶ 5.0

Overview

- Starfield: primary care is foundation for sustainable health care system
- View of quality
- D2D: team-based interprofessional teams illustrate Starfield's principles in action for 3 million patients in Ontario – population focused
- AFHTO early analysis
- The Primary Medical Home provides a place for continuous quality improvement

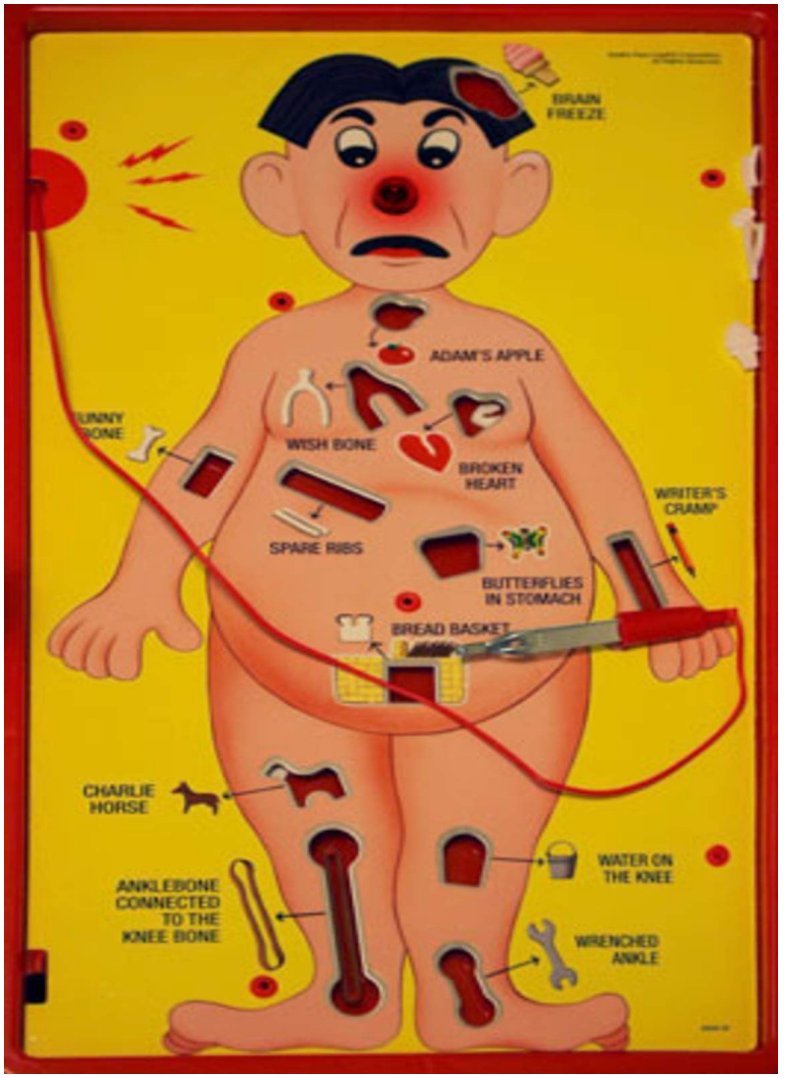
VALUE OF TEAM-BASED PRIMARY CARE



Starfield, B. (1994) "Is primary care essential?", Lancet, 344, p 1129-1133

AFHTO's view of Quality

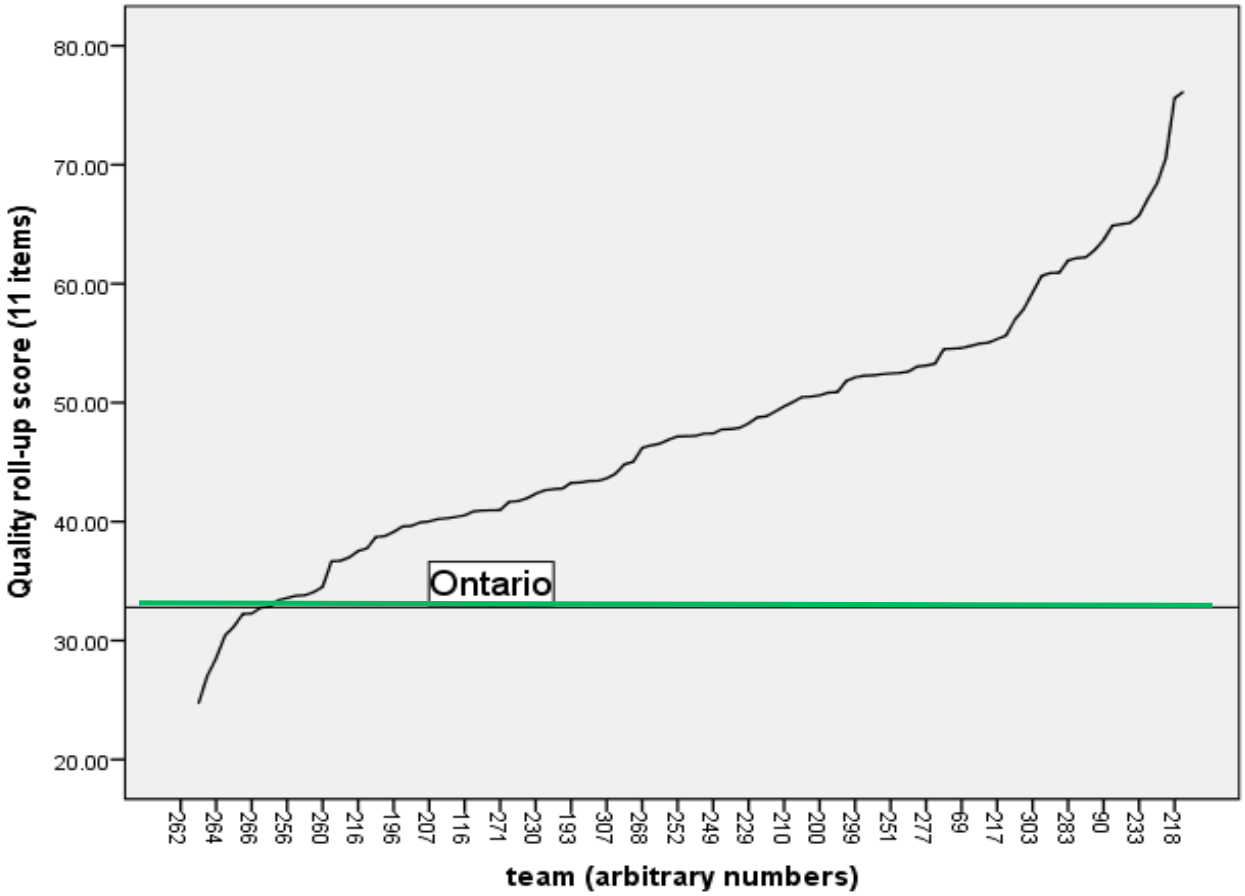
- Quality roll-up indicator
- Introduced in D2D 2.0 (via expanded data indicators)
- Alternative to "body-part" measures:
  - "You are more than your joints, your gastrointestinal system and your hormones"
- Incorporate patient priorities
- More a system (vs team) level measure so far
  - Composites generally are hard to take action on
  - Incomplete data



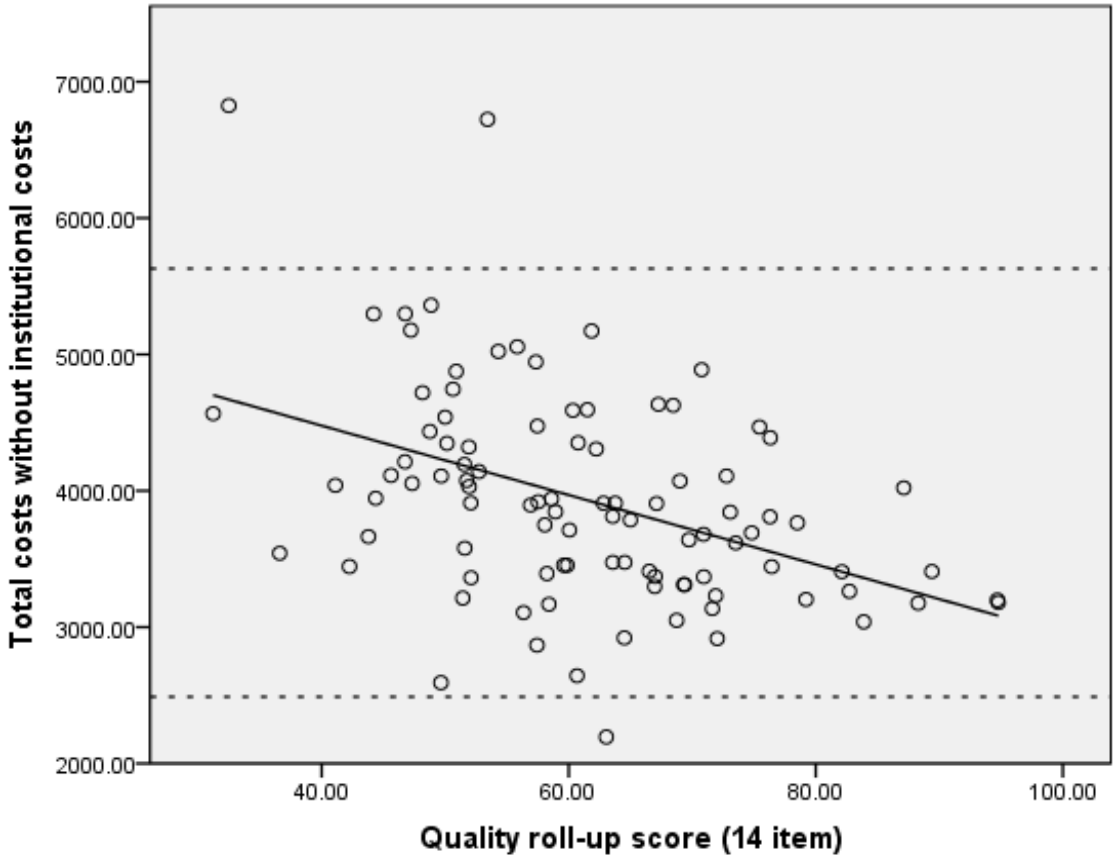
http://www.burnabynow.com/community/health/five-reasons-why-you-need-a-family-doctor-1.408917

Quality Roll-up components (in descending patient priority)	Weight
% of patients **involved in decisions** about their care as much as they want	0.96
% of patients who had **opportunity to ask questions**	0.95
% of patients who felt providers **spent enough time** with them	0.95
% of patients who can book an appointment within a **reasonable time**	0.94
% of patients with **readmission within 30 days after hospitalization**	0.90
% of visits made to patients' **regular primary care provider team**	0.90
Emergency department visits per patient	0.87
Ambulatory care sensitive hospitalizations per 1000 patients	0.78
% of eligible patients screened for **colorectal cancer**	0.69
% of eligible patients screened for **cervical cancer**	0.69
% of eligible patients screened for **Breast cancer**	0.69
% of eligible patients with **Diabetic management & assessment**	0.69
% of eligible **children immunized** according to guidelines	0.52
% of patients able to get an **appointment on the same or next day**	0.38

Quality Roll-up score distribution: AFHTO teams

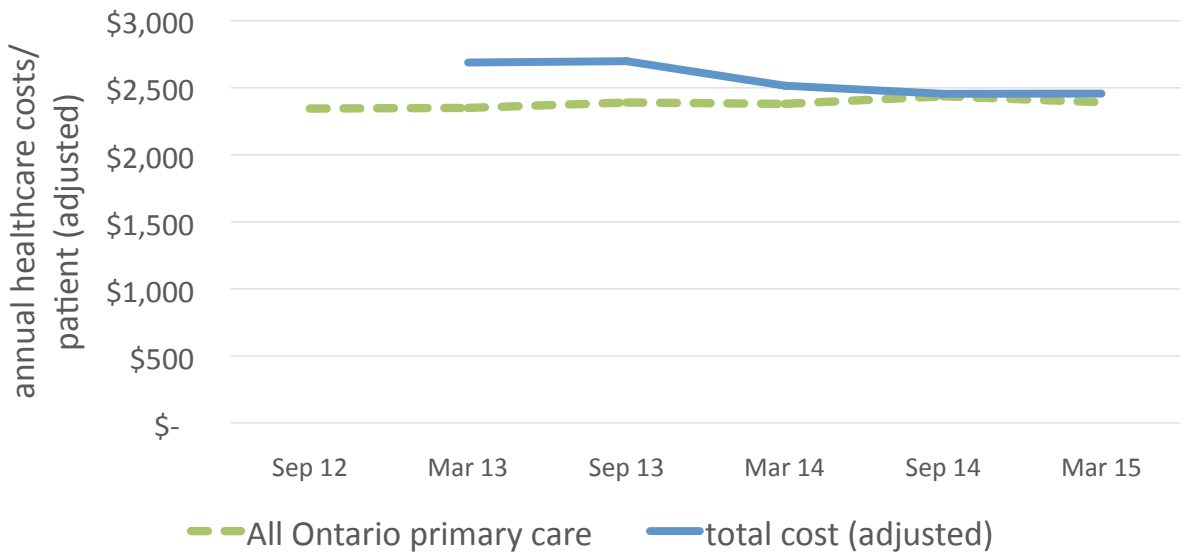


Quality and cost



Healthcare costs per patient in teams

(vs Ontario average)



Team profile data: New for D2D 5.0!

- Makes it FINALLY possible to understand enablers of high-performance
- Community characteristics
  - Examples: income, immigrants, clinical complexity
- Team structure
  - Examples: governance, age, co-location, shared resources, clinical staff complement
- Technology
  - Examples: use of electronic systems for scheduling, information sharing
- Quality improvement activity
  - Examples: conversations about performance, physician champions, QIDSS partnership

EARLY analysis of high-performing teams …

- Single site teams tend to have lower costs and higher quality over time
- Analyses are still underway to find out what it is about single-site that seems to be having an impact
- However, these early analyses show that team structure does need to be taken into account in considering team performance

DATA TO DECISIONS (D2D) 5.0: A QUICK LOOK

The Good News about cost continues!

- *Healthcare costs for patients of teams are dropping even while costs across the province are relatively stable.*
- *Higher quality is STILL related to lower healthcare system costs!*

More teams, more data

- *A few more teams joined D2D 5.0, including a few first-timers, which means that 172 or 93% of teams are in at least one iteration of D2D.*
- *Teams are sharing more data, resulting in more complete data for and therefore increased reliability of the Quality Roll-up indicator.*

High-performing teams

- *Over half of D2D participants shared team profile data. Combining this with team performance data allows AFHTO to address gaps in previous studies and better unravel the mystery of what makes a high-performing team, from the ground up.*

Learning from each other

- *D2D 5.0 now has LHIN sub-region summaries based on data from 95% of teams in D2D. This makes it easier for teams to find and learn from local peers. It also will help track impact of Patients First in a way that reflects what matters to patients.*
- *36 teams reported openly instead of anonymously. AFHTO members can see exactly who they are and how they are doing, opening the door further to learning together.*

Summary

- Team based care is population focused
- Evidence through the AFHTO D2D initiative demonstrates the value of inter professional teams (high quality low cost)
- Investment in infrastructure supports continuous quality improvement – meeting Quadruple Aim
- The learning can influence the spread of team based care and a **Primary Medical Home** for patients across the province

South West LHIN Board – Quality Committee
Thursday, November 23, 2017 – 12:30 to 2:30 pm
South West LHIN Downtown Office, 201 Queens Avenue, London

Minutes
Draft

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

Guests: Dr. Sarah Jarmain, Chair, Medical Advisory Committee and Director Medical Quality, St. Joseph's Health Care London
Brenda Lewis, Board Member and Quality Committee Chair, St. Joseph's Health Care London
Leslie Showers, Board Director

Staff: Mark Brintnell, Vice President, Quality, Performance and Accountability
Donna Ladouceur, Interim Co-CEO and Vice President, Home & Community Care
Steven Carswell, Director, Quality
Marilyn Robbins, Executive Office Assistant *(Recorder)*

Regrets: Glenn Forrest, Board Director

1. Call to Order

Linda Ballantyne called the meeting to order at 12:35 pm. No members of the public were in attendance.

2. Approval of Agenda

Item 3.1 – Engagement with SJHC was moved later in the agenda to accommodate guests attending for that discussion.

MOVED BY: Myrna Fisk
SECONDED BY: Aniko Varpalotai

TO approve the agenda for the November 23, 2017 meeting of the South West LHIN Quality Committee as amended.

CARRIED

3. Patient Relations Function – Overview and Relation to Committee

Steven Carswell, Director, Quality referred to the presentation circulated in the meeting materials to provide an overview of the role and current state of the patient relations function for Home and Community Care in the South West LHIN. The presentation included the respective standards and accountabilities, sample Home and Community Care feedback data, strengths and future opportunities through the alignment of legacy LHIN and legacy CCAC structures, and the role of the Quality Committee and Board in patient relations.

In response to questions about getting feedback from clients/patients who can't make a complaint on their own or through the processes described, staff confirmed that the process is available to family members and caregivers, and that it is recognized that there is underreporting from the indigenous community due to cultural safety issues.

In reviewing data illustrating since January 2017 the volume of complaints, risk events, and compliments along with current lists of Top 10 Risk Events and Top 10 Complaints, the committee considered how and what of this type of information should come to the full board. They discussed some of the trends identified, specifically health worker safety, and the impact of the current PSW shortage in service delivery.

While the data in the presentation summarized feedback pertaining to Home and Community Care, staff suggested that system complaints most typically relate to access (e.g. wait times) and issues with provider to provider communications. It is expected that while the legacy processes each address different types of feedback, an alignment of those processes will allow for some efficiencies and broader utilization of patient relations data for improvement activities across the organization.

The last slide of the presentation summarized the role of the Board of Directors as follows...

- Understand and ensure the organization has robust processes in place to receive, manage and respond to patient feedback in a timely manner;
- That patients are able to provide feedback in a safe and effective manner (including culturally appropriate feedback processes);
- Review data related to the types and numbers of complaints, compliments and risk events;
- Receive anonymized reports on critical adverse events (high risk events leading to injury or death) and management's plans to address these areas;
- Ensure management is taking appropriate actions to translate patient feedback into meaningful and sustainable quality improvement; and
- Management is fostering a just-culture, where the organization is promoting reporting from a learning perspective, and not a blame perspective.

The committee agreed to advise of any items they feel should be shared with the full board in addition to the minutes being included in the consent agenda. One suggestion was to hold an education session with the board on what the Quality Committee is about and the work ahead.

4. Emerging Themes & Risks – PSW Capacity Challenge

Donna Ladouceur, Interim Co-CEO and Vice President, Home & Community Care and Mark Brintnell, Vice President, Quality, Performance and Accountability provided an update on the current PSW capacity challenge reporting that staff have been triaging to ensure that the most complex patients are getting service. Hospital partners have been asked to provide as much advance notice of discharge as possible in order to allow additional time for care plans to be created and coordinated. Flu incidents are also being monitored in anticipation of impact to workers available.

Staff reported that the following three areas are being focused on to address the PSW shortage and missed care.

1. – supporting patients who are missing care by communicating alternatives
2. – increased understanding of the challenges providers face (i.e. smoothing out/redistribution of morning service demand)
3. – client preferences pertaining to worker (e.g. gender) and the development of policy regarding patient choice balanced against ability to deliver service with foundational principles of clarity and equity.

The committee looks forward to receiving data illustrating risk balance as this issue continues to be addressed and monitored.

5. Quality Improvement Plan (QIP)

The 2017/18 QIP was developed and approved by the Board of Directors of the legacy CCAC, and was assumed by the South West LHIN. The report included in the meeting package summarizes the following activities undertaken by management to integrate the QIP…

1. Ensure appropriate Board Governance (completed)
2. Ensure continued Home and Community Care oversight (completed)
3. Integrate QIP measures into Board and Organizational reporting structures (completed)
4. Creation of a QIP Development Plan for 2018/19 (under development)

The committee examined the Quality Improvement Work Plan 2017/18 updated as of November 2017 illustrating the current status of aim-related activities and the respective measures and targets.

Regarding the 2018/19 QIP, the committee briefly discussed the possibility and challenges of a collaborative QIP and staff confirmed that the South West LHIN's QIP will focus only on Home & Community Care – as agreed at the provincial level.

6. Accreditation Update

Staff reviewed the following four options to extend accreditation status.

1. Interim report – 6 month extension of accreditation, then proceed with one of next three options
2. Bridging survey visit – 2 year extension of accreditation status
3. Sequential survey visits – 2 year extension of accreditation status
4. Primer survey visit – 2 year extension of accreditation status

Each LHIN can determine which of the 4 options best suits them individually. South West LHIN staff are recommending option 4 to the Board, the rationale being that this is a new organization with a new mandate and new leadership. Option 4 would level-set for both board and staff while providing time for the organization to harmonize legacy processes and procedures. While the South West LHIN's accreditation standing lapsed in October 2017, Accreditation Canada has stated that status will be maintained as long as a commitment to next steps is demonstrated. The committee was generally supportive of option 4 and understands it to ultimately be a decision of the Board with the committee to provide governance oversight to whatever accreditation approach is adopted.

7. Committee Work Plan Update

Staff reported that the committee can expect to receive a final draft work plan for their review/adoption at the next meeting.

8. Engagement with St. Joseph's Health Care, London Quality Committee Members

Brenda Lewis, Board Member and Quality Committee Chair, St. Joseph's Health Care, London and Dr. Sarah Jarmain, Chair, Medical Advisory Committee and Director Medical Quality, St. Joseph's Health Care, London joined the meeting. Brenda and Sarah shared their Quality Committee experience speaking to its evolution, patient engagement, and connection to the SJHC Board of Directors.

Some of the discussion points included…

- Need to be thoughtful when bringing on patient voice so that it is meaningful to the initiative. Co-create the opportunity.
- Annual work plan focuses on areas where a lot of change or risk is on-going as well as both QIP and corporate indicators.
- Committee continues to reinforce the importance of a focus on Quality at the Board when a financial focus is prevalent. Preventable deaths, and measuring for improvement in care is important.
- Recommend attending OHA Patient Safety Conference.
- Culture-shift takes a while. Each SJHC Board meeting agenda includes at least two items (each of 15 to 20 minutes) on Quality. Quality Committee presents to Board on key risks and opportunities.
- It can be challenging to keep the committee (and board) at the governance level with enough detail to understand issues without taking over operations. Members can expect to be lobbied about an individual's quality concerns/experience. The quadruple aim approach can be helpful.
- Commit to broader system view as we have an accountability to make things better for patients even if not within our facility and out of our immediate control.
- Create a just culture that recognizes human error happens despite best efforts and support catching mistakes early with no blame or shame.
- As a new venture be open to lessons learned and the path not yet clear or changing.

In responding to a request for guidance on how to best interact with the new South West LHIN Patient Family Advisory Council (PFAC) the guests reported that they continue to work on strengthening the board's connection to their own patient councils and that they are starting with asking those same councils for suggestions on what would best work for them. It was suggested that it would be good to allow PFAC to get themselves sorted and functioning before approaching them to co-design their involvement with the Quality Committee. Avoid thinking

too far out and making assumptions before sitting down with them to figure out together the opportunity.

The group briefly considered means and value to connecting Quality Committees for regional discussion on mental health or other issues.

Brenda and Sarah were thanked for attending and departed the meeting.

The committee agreed that the presentation from SJHC was valuable and briefly discussed other opportunities for learning, for patient engagement, and communicating to the Board.

ACTION: Brief highlights to be drafted for the board's December 19 meeting agenda.

9. Approval of Minutes

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

TO approve the minutes of the South West LHIN Quality Committee meeting held October 26, 2017.

CARRIED

10. Adjournment

The meeting adjourned at 2:50 pm. The next meeting is scheduled for Thursday, December 21 at 2 pm.

APPROVED: _____
Linda Ballantyne, CHAIR
QUALITY COMMITTEE

Date: _____

South West LHIN
Governance & Nominations Committee
Tuesday, November 28, 2017

Minutes
DRAFT

Present: Aniko Varpalotai, Governance & Nominations Committee Chair
Andrew Chunilall, Acting Board Chair via teleconference
Wilf Riecker, Board Director
Leslie Showers, Board Director
Cynthia St. John, Board Director

Guests: Jean-Marc Boisvenue, Board Director

Staff: Kelly Gillis, Interim Co-CEO and Vice President, Strategy, System Design & Integration
Donna Ladouceur, Interim Co-CEO and Vice President, Home & Community Care
Stacey Griffin, Executive Office Coordinator
Marilyn Robbins, Executive Office Assistant *(Recorder)*

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1. Preamble & Call to Order

Minutes of a meeting of the South West LHIN Governance & Nominations Committee held in the Main Boardroom at the LHIN's Downtown Office at 9 am on Tuesday, November 28, 2017.

The meeting was called to order at 9:02 am. There was quorum. No members of the public were in attendance.

2. Declaration of Conflict of Interest

There was no declaration of conflict of interest.

3. Approval of Agenda

MOVED BY: Wilf Riecker
SECONDED BY: Leslie Showers

THAT the agenda for the November 28, 2017 meeting of the South West LHIN Governance & Nominations Committee be approved as circulated.

CARRIED

4. Approval of Minutes

MOVED BY: Leslie Showers
SECONDED BY: Cynthia St. John

THAT the minutes of the September 12, 2017 meeting of the South West LHIN Governance & Nominations Committee be approved as circulated.

CARRIED

5. HSP Governance/Community Engagement Update

Leslie Showers, Board Member and Kelly Gillis, Interim Co-CEO and Vice President, Strategy, System Design & Integration reported that after some discussion, the Board-to-Board Reference Group indicated their support for the proposal to establish Local Board-to-Board Reference Groups in each sub-region. The role of the local groups is to facilitate governance and community engagement. The initiative will be announced in December via webinar with inaugural meetings in each sub-region to be held in April/May.

The committee was asked to make a recommendation on the number of LHIN board members to be assigned to each local group. There was general agreement that to start, two LHIN board members would be assigned to each and that one should be local to the area and one from outside the geography as available.

ACTION: Staff to prepare a draft Terms of Reference for the Local/Sub-region Board-to-Board Reference Groups for consideration by the Board on December 19.

Kelly described plans for the webinar announcement to be held December 20.

ACTION: Staff to send to LHIN board members a calendar invitation/appointment for December 20 webinar.

6. Board Committees/Appointments

The committee reviewed the compilation of board member preferences for the 2018 committees and the resulting proposed slate as circulated in the meeting materials.

MOVED BY: Leslie Showers
SECONDED BY: Wilf Riecker

TO recommend to the Board of Directors the appointment of the following committee slates effective January 1, 2018.

Audit Committee – Myrna Fisk (Chair), Andrew Chunilall, Glenn Forrest, Wilf Riecker, and Linda Ballantyne.

Board-to-Board Reference Group – Leslie Showers (Chair), Andrew Chunilall, and Cynthia St. John.

CEO Performance Task Force – Andrew Chunilall (Chair), Linda Ballantyne, and Wilf Riecker.

Governance & Nominations Committee – Cynthia St. John and Aniko Varpalotai (Co-Chairs), Jean-Marc Boisvenue, Andrew Chunilall, Wilf Riecker, and Leslie Showers.

CARRIED

A board nominations update was included in the meeting materials.

7. Board Orientation/Education and Development

Board Education Sessions

Kelly Gillis, Interim Co-CEO and Vice President, Strategy, System Design & Integration introduced discussion about changing the board's approach to Board Education Sessions. She proposed that the current pre-board meeting sessions be retired and replaced with focused/generative discussion sections within the board's regular business agenda. The committee was also asked to provide feedback on the discussion topics proposed in the meeting materials. The December board meeting will include a focused discussion on Primary Care. A discussion on Mental Health and Addictions is being planned for the January meeting.

Feedback included…

- General support for the December and January topics
- A suggestion to add a provincial pulse check (political) to the list of topics
- A request to discuss French language services sooner than later due to recent meetings attended by board members and a suggestion to invite the French Language Services Commissioner to participate to provide context
- More rich, generative discussion at each meeting should better position the board to embrace innovation over the operational and see the "possible"
- A suggestion to add a discussion on the opioid crisis to the list of topics
- A suggestion to add Public Health to the list of topics

The committee considered the sequencing of board agenda items and reflected on the content and quality of their November board discussions.

Donna Ladouceur, Interim Co-CEO and Vice President, Home & Community Care joined the meeting at 10 am.

Organizational Advancement Workshop – December 18 & 19

Aniko Varpalotai, Committee Chair reported that Chris Moss has been engaged to facilitate team-building work with the Board and Senior Leadership Team on Monday, December 18. Lyn McDonell has been engaged as the lead contractor to observe and provide end-of-day comments on December 18 to set the stage for her governance development work with the Board and Senior Leadership Team on Tuesday, December 19. Participants should expect to spend some time on the Monday in their respective board and staff groups and will be asked to complete a pre-session survey.

The aim of the workshop is to build a better culture and team. It was noted that April 3 and 5 have been held in calendars for a spring workshop.

The Interim Co-CEOs reported that the Senior Leadership Team are concerned that some of the session is a duplication of the work they are currently doing with KPMG. They are not supportive of being interviewed individually by Chris Moss in view of the KPMG work on role alignment, and that board members are not being interviewed for staff understood to be a board development session.

It was agreed that interviews with Chris Moss would be scheduled for each of Andrew Chunilall (Acting Board Chair), Linda Ballantyne (Vice Chair), Kelly Gillis and Donna Ladouceur (Interim Co-CEOs) with the rest of the Senior Leadership Team and Board invited to interview if they so choose.

ACTION: Staff to connect with facilitators to finalize the workshop approach and agenda, and schedule interviews.

Orientation

Aniko Varpalotai, Committee Chair introduced the board orientation discussion noting the previous legacy LHIN process comprised of letters of introduction, materials, and key meetings. It was acknowledged that the process was lacking for the last two members appointed due to transition work underway. The goal now is to harmonize and improve orientation for all members joining the Board of Directors for the new LHIN organization.

The committee discussed how to get new board members comfortable and ready to participate in meaningful discussion as quickly as possible considering background, tools, and training. There was general agreement that a self-assessment tool that explores how individuals think, work and behave (i.e. KOLBE, StrengthFinders, Connective Intelligence) is most valuable when there's a commitment to reviewing and applying the results as a group. It was also suggested that orientation include a primer and/or training on how to have good, generative discussion.

In reviewing the draft South West LHIN Orientation Process Checklist included in the meeting materials it was agreed that board member mentors would be confirmed by the Chair on a case-by-case basis after inviting volunteers and asking the new appointee for

their preference. The partnership would be formed for the short-term to provide new board members with a “go-to person” to be contacted as needed.

ACTION: Staff to summarize principles for “board member to mentor” item on the orientation checklist.

Staff are developing a new orientation package to provide board members with core content and background information. The material is intended to be high-level with a “placemat” of information for each health care sector in the South West LHIN. The Home and Community Care “placemat” will include more detail being a direct responsibility of the new LHIN board. The draft material will come to the committee at a future date.

Board Portal Feedback/Suggestions

The committee was asked for feedback to date on the function of the board portal and LHIN-issued iPads. Comments included…

- User-friendly
- Would appreciate a “Tips and Tricks” session on using iAnnotate
- Would appreciate clarity around the rules for using the LHIN-issued iPad. Is there a user agreement or policy with do’s and don’ts?
- Request to include news releases and media articles in a searchable format on the portal

8. Board Governance Policies

The committee paused their governance policy development work in March 2017 just prior to transition. The committee discussed next steps to either start from scratch for the new organization with an exploration of foundational governance models or rather focus on harmonizing and refreshing existing governance policies for the new organization.

ACTION: Harmonizing legacy policies and refreshing for the new organization to commence at the next meeting of the Governance & Nomination Committee.

Andrew Chunilall, Kelly Gillis, Donna Ladouceur, and Leslie Showers departed the meeting at 11 am.

CEO Search/Succession Policies

Aniko Varpalotai, Committee Chair suggested that the current policies do not provide for a succession plan in the event of the sudden loss of the services of the Interim Co-CEOs.

ACTION: Harmonized policy related to CEO Succession to come to the committee for consideration and board recommendation at the next meeting.

Evaluation

The committee was positive about their experience to date with having a Governance Monitor report on each of the last three board meetings and discussed the merits and challenges of verbal reporting at the end of a meeting versus written reporting to follow.

There was general agreement to keep on with the three-question paper survey to evaluate each board meeting and the committee discussed the value of examining the survey results and monitoring reports overtime to identify trends and patterns with a view to improvement.

ACTION: Committee Chair to review the Governance Monitor Reports and Board Meeting Survey summaries for the last several months and report back on any trends/issues identified.

ACTION: Closed agenda for December 19 to include the Governance Monitor Report.

ACTION: Wilf Riecker to serve as Governance Monitor for the December 19 meeting of the Board.

ACTION: Staff to distribute an electronic version of the three-question survey at each board meeting.

9. Accreditation

Aniko Varpalotai, Committee Chair provided a brief update from the Quality Committee regarding the accreditation process confirming that accreditation-related responsibilities remain with the Quality Committee who will advise the Governance & Nominations Committee and/or Board as needed and until further direction.

10. Adjournment

The meeting adjourned at 11:30 am.

The next meeting will be scheduled for January or February, preferably on a different day than board meetings.

APPROVED: _____

Aniko Varpalotai, Chair
Governance & Nominations Committee

DATE: _____

Agenda item 5.3

Report to the Board of Directors

Service Accountability Agreement Renewal for 2018/19

Meeting Date: **December 19, 2017**

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

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

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

Purpose

To provide a status update on the planning and actions underway to finalize service, financial, and performance requirements of health service providers as part of the Service Accountability Agreements (SAAs) for 2018/19. The South West LHIN manages 182 agreements.

Background

It is a requirement of the *Local Health System Integration Act, 2006 (LHSIA)* that LHINs enter into a SAA with each health service provider (HSP) that it funds.

The Hospital Service Accountability Agreement (H-SAA) and Multi-Sector Service Accountability Agreement (M-SAA) with community HSPs are set to expire March 31, 2018. The Long-Term Care Home Service Accountability Agreement (L-SAA) is in place until March 31, 2019. In light of LHIN renewal through Patients First, there was pan-LHIN agreement to minimize the number of changes to the SAA templates applicable to the 2018/19 fiscal year.

Current State

H-SAA

- The current 2008-18 H-SAA will be extended until March 31, 2019.
- Hospital Accountability Planning Submission (HAPS) templates for 2018/19 were submitted from each of the hospitals to the LHIN November 24, 2017 – staff are currently analyzing the submissions.
- LHIN staff will be meeting with hospitals in December and January to discuss service, financial and performance plans as well as shared responsibilities and opportunities. The first meeting with hospitals in the South region was held December 6, meetings with the Central and North region hospitals are slated for December 15 and January 9 respectively. The final meeting with the two London hospitals is set for January 12 (scheduling issues prevented attendance on December 6). Themes identified from the meetings will be shared across sectors to inform planning.
- Negotiated H-SAAs will be issued to hospitals in early February for Board approval.
- Hospital approved H-SAAs will be considered for approval by the South West LHIN Board at its March 20, 2018 meeting.

- Preliminary review: several hospitals are facing financial pressures in the first round of HAPS submissions. Hospitals are continuing to explore budget balancing measures. Hospitals have until January 12th to file final submissions. Financial pressures are primarily the result of flat revenue projections and inflation estimates on major cost components such as compensation, supplies, and energy ranging from 1.4%- 2% for compensation costs and up to 5% for supplies and energy. Localized capacity pressures, (e.g. ALC and mental health beds), and increased activity, (e.g. stroke patients at the designated stoke centres), are driving costs beyond regular inflation for some hospitals. A fulsome report on risks identified from the HAPS analysis will be provided in January and February.

M-SAA

- The current 2014-18 M-SAA will be extended until March 31, 2019.
- Community Accountability Planning Submission (CAPS) templates for 2018/19 were submitted by Community HSPs to the LHIN on November 17, 2017.
- Negotiated M-SAAs will be issued to community HSPs in February for Board approval.
- Community HSP approved M-SAAs will be considered for approval by the South West LHIN Board at its March 20, 2018 meeting.
- Preliminary review: several large HSPs have indicated that additional costs required to comply with *Bill 148 - Fair Workplaces, Better Jobs Act, 2017* may require service level adjustments as a component planning for balanced budgets. A fulsome report on risks identified from the CAPS analysis will be provided in January and February.

L-SAA

- The current L-SAA will expire March 31, 2019. LHIN staff will work with local LTC Homes on any required updates to the agreements.

Next Steps

LHIN staff will continue to provide SAA updates to the Board regarding progress and identification of issues that may emerge through the review and negotiation steps of the process. All negotiated SAAs and relevant information around service, financial and performance changes along with any identified risks will be tabled for review and discussion at the February 20, 2018 meeting and approval of the SAAs at the March 20, 2018 meeting.

Agenda item 5.4

Report to the Board of Directors

Health Service Provider 2017/18 Quarter 2 Report and Non-Discretionary Funding Provided to the LHIN

Meeting Date: **December 19, 2017**

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

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 hospital, community sector, and long-term care homes health service provider (HSP) 2017/18 second quarter (Q2) performance. Non-discretionary (directed) funding provided to the LHIN in the second quarter is also summarized.

Hospital Sector

Performance Highlights and Actions to Improve[1,2]

- Despite increases in Emergency Department (ED) volumes, ED waits are within allowable performance corridors for patients with complex conditions, except at London Health Sciences Centre (LHSC). LHSC and one community hospital also experienced wait times beyond corridor for patients with minor/uncomplicated conditions in Q2.

    - *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 including the creation of a Geriatric Mental Health Behavioural Unit and a Mental Health ED Consolidated Unit at LHSC; Knowledge Transfer Collaborative at three additional high-volume sites to spread ideas and strategies more broadly; Mental Health Capacity Planning; one-time surge and flex bed funding from the Ministry of Health and Long-Term Care; Chief Nursing Executives (CNEs) partnering to provide leadership and oversight for improving patient access and flow including surge planning; new and renewed clinical leadership to engage physicians.*

[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.

- South West LHIN hospitals continue to report heightened challenges with mental health and substance abuse pressures. Two hospitals that have pressures and are challenged to sustain improvements as noted through the quarterly reporting process are LHSC and GBHS.

    - *LHIN interventions to improve ED revisits: Enhanced Community Capacity: Crisis Response & Transitional Case Management; Crisis Centre; LHIN-wide Mental Health & Addictions capacity planning; Peer Support Strategy; London Emergency Medical Services (EMS) process for transporting patients to the Crisis Centre instead of ED; planning for additional mental health supportive housing options; creation of mental health step-down beds through a hospital-community partnership in London.*

- Alternative Level of Care (ALC) days in acute beds remains the 2nd lowest among Ontario LHINs. When all bed types are considered, the LHIN is 2nd best in terms of ALC rate with 13 of 17 hospitals meeting their ALC targets. Four of five hospitals with Coordinated Access have rehab-appropriate patients in rehab beds but only three of ten hospitals meet 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 including a Home First 'refresh', spread of ALC avoidance practices, and a focus on strategies for extraordinary needs patients; LHIN Levels of Care and Respite Care investments; creation of a Transitional Care Program targeting mental health patients.*

- Hospitals continue to demonstrate improvements towards meeting their respective H-SAA targets for diagnostic imaging—though all five hospitals fall short of meeting clinical standards for targeted wait times for MRI. Conversely, eight of 10 hospitals do meet the clinical standards for targeted wait times for CT scans.

    - *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.*

- Five 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: 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 a centralized intake and scheduling process with implementation aligned with the provincial MSK (musculoskeletal) strategy; targeted funding late in Q4 2016/17 to address long waits; QBP growth funding and Priority for Investment (PFI) for additional volumes in the latter half of 2017/18.*

- Only five of 18 hospitals experienced a higher rate of readmissions than expected for the period of July through September of 2017. Excess readmissions for acute myocardial infarction, congestive heart failure, and gastrointestinal disorders drove up rates. Fewer readmissions for chronic obstructive pulmonary disease (COPD) continue to be 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 is demonstrating improvements in readmissions for patients with COPD.

Financial Highlights

- Three hospitals are projecting total margin deficits at the end of 2017/18: Alexandra Marine and General (AMGH) - $619,118; Strathroy Middlesex General (SMGH) - $428,884; and Grey Bruce Health Services (GBHS) - $405,604. AMGH's deficit projection was not expected but the deficit is primarily driven by one-time events. Both SMGH and GBHS have 2017/18 budget waivers in place and both hospitals are projecting results well within the waiver limit. All deficit positions remain the sole financial responsibility of the hospital corporation.

Community Sector

Performance Highlights and Actions to Improve

- Local coordinated access measures for community mental health and addictions providers are maturing and improving—hospital programs showing progress towards adopting the screening approach using a Global Appraisal of Individual Needs (GAIN) tool.
  - *LHIN interventions to improve coordinated access for mental health and addictions: communicate and support implementation through training sessions.*

- Despite increasingly more aggressive targets, CHCs were all within their respective corridors for diagnostic access and safe and effective best practice measures. In addition, CHCs showed improvements in their access measure (i.e. panel size) despite continued pressures in attracting and retaining physicians and nurse practitioners; all five were within performance corridors for this measure.

- LHIN Home & Community Care (i.e. legacy CCAC) wait time measures demonstrated a decline in performance in Q2. Waits were longer than targeted when initiating service from both the hospital and community setting.

Financial Highlights

- All Community Support Services (CSS) and Community Health Centres (CHC) are projecting balanced budgets at year end. Three Community Mental Health HSPs are projecting very modest year end deficits. The Middlesex and Elgin Community Mental Health Association (CMHA) agencies are projecting balanced budgets based on the implementation of Performance Improvement Plans (PIP) after ending last year in a deficit position. The Oxford CMHA is projecting a year end deficit of $105,000 – the HSP is working on a PIP that will lead to a balanced position. Progress against the three PIPs is being closely monitored. All deficit positions remain the sole financial responsibility of the HSP.

Long-Term Care Sector

Performance Highlights and Actions to Improve

- Introduced to South West LHIN long-term care homes as new local performance obligations for 2016/17, at Q2 of 2017/18, 99% 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 where 1:1 staffing has been introduced to help support residents with responsive behaviours to remain in their long-term care homes. These 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

- Not applicable, the LHIN does not receive Q2 financial projections from the Long Term Care Homes

Non-Discretionary Funding

- The LHIN Board receives information about new discretionary funding provided to the LHIN, In all cases, except for spending approved using LHIN 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 approved during Q2 2017/18.

Attachments:

Appendix 1 – Q2 2017/18 Service Accountability Agreement Review: Performance Outcomes, Financial & Service Activity Perspectives. The report highlights the extent to which targets are met as outlined in HSPs' respective Service Accountability Agreements (SAAs). SAA indicators have been grouped according to the following four dimensions: Patient Experience, System Perspective & Integration, Organizational Health, and Service Activity.

Appendix 2- lists all new directed funding added during Q2 2017/18.

Appendix 1 - Q2 2017/18 Service Accountability Agreement Review: Performance Outcomes, Financial & Service Activity Perspectives

	Hospitals				LHIN Home & Community Care				Community Support Services (CSS)				Community Health Centres (CHC)				Community Mental Health & Addictions (CMH&A)				Long-Term Care Homes			
Patient Experience																								
	H-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	L-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management
Access	90P ED LOS complex	92%	89%	Improved performance in ED waits despite increase in volumes. LHSC continues to be challenged by long waits. P4R plans and Knowledge Transfer underway. Coordinated Access improved quickly in one hospital.	90P Wait from Hospital	0%	50%	Wait times to initiate service from either hospital or community setting have lengthened. 5 day wait time measures are close to meeting targets and within performance corridors.					Access to Primary Care	100%		Improvements seen in achieving panel size targets even with increasingly more aggressive targets.	Coord-inated Access (% GAIN screened)	70%		(LOCAL) 3 of 10 providers (including hospitals with M-SAAs) did not submit evidence of assessing using a Global Appraisal of Individual Needs tool at targeted rate for Q2.				
	90P ED LOS minor/ uncomplic.	85%			90P Wait from Community	0%																		
	Coord-inated Access (% GAIN screened)	100%			% Nursing Visit Within 5d	100%																		
					% PSW Visit Within 5d	100%																		
Diagnostics Access	MRI-- % P2,3,4 within target	80%	93%	Despite missing clinical wait time targets for MRI and CT in some instances, most hospitals are meeting HSAA targets (4/5 for MRI and 10/10 for CT).									Cervical	100%	100%	Despite increasingly more aggressive targets, improvements observed for screening measures and all CHCs are within performance corridors.								
	CT-- % P2,3,4 within target	100%											Colorectal	100%										
													Breast	100%										
Surgical Access	Hip-- % P2,3,4 within target	17%	17%	Access to both knee and hip surgery remained well below target in Q2 for 5 of 6 hospitals. Open wait list clean-up, enhanced volumes, central intake, and sharing surgeon wait times all aim to improve.																				
	Knee-- % P2,3,4 within target	17%																						
Safe & Effective	C. diff	82%	62%	Hospitals have made improvements for C. diff despite a shift from QIP as a focus area.									Influenza	100%	100%	All CHCs within performance corridors for best practice measures.								
	Stroke/ TIA adm to Stroke Unit	50%		(LOCAL) 2 of 4 designated stroke centres met targets.									Diabetes	100%										
	ICS	42%		(LOCAL)--Better instructions will be sent to complete.	ICS	100%	100%	(LOCAL)	ICS	38%		(LOCAL)--Better instructions will be sent to complete.	ICS	100%		(LOCAL)	ICS	52%	57%	(LOCAL)--Better instructions will be sent to complete.				
	FLS	100%		(LOCAL) both teaching hospitals have submitted plans.	FLS	100%		(LOCAL)					FLS	100%		(LOCAL)--1 CHC only	FLS	100%		(LOCAL) 3 of 3 HSPs have submitted plans.				
System Perspective & Integration																								
30d ED Revisit Rate for Mental Health	0%	see below (70%)		(LOCAL) LHSC & GBHS continue to experience exceptional challenges with mental health ED revisits in Q1.																				
30d ED Revisit Rate for Substance Abuse	50%			(LOCAL) Targets align with the LHIN's MLAA target--despite drug pressures, GBHS was within corridor for substance abuse revisits in Q1 but not LHSC.																				
Readmissions within 30 days	72%			Rates of readmissions for 13 of 18 hospitals were within expected rates (Q4 16/17 data)--up from prior quarter.																				

100% of providers* achieving target — 0% of providers* achieving target

*for which indicator applies

Appendix 1 - Q2 2017/18 Service Accountability Agreement Review: Performance Outcomes, Financial & Service Activity Perspectives

System Perspective & Integration (cont.)

	Hospitals				LHIN Home & Community Care				Community Support Services (CSS)				Community Health Centres (CHC)				Community Mental Health & Addictions (CMH&A)				Long-Term Care Homes			
SAA Indicator		% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	L-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management
% Eligible Pts in Rehab		80%	72%	(LOCAL) 4 of 5 hospitals with Coordinated Access had rehab-appropriate patients in rehab beds and only 3 of 10 met CCC eligibility targets for CCC beds.	100%	86%	(LOCAL) Low occupancies (and to a lesser extent, ALCs) challenge ensuring that rehab-appropriate patients are in rehab beds. CCC eligibility targets not met largely due to ALCs but also as a result of unoccupied beds.																	
% Eligible Pts in CCC		30%			0%																			
ALC Rate		76%		13 of 17 hospitals met targets (better than prior Q). Increasing complexity of ALCs and those with specialized needs is focus of CNEs.	100%		The LHIN's overall ALC rate has met the MLAA target.																	
theHealthLine.ca		95%		(LOCAL)	100%		(LOCAL)		100%		(LOCAL)		100%		(LOCAL)		100%		(LOCAL)		99%	99%	(LOCAL)	
ADP Occupancy					100%		(LOCAL) Given the role in facilitating admissions to Adult Day Programs, the LHIN is evaluated for overall occupancy against the target of 90%. Target met.		92%	98%	(LOCAL) 1 of 12 HSPs fell short of their allowable corridors. Realignment of spaces will further improve occupancies.													
% ALC Days (Acute)					100%		The overall LHIN % ALC Days remained the 2nd lowest among Ontario LHINs for Q1 (most recent data).																	
Residents with Responsive Behaviours Discharged from LTC																					99%		(LOCAL)	
1:1 Staffing Implemented for Residents with Responsive Behaviours																					99%		(LOCAL)	

Organizational Health

	H-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	L-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management
Total Margin	Total Margin %	95%	93%	Three hospitals are projecting deficits, but only one is projecting a deficit beyond the waiver limit.	Total Margin %	100%	100%	Year-end balanced position; enhanced targeted funding received for Levels of Care and Respite	Total Margin %	100%	100%	All HSPs are projecting year-end balanced positions.	Total Margin %	100%	85%		Total Margin %	88%	92%	Three HSPs projecting deficits at year-end. Three (other) HSPs implementing Performance Improvement Plans to balance				
Balanced Budget	Fund Type 1 Balanced Budget	94%			Fund Type 2 Balanced Budget	100%			Fund Type 2 Balanced Budget	100%			Fund Type 2 Balanced Budget	100%			Fund Type 2 Balanced Budget	88%						
Sector-Specific	Current Ratio (YE)	89%			% Spent on Admin	100%			% Spent on Admin	100%			% Spent on Admin	80%			% Spent on Admin	100%						
													Retention Rate	60%										

Appendix 1 - Q2 2017/18 Service Accountability Agreement Review: Performance Outcomes, Financial & Service Activity Perspectives

Service Activity		Hospitals			LHIN Home & Community Care				Community Support Services (CSS)				Community Health Centres (CHC)				Community Mental Health & Addictions (CMH&A)				Long-Term Care Homes			
		H-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at target*	dimension wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management	L-SAA Indicator	% of HSPs at Target*	Dimension wt avg	Analysis & Performance Management
Volumes/ Activity		Visits: Amb Care	89%	78%	Hospitals are generally projecting to meet service activity targets. The CCC variances projected are not unexpected as hospitals adjust to bed reallocations and occupancy challeges that persist in some sites. Mental Health bed variance is based on over corridor projections (high occupancy)	Indiv. Served	100%	100%	Variances observed but masked at the roll-up level e.g. school health, therapies, respite, residential hospice, and nursing lower than budget.	Indiv. Served	86%	76%	As Assisted Living hubs ramp up, they are balancing higher-need clients. Also, competition for PSW human resources and individuals being served longer all explain some of the lower-than-targeted Individuals Served and Hours of Care. Case management capacity not fully utilized but will improve as the "one sector" experience work evolves. Ridership down with some rural transportation providers. Volunteer staffing reported as challenge. Referrals for meal services down linked to available alternatives that challenge value and quality but some improvement seen.	Indiv. Served	100%	91%	As CHCs are able to recruit and retain staff, practices can expand (patients and staffing) and improvements have been observed in individuals served, visits, and access.	Indiv. Served	83%	81%	Some attendance days and visits targets missed as reporting systems have been improved and have surfaced erroneous targets--numbers trending up despite not hitting targets. Follow-up to better understand utilization of sessions underway to ensure optimization of resources.				
		Weighted Pt Days: CCC	50%			Visits F2F, phone, cont.out	100%			Visits F2F, phone, cont.out	68%			Visits F2F, phone, cont.out	100%			Visits F2F, phone, cont.out	68%						
		Weighted Visits: DS	88%			Hours of Care	100%			Hours of Care	50%			Hours of Care	n/a			Hours of Care	n/a						
		Weighted Cases: ED	95%							Attendance Days (F2F)	64%			Attendance Days (F2F)	100%			Attendance Days (F2F)	83%						
		Visits: ED & Urg Care	95%							IP/Res Days	95%			IP/Res Days	100%			IP/Res Days	90%						
		Days: IP MH	71%							Group Participant Attendan	88%			Group Participant Attendan	100%			Group Participant Attendan	70%						
		Days: IP Rehab	88%							Not Uniquely ID'd Svc Rec	80%			Not Uniquely ID'd Svc Rec	0%			Not Uniquely ID'd Svc Rec	87%						
		Weighted Cases: IP Acute	68%							Group Sessions	83%			Group Sessions	100%			Group Sessions	77%						
										Meals Delivered	75%			Service Provider Interactions	100%			Service Provider Interactions	50%						
														Meals Delivered	n/a			Mental Health Sessions	90%						
						Variance-Forecast: Actual Svcs	100%			Variance-Forecast: Actual Svcs	64%		Conservative forecasting observed again at Q2.	Variance-Forecast: Actual Svcs	22%		Conservative forecasting still at Q2--improvements targeted through education.	Variance-Forecast: Actual Svcs	52%		Consistency in conservative forecasting practices.				
Total # of Provid-ers:		**20**				**1**				**51**				**5**				**27**				**77**			

Appendix 1 - Q2 2017/18 Service Accountability Agreement Review: Performance Outcomes, Financial & Service Activity Perspectives

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 2

Non-Discretionary (Ministry Directed) 2017/18 Quarter 2 Culmulative Ministry-LHIN Accountability Agreement (MLAA) Fundin

Initiative	Sector	Base (B) or Onetime (O)	Fiscal	Annual*	Quarter
Health Based Allocation Model (HBAM) Investment	Hospitals	Base		$4,320,100	Q1
Quality Based Procedures (QBP) funding	Hospitals	Base		$5,194,043	Q1
HBAM Contribution (net change)	Hospitals	Base		$5,972,100	Q1
HBAM Adjustment (net)	Hospitals	Base		-$8,156,400	Q1
Investment for Medium sized Hospitals	Hospitals	Base		$2,525,100	Q1
Investment for High Growth Hospitals	Hospitals	Base		$251,800	Q1
Base Sustainability Investment	Hospitals	Base		$4,393,200	Q1
One-Time Sustainability Investment	Hospitals	Onetime	$3,565,600		Q1
Post Construction Operating Plan (PCOP)	Hospitals	Base		$2,650,000	Q1
Provincial Programs (cardiac, transplants, etc.)	Hospitals	Base		$6,128,100	Q1
Provincial Programs (cardiac, transplants, etc.)	Hospitals	Ontime	$424,000		Q1
Wait Time funding (CT, MRI, General Surgery, etc.)	Hospitals	Onetime	$660,712		Q1
Pay for Results	Hospitals	Onetime	$5,891,000		Q1
Priority Wait Times Orthopedic	Hospitals	Onetime	$386,672		Q1
Small Hospitals 2% Base Increase	Hospitals	Base		$3,283,400	Q1
Strategy to Prevent Opioid Addicition and Overdose	Community Mental Health/Community Heath Centres	Base		$1,000,000	Q2
Hospice Expansion	Home Care	Base		$1,470,000	Q2
Long Term Care Homes - Level of Care Per Diem Base Funding Increase	Long Term Care Homes	Base		$6,880,953	Q2
Pediatric Oncology	Hospital	Onetime	$226,800	$226,800	Q2
Dehavioural Supports Ontario - Specialized Staffing Initiatives	Long Term Care Homes	Base		$705,735	Q2
Total			**$11,154,784**	**$36,844,931**	

*The annual amount will be paid in fiscal 2017/18 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 2017/18 due to timing constraints - funding is listed 'as provided' rather than as applied.

Agenda item 5.5

Report to the Board of Directors

Board Director Reports

Meeting Date: **December 19, 2017**

Submitted To: ☒ **Board of Directors**

Purpose: ☒ **Information Only**

Linda Ballantyne

Attended the following LHIN meetings:
Attended:

- Nov. 17, 2017 – Teleconference with Board A/Chair and Vice President, Human Resources
- Nov. 21, 2017 – LHIN Board Meeting – Seaforth
- Nov. 23, 2017 – Quality Committee Meeting
- Nov. 24, 2017 – Teleconference – Board Meeting
- Nov. 28, 2017 – Teleconference with Board A/Chair and Vice President, Human Resources
- Dec. 6, 2017 – Teleconference re Board Educational
- Dec. 8, 2017 – Teleconference – VP, Human Resources and CEO Vendor Search Committee

Cynthia St. John

November Board meeting – I was away

November 28th Governance Committee meeting – I attended.

November 29th Public Appointment Secretariat (PAS) training in Toronto. Highlights of the training include:

- Several LHIN board members in the room struggling with the same issues –how to create a new organization now that T Day has passed.
- Good discussion about how do you balance public interest in your role as a board member with the mandate letter you are supposed to uphold on behalf of the Minister. Sometimes the two conflict. You are acting in the best interest of the public but you are not accountable to the public.

- The LHINs now have considerably more say in what appears in the mandate letter than ever before.

- Board members should be mindful of your standard of care. If you have a specific designation, your standard of care at the board may be different than another board member. There is a movement underway that the standard of care will be raised for everyone regardless of their designation. This relates to the importance of board orientation and training.

- New Board members are required to give Oaths of affirmation of allegiance and of Office – two swearings must be made. The swearing should be to the Chair of the Board or at a Board meeting. The swearing is not optional

- PAS is particularly interested in appointing women to public boards so we were asked to please consider spreading the word to female colleagues that might be appropriate for public boards as there are several vacancies.

Aniko Varpalotai

- Attended Quality Committee meeting
- Attended Organizational Advancement Workshop planning with Co-CEOs, Chair and Facilitator
- Reviewed applications from search firms for CEO search.

Agenda item 5.6

Report to the Board of Directors

Board Committee Reports

Meeting Date: **December 19, 2017**

Submitted To: ☒ **Board of Directors**

Purpose: ☒ **Information Only**

Audit Committee

The next Audit Committee meeting is scheduled for Tuesday, February 20, 2018 to review the 2017/18 Deloitte Audit Service Plan.

Board-to-Board Reference Group

The next meeting is currently being rescheduled. Tuesday, January 9, 2018 will be cancelled and tentatively Thursday, February 8 will be the new date.

Governance & Nominations Committee

The Governance Committee at its Nov. 28, 2017 meeting:

- heard about developments regarding the sub-region board to board reference groups and community engagement
- recommended committee memberships for 2018
- provided feedback for the upcoming Organizational Advancement Workshop (Dec. 18-19)
- discussed topics for future board education sessions to be included during regular board meetings
- reviewed orientation materials for new board members
- reviewed board meeting evaluation materials and feedback
- discussed plans for the next round of accreditation and the Governance Committee's role
- agreed to begin a review and harmonization of legacy LHIN and CCAC policies

The draft minutes are included in the consent section of the agenda package.

Quality Committee

See *Board Quality Committee Highlights and Reflections* under the Agenda Items for Information/Discussion section of the board package. The draft minutes of November 23, 2017 are included in the consent item section.

The next meeting will be held on Thursday, December 21, 2017

Agenda item 6.1

Report to the Board of Directors
2018/19 Draft Annual Business Plan

Meeting Date: **December 19, 2017**

Submitted By: **Kelly Gillis, Interim Co-Chief Executive Officer / Vice President, Strategy, System Design & Integration**
Kristy McQueen, Interim Senior Director, System Design and Integration

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

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

Suggested Motion:
THAT the South West LHIN Board of Directors approves the 2018/19 Draft Annual Business Plan for submission to the Ministry of Health and Long-Term Care by December 31, 2017.

Purpose:
In follow up to the Annual Business Plan (ABP) Board agenda in November 2017, the 2018/19 Draft Annual Business Plan is now being brought forward to the Board for approval. The ABP is due to the Ministry of Health and Long Term Care (MOHLTC) by December 31, 2017 and operationalizes the third year of the 2016-19 IHSP.

Ministry/LHIN Accountability Framework:

- The ABP is a key component of the ministry/LHIN accountability framework
- The accountability and reporting relationship between the ministry and LHINs is grounded in the legal requirements in the Local Health System Integration Act, 2006 (LHSIA), the Memorandum of Understanding (MOU) between both parties and the Ministry LHIN Accountability Agreement (MLAA), in addition to government directives such as the Agencies and Appointments Directive (AAD)
- The ADD requires all provincial agencies with governing boards, including Local Health Integration Networks (LHINs), to provide an ABP to the Minister for approval
- The 2018/19 ABP outlines plans to deliver on the priorities in the Minster's 2018/19 Mandate letter while continuing to deliver on priorities outlined in the LHIN Integrated Health Service Plans (IHSPs)
- In addition to the requirements outlined in the AAD, the Minister's 2018/19 Mandate Letter and LHIN IHSPs, LHIN ABPs takes into consideration:
  - The Minister's Patients First: Action Plan for Health Care;
  - The Patients First Act, 2016;

- The Local Health System Integration Act, 2006 (LHSIA);
- The LHINs' new role in the delivery of home and community care and as a health-system manager;
- French Language Services and Indigenous Peoples; and,
- The Memorandum of Understanding and Accountability Agreement between the Ministry and each LHIN.

2018/19 Annual Business Plan:

- The 2018/19 Annual Business Plan format aligns to the Ministry of Health and Long-Term Care guidelines and reflects the key considerations listed above and includes:
  - ***Context*** including the LHIN's mandate; alignment of ABP with 2018/19 Minister's Mandate letter; overview of current and planned programs/activities aligned with the IHSP; and an environmental scan
  - ***Health System Oversight and Management*** capturing priorities, key goals and action plan of the LHIN
  - ***LHIN-delivered Home and Community Care*** capturing priorities, key goals and action plans of the LHIN as the service provider of LHIN-delivered home and community care.
  - ***French Language Services*** outlining the LHIN's commitment and plan to ensure the effective provision of French language health services
  - ***Indigenous Peoples***: demonstrating how Indigenous people were included in health care planning and how the LHINs took into consideration their health care needs and services, including culturally safe care for Indigenous people
  - ***Performance Measures*** identifying operational and outcome-focused measures and quantified annual targets for the priorities, key programs, services and goals/plans noted above
  - ***Risks and Mitigation Plans*** identifying key risks/barriers including mitigation approach to the successful implementation of priorities, key programs, services and goals/plans.
  - ***LHIN Spending and Staffing Plans***
  - ***Integrated Communications Strategy*** outlining the overall strategy including objectives, target audience, strategic approach, key messages, tactics or vehicles that the LHIN will use to get its messages across to the public and stakeholders
  - ***Community Engagement*** describing plans for community engagement and plans for specific initiatives for which the LHIN receives additional operational funding
  - Given the timing of submission of the draft ABP, the spending and staffing plan for the LHIN are preliminary and will be finalized in February as part of the budgeting cycle in early 2018.

Next Steps:

- Subsequent to the LHIN Board's approval, the draft ABP will be submitted to the Ministry of Health and Long Term Care prior to December 31, 2017.
- The LHIN will await the Ministry's response to the draft ABP which is expected by the end of January 2018. At that time, necessary revisions will be made, and the completed operations spending and staffing plan will be updated so that the Board can approve the final ABP at the February 20, 2018 Board meeting.
- The final Board approved ABP will be submitted to the Ministry on or before March 1, 2018.
- It is expected that the Minister's final approval will occur by April 1, 2018.

South West Local Health Integration Network

DRAFT Annual Business Plan 2018/2019

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

December 19, 2017

Table of Contents

1. Context

A. Transmittal Letter from the LHIN Board Chair

To: *Tim Hadwen* Assistant Deputy Minister
Health System Accountability, Performance and French Language Services Division

Subject: South West Local Health Integration Network – Annual Business Plan, 2018/19

I am pleased to submit the South West LHIN's 2018/19 Annual Business Plan, which details our action plans and key activities for the coming fiscal year. *Patients First* is strongly reflected in our Integrated Health Service Plan (IHSP) for 2016 to 2019. The IHSP identifies strategic directions and steps required to make our overall vision of an improved and integrated health system for all a reality. The plan's initiatives and actions position us well to deliver on the expectations outlined in the Minister's Mandate letter dated November 24, 2017 including the work ahead with both local and provincial partners to move health system renewal and transformation forward.

This year has been a year of transition as the delivery of home and community care was integrated into the LHIN on May 24, 2017. We have established a new organizational structure and continue to work on aligning key processes, creating the strategic vision for the new organization, and establishing the culture needed to advance *Patients First* goals and broader health system transformation. For 2018/19 we will build on the solid foundation that we have established and continue to focus on delivering quality patient care and working collaboratively with health system partners to transform health care within and across our five LHIN sub-regions.

Local planning and decision-making is the model that the LHINs are built on, and one that values the input of community members, health care professionals, and stakeholders. The newly formed Primary Care Alliances, Sub-Region Integration Tables, our Patient and Family Advisory Committee, our Clinical Quality Table, as well as our Health System Renewal Advisory Committee will enable us to include a stronger patient/family/caregiver voice focused on integrated service planning and delivery. These groups will advise the LHIN on system-wide priorities and help drive change locally. With the input of these important partners, the South West LHIN will continue to engage its communities to build a system that better understands and meets the needs of individuals and families in the LHIN.

Sincerely,

Andrew Chunilall, Acting Board Chair
South West LHIN Board of Directors
cc: Kelly Gills, Interim Co-CEO, South West LHIN
Donna Ladouceur, Interim Co-CEO, South West LHIN

B. Mandate

Across Ontario, Local Health Integration Networks (LHINs), along with health service providers and partners, have the important responsibility of transforming the health system to put individuals and families at the centre of the system.

In the *Patients First: Action Plan for Health Care* (February 2015), the province set four key goals that focused on creating a person-centred health care system by improving Ontarian's health care experience and health outcomes. The four key goals are:

1) ***Access:*** Improve access – providing faster access to the right care.
2) ***Connect:*** Connect services – delivering better coordinated and integrated care in the community, closer to home.
3) ***Inform:*** Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.
4) ***Protect:*** Protect our universal public health care system – making decisions based on value and quality, to sustain the system for generations to come.

The passing of Ontario's *Patients First Act, in 2016* was an important step forward as it strengthens the role of LHINs to achieve the following goals:

- Effective integration of services and greater equity.
- Timely access to, and better integration of, primary care.
- More consistent and accessible home and community care.
- Stronger links to population and public health.
- Inclusion of Indigenous voices in health care planning.

For 2017/18, the transfer of CCAC staff and functions, effective May 24, 2017, has been a significant undertaking. Throughout this transition, the LHIN's foremost priority has been to maintain the continuity of patient care for individuals and families across the LHIN. The South West LHIN has been working collaboratively to support a smooth and seamless transition of high quality and integrated care for people in the South West LHIN.

This first year of transition has also seen considerable attention focused on establishing the organizational structure and aligning key processes, creating the strategic vision for the new organization, and establishing the culture needed to advance the key goals of the *Patients First Action Plan* at the regional and sub-region levels within the LHIN. Work to date has included formalizing 5 sub-regions: Grey Bruce, Huron Perth, London Middlesex, Oxford and Elgin along with creating new conversations with a stronger patient/family/caregiver voice and an approach for engaging primary care. The Patient and Family Advisory Committee and Health System Renewal Advisory Committee will advise the LHIN on system-wide priorities while the five sub-region integration tables and the five primary care alliances will drive change locally. These new committees will be interdependent to achieve a common goal of improving health and wellness, patient experience and outcomes, as well as value for money.

The Minister's Mandate Letter received November 24, 2017 outlines the expectations of the LHINs for the year ahead including the continued implementation of the *Patients First Act* to support building a more sustainable, efficient and accessible health care system for future generations. Collective key priorities identified in the mandate letter are in alignment with our plan and strategy and include: Improving the patient voice and experience, addressing the root cause of health inequities, improving access to care, ensuring seamless transitions of care for patients, and supporting innovations to care and technologies.

Transformation will continue for many years and will be guided by our long-range plan, the *Health System Design Blueprint*, which works towards achieving an integrated health system of care by 2022. To help guide longer-term system transformation, all LHINs produce a three year Integrated Health Service Plan (IHSP) for the local health system. This 2018/19 Annual Business Plan (ABP) aligns with our IHSP plan and the provincial goals set forth in the Ministers Mandate letter. We will continue to work toward the achievement of this overall vision.

Strategic Directions

When developing the South West LHIN's IHSP for 2016-19 we had a vision – *A health system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren* – and we adopted the Institute for Healthcare Improvement's Triple Aim framework. This year, with the integration of the CCAC and the LHIN, we developed a new Vision and Mission to guide us. Our Vision - *A healthier tomorrow for everyone, along* with our Mission - *Working with communities to deliver quality care and transform the health care system* – builds on the foundational work and strategic direction of our IHSP for 2016-19 and also provides us with a vision and mission for the future.

Our IHSP for 2016-19 outlines the strategies and priority populations all health service organizations, sectors and networks will need to consider in their strategic and operational plans to collectively advance health system improvements within the South West LHIN. The IHSP also details how we demonstrate and measure success in the LHIN.

Our IHSP system view describes the pursuit of population health, experience of care, and value for money, through the advancement of five implementation strategies across seven priorities. Our intent is to achieve an integrated system of care for all LHIN residents with an emphasis on the following populations:

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

C. Alignment with the Priorities of the Minister's Mandate Letter

The following table outlines the priorities of the Minister's Mandate Letter and the associated goals and actions the LHIN will undertake to deliver on them:

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
Transparency and Public Accountability *E.g. working with Health Shared Services Ontario (HSSOntario) on an enterprise-wide review of the LHINs, managing risks effectively, and meeting reporting and accountability obligations.*	Increase transparency with publicly-available reporting: • Design performance reporting and monitoring that drives the execution of the organization's strategy, and supports operations, organizational health, and improvement in key priorities. • Establish focused complimentary key performance indicators that cascade to support improvement for internal and external teams. • Align responsibility and accountability for reporting, monitoring and improvement. • Develop a Corporate Risk Profile and implement an Enterprise Risk Management approach. • Integrate key elements of the performance management and accountability approach for Health Service Providers and Service Provider Organizations. • Continue to implement and enhance value for money assessments of LHIN-wide initiatives to understand impact of investments and direct alignment of initiatives to outcomes. • Support our sub-regions along a maturity journey toward shared accountability for performance, outcomes and results.
Improve the Patient Experience *E.g. initiatives to reduce caregiver stress and improve transitions between care settings, Patient and Family Advisory Committee(s) engagement*	• Work in partnership with our new Patient Family Advisory Committee to co-design a patient engagement plan. • Work with patient and family partners to gain feedback on how we identify priorities and communicate and report on progress and outcomes. • Ensure that patient, family and caregiver partners are working with providers in key committee structures to create solutions together leveraging their lived experience.

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	• Work alongside health service providers to consistently embed patient engagement approaches (e.g. Experience Based Design) to advance quality improvement. • Work with health service providers to develop a coordinated approach to engage people who receive services and determine experience of care measures. • Increase access to Congregate Residential Living.
Build Healthy Communities Informed by Population Health Planning *E.g. assessing local population health needs, identifying how providers in sub-regions will collaborate to address health gaps, working with public health and others to incorporate health promotion strategies.*	• Work with our Sub-Region Integration Tables to pursue opportunities to transform the health system to integrate population and public health planning with other services to create stronger links to health promotion and disease prevention. • Provide integrated, population-based care by strengthening end-to-end integration at a multi-community and local level across the South West LHIN. • Ensure Public Health is effectively engaged as partners in sub-region and regional priorities.
Quality Improvement, Consistency and Outcomes-Based Delivery *E.g. enhancing performance and quality measurement frameworks, working with Health Quality Ontario to support implementation of quality standards*	• Work alongside health service providers to consistently embed patient engagement approaches to advance performance and quality improvement. • Implement the South West LHIN Quality, and Performance Management and Improvement Approach. • Provide leadership in establishing shared improvement strategies through Improvement Plans across sub-regions and within sectors to advance key priorities. • Work alongside health service providers to implement best practices (e.g. Quality Based Procedures) and reduce variation within and among organizations to improve outcomes and value for money.
Equity *E.g. Promote health equity and recognize the impact of social determinants of health, ensuring engagement with Indigenous and Francophone leaders, enhance access to French language services.*	• Continue to apply an equity lens to decision-making leveraging guidelines to increase the application of the Health Equity Impact Assessment tool. • Work alongside health service providers to consistently embed patient engagement approaches to advance performance and quality improvement. • Ensure Public Health is effectively engaged as partners

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	in sub-region and regional priorities. • Work with our Sub-Region Integration Tables to pursue opportunities to transform the health system to integrate population and public health planning with other services to create stronger links to reduce health disparities for vulnerable populations • In partnership with the French Language Health Services Planning Entity continue to advance our Joint Action Plan • Engage regularly with the South West Indigenous Health Committee to provider leadership and advice to advance the Indigenous Inclusion and Reconcili-ACTION Roadmap
Primary Care *E.g. working with providers to implement sub-region plans to use an equity lens, advance the implementation of coordination of care plans, enhance care coordination, and improve access and care transitions*.	• Implementation of Primary Care Alliance structure aligned with sub-regions to improve access, and better support transitions of care post-discharge from hospital. • Continue to explore and spread models to enhance access to team-based care aligned with population need. • Ensure primary care clinical and administration leadership are effectively engaged as partners in the Sub-Region Integration Tables. • Create strong linkages between the new Primary Care Alliances and the Sub-Region Integration Tables. • Work within sub-regions to develop transition plans for coordinated care planning to be embedded in sub-region work processes. • Improve the relationship between primary care and home and community care through evolving the care coordination model.
Hospitals and Partners *E.g. working with system partners to improve the patient journey through hospitals, and supporting hospitals to adopt innovations like bundled care.*	• Spread and sustain integrated care models to improve transitions in care between hospital and community. • Leverage sub-regions to improve patient access and flow. • Grow and sustain strategies for patient access and flow to maintain access to acute care beds. • Implement improved admission and discharge practices for patients admitted to mental health beds to improve capacity and access.

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	• Clinical Services Plan for stroke (hospital realignment and community-based care), rehabilitative care, and diagnostic imaging. • Ensure hospitals are effectively engaged as partners in the Sub-Region Integration Tables.
Specialist Care *E.g. working with providers to enable communications and improve appropriate care for people suffering from musculoskeletal (MSK) pain and mood disorders, drive more effective and appropriate specialist referrals*	• Create a more streamlined patient experience and integration with primary care through implementing central intake and assessment focused on the musculoskeletal pathway. • Spread the implementation of Novari to improve timely access to surgery. • Investigate strategies to improve Wait 1 and Wait 2 in priority areas. • Champion the spread of eConsult and eReferral processes to reduce unnecessary referrals to specialists and give primary care physicians and their patients more timely access to specialists.
Home and Community Care *E.g. reducing home and community care wait times, improving coordination and consistency with input from patients, caregivers and partners, working with the ministry and Ontario Palliative Care Network to expand access to palliative and end of life care.*	• Continue to advance the 'One-sector' Home and Community Care Experience. • Continue to grow the supports available through our Palliative Care Outreach teams to provide high quality palliative care and offer integrated supports across the continuum. • Support improvement in the delivery of high quality Home and Community Care by evolving the care coordination model to align with best practices. • Engage with internal and external stakeholders including patients and families in all improvement activity. • Work collaboratively with partners to plan and address health human resource shortages in order to meet increasing demand for services. • Commit to ensuring that home and community care is available in culturally and linguistically safe ways that ensure equitable access to care for Indigenous and Francophone populations.
Long-Term Care *E.g. Work with the ministry to strengthen the long-term care home sector, including through the*	• Continue to support effective Long-Term Care (LTC) Home Redevelopment. • Effectively engage Long-Term Care Homes in Sub-region planning

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
redevelopment of long-term care homes across the province.	
Dementia Care *E.g. Implement regional dementia capacity plans*	• Develop and implement a regional dementia capacity plan aligned with the provincial and South West LHIN dementia strategies • Ensure the dementia capacity plan is integrated with the Individuals with Complex Needs strategy with a particular focus on Seniors who are frail
Mental Health and Addictions *E.g. working with partners to expand access to services including structured psychotherapy and supportive housing, reduce wait times for community mental health services, supporting the provincial opioid strategy and connecting patients with high-quality addictions treatment.*	• Work with partners to expand access to services including structured psychotherapy, peer support, specialized units, and supportive housing. • Support the provincial opioid strategy. • Work across sectors and care settings to reduce variation in processes and practices. • Develop strategies to further integrate Mental Health & Addictions community providers within sub-regions. • Advance integration across sectors especially between primary care, home and community care and mental health and addictions to improve the patient experience.
Innovation, Health Technologies and Digital Health *E.g. support the ministry's Digital Health Strategy including HIS, virtual and digital models of care, and referral processes.*	• Advance provincial digital health priorities through the South West Digital Health Strategy. • Leverage digital health solutions to improve coordination of care and sharing of information between providers to enhance the patient experience. • Optimize digital health technologies for timelier access to services and to reduce unnecessary transfers. • Continue to advance the adoption of ClinicalConnect to support high-quality, safe and timely care. • Improve patient access to health information through the implementation of MyChart (patient portal). • Implement digital health tools to allow clinicians or health services providers to collaborate with other care team members and maintain shared, coordinated care plans and have access to timely and secure assessment information. • Advance hospital reporting systems so that primary care providers, specialists and nurse practitioners anywhere can receive patient reports electronically

Minister's Mandate Letter Priorities	Key commitments, goals, actions and/or outcomes from the LHIN's ABP
	from participating hospitals or independent health facilities. • Ensuring that any hospital information system (HIS) renewal decisions are consistent with HIS Renewal Advisory Panel clustering recommendations and reflect a commitment to reduce the overall number of HIS instances in the province.

D. Overview of Services within the South West LHIN

To meet the health care and social support needs of residents, a variety of services from an array of LHIN and non-LHIN funded organizations are available in the South West. With the passing of *Patients First* and the integration of CCACs into the LHINs, the South West LHIN will directly provide services to residents in 2018/19. These services include care coordination, nursing and personal care, allied health, direct nursing, placement, information and referral, and medical supplies and equipment services.

The following LHIN-funded organizations also play a critical role in delivering health services to South West LHIN residents:

- 20 hospital corporations (33 sites)
- 78 long-term care homes
- 5 community health centres
- 52 agencies provide community support services
- 14 agencies provide assisted living supportive housing services
- 22 agencies provide mental health services
- 10 agencies provide addictions services
- 3 agencies provide acquired brain injury services
- 14 Home and Community Care Service Providers Organizations and 4 Vendors

In the South West LHIN, approximately 950 family physicians practice within its geographic boundaries of which 65% provide comprehensive community-based primary care. The remaining 35% of family physicians work in alternative practice models including emergency medicine, walk-in clinics and inpatient hospitalist care. 52% of the primary care practitioners that provide comprehensive primary care in the community are affiliated with team-based care through 19 family health teams, 5 community health centres, 2 nurse-practitioner-led clinics, and 1 Aboriginal Health Access Centre.

The Patients First Act, 2016, enables LHINs to plan for and better integrate primary care in the local health system. It allows LHINs to fund and have accountability relationships with additional health service providers including family health teams (non-physician

funding), Aboriginal Health Access Centres, nurse-practitioner-led and physiotherapy clinics. With home and community care now integrated into the LHIN, the LHIN will also fund and have accountability relationships with three residential hospices. In addition, as part of the LHIN's population health planning, a formal relationship will be established between the LHIN and the six local boards of health to support population health services planning.

1.4 Environmental Scan

To understand the ability of the health system to meet the health care needs of the population, it is important to understand the demographics and population characteristics of the South West LHIN. The following provides a brief summary. A detailed environmental scan was completed as part of IHSP 2016-19.

Demographics:

- The South West LHIN is home to an estimated 971,500 people, or 7.0% of the population of Ontario.
- According to the 2011 Census, nearly 50% of LHIN residents lived in a large urban population centre (100,000+), and almost 30% lived in rural areas.
- The only large urban centre located in the South West LHIN is London.
- Between 2010 and 2015 the South West LHIN's population increased by 2.6%, compared to 5.1% growth for Ontario overall.
- Seniors (aged 65+) accounted for just over 18% of the LHIN's population, compared to 16% in 2010.
- The population of the South West LHIN was projected to increase by 2.9% between 2015 and 2020, and 6.0% between 2015 and 2025. By comparison, the projected rates of growth for Ontario were 5.3% for 2015 to 2020 and 11.1% for 2015 to 2025.

Population characteristics:

- According to the 2011 Census, 86% of South West LHIN residents reported English and less than 2% reported French as their mother tongue.
- In 2011, immigrants accounted for 14.0% of the South West LHIN population. 1.6% of residents were recent immigrants, having arrived in Canada between 2006 and 2011.
- Less than 8% of the South West LHIN population self-identified as belonging to a visible minority group, compared to 26% of Ontario's population.
- In 2011, the unemployment rate for South West LHIN residents (7.6%) was comparable to the provincial average (8.3%).
- The proportion of South West LHIN residents living in low-income households was 14.0%, similar to the provincial rate of 13.9%.

As the South West LHIN continues to work toward patient focused high-quality care within the five sub-regions, it is also important to understand the characteristics and needs of these sub-region populations as well as existing care patterns. Descriptive Profiles for each sub-region can be found on the South West LHIN website.

2) Health System Oversight and Management

To succeed in transforming the health care system, all health service providers and the LHIN must share a collective plan of action and have a shared focus. Identifying top areas of focus in the form of overarching priorities helps to focus our work efforts and move forward.

Priorities:

Our three overarching priorities for our 2018/19 plan include:

- **Improve the Patient and Family Experience across the health system**
- **Deliver high quality Home and Community Care**
- **Strengthen the new LHIN organization to drive the goals of Patients First**

As we work to deliver on these priorities and the goals that are associated with them, we will continue to embed the following five implementation strategies in all the work we do to implement provincial, LHIN-wide, and sub-region priority initiatives:

- **Health equity:** Consistently apply a Health Equity lens to enable access to quality care.
- **eHealth and Technology**: Leverage and expand the use of eHealth technologies to access and exchange health information, inform effective decision making, and enhance “hands on” care.
- **Integration and Collaboration**: Work together to better organize and connect services to meet the needs of the population and ensure optimal use of resources.
- **Quality Improvement and Innovation**: Partner with LHIN residents to understand their experiences of care and continuously collaborate with them to co-design improvements, broadly share quality evidence and best practices and demonstrate quality outcomes across the health care system.
- **Transparency and Accountability**: Strive for transparent decision-making and better performance by reporting on measures of success and holding individuals and organizations accountable for results.

In 2018/19, the South West LHIN will continue to honour and advance the seven priorities of our current Integrated Health Services Plan. We will leverage these priorities to articulate a refined strategic focus for 2018/19 that aligns with provincial directions and priorities, and the 2018/19 Ministry Mandate letter to the LHIN’s. This focus will enable us to effectively and efficiently monitor and manage the performance of the system, our LHIN-delivered home and community care service delivery, and ourselves. The seven priorities include:

- Ensuring **primary health care** is strengthened and linking with the broader health care system.
- Optimizing the health of people and caregivers living at **home, in long-term care and in other community settings.**[1]
- Supporting people in **preventing and managing chronic conditions.**
- Strengthening **mental health and addiction services** and their relationship with other partners.
- Ensuring timely access to **hospital-based care** at the LHIN-wide, multi-community, and local level.
- Enabling **a rehabilitative approach** across the care continuum.
- Putting people with life-limiting illnesses and their families at the centre of **hospice palliative care.**

To help understand the risks associated with implementing each initiative we undertake, the LHIN considers human resource availability and capability, funding availability, leadership champions, technological challenges, project management challenges, level of stakeholder commitment and challenges associated with change. Multiple risks are often associated with each initiative which then requires careful planning and staging to assist with mitigating those risks.

The tables below summarize the three priorities for 2018/19, their goals and objectives, how success is measured, the status of the initiatives to meet the objectives and risks that need to be mitigated in order to ensure success.

PART 1: IDENTIFICATION OF PRIORITY
Priority
Improve the Patient and Family Experience across the health system.
Priority Description
The South West LHIN will continue to focus our time, resources and efforts on ensuring that people with complex needs receive more integrated and coordinated home and community care, primary care, mental health and addictions support and experience smooth transitions between care settings. A high-quality health system as defined in the Excellent Care for All Act (ECFAA) is “A health system that delivers world-leading safe, effective patient-centered services, efficiently and in a timely fashion, resulting in optimal health status for all communities.” In alignment with this vision, the South West LHIN is building on the existing work of our health service providers and other partners

[1] People living in community settings may also include those in temporary living accommodations, or who may be experiencing homelessness

and will continue to demonstrate the value of learning from the experiences of patient, family and caregiver partners to guide continuous quality improvement in the system and improve health outcomes. Through a focus on better understanding capacity needs; improving integration between key sectors, care settings and care providers; and addressing health inequities we believe we can improve the patient and family experience across the health system.

Current Status

During the development of our IHSP we conducted several focus groups of people living in the South West LHIN. The themes from those focus groups continue to help inform and shape our strategic focus. Here is what patients, families and caregivers are telling us:

Our system provides quality care – let's not lose that

Once people are linked up with the right care, they are generally pleased with the quality. However, a constant change in who is providing care and what care can be provided is frustrating for people and their caregivers.

Respect Me

People want to be treated with respect no matter what their life circumstance.

Provide me with the best care no matter who I am

People feel that who you are and where you live affect the health care you receive. People struggling with mental health and substance abuse issues and people from Indigenous communities feel stigmatized.

Recognize the increasing role family and friends play in health care and the risk to caregiver health

Caregivers can become exhausted and frustrated with the system and feel guilty when they are unable to provide care. They are reluctant to ask for help because they fear loss of autonomy.

Navigating the system is getting really difficult

The system is complex, disjointed and forever changing. When health service providers work well together, people have positive experiences with the system. Many people felt that there is a great lack of communication between providers.

The Health System is being stretched to its limits

People are not sure if the healthcare system can sustain itself. They feel providers are already at capacity. Eligibility criteria is getting more stringent and wait times seem to keep growing. People were concerned that they were not aware of or didn't understand which services are publically funded and which ones they had to pay for themselves.

The South West LHIN continues to actively embed an experience based design approach in projects and initiatives to ensure the patient voice and story are guiding and informing our approach. For example, patients and providers in London Middlesex and Grey Bruce have attended small group sessions where they have shared their experiences with coordinated care planning.

For the Indigenous population and those who are experiencing mental health and addictions challenges, emotional mapping of their experiences has occurred and co-designing revisions to the coordinated care planning process is underway. For others with complex needs, recommendations from the co-design work has been shared with key local committees to build into work plans. The learnings from this work are being shared with other providers across the South West through the Health Links Learning Collaborative.

We continue to report, monitor and respond to our longer-term big dot priorities as identified in our IHSP 2016-19. The summary below provides a view of our current performance (reported in the South West LHIN Report on Performance as at Q1, 2017-18), and supports the rationale for goals we have identified in 2018-19 as follows:

Big Dot 1: Self-Reported Health Status — the percentage of South West LHIN respondents to the Canadian Community Health Survey reporting their health as "very good" or "excellent" is 61.6% and is the highest (best performing) of all 14 LHINs. In three years, we aim to reach 63%.

Big Dot 2: Faster Access to Care in the Community — three components that describe access to key community services make up this Big Dot: 1) wait time for mental health case management, 2) receiving a personal support worker (PSW) visit within five days and, 3) timely access to a primary care provider. Receiving a PSW within five days is showing progress. The other two components did not show improvements from baseline and, together, the net result of the three components means access to care in the community is 58% slower than at baseline. Our goal over three years is almost 20% faster access.

Big Dot 3: Satisfaction with Health Care in the Community — the percentage of adults who reported they were "very satisfied" or "somewhat satisfied" with health care in their community is down slightly to 87.0% from the baseline of 88.3%. In three years, we aim to reach 92%.

Big Dot 4: Value Realized by Reducing Hospital Visits and Days — reducing re-admissions to hospital, reducing unnecessary Emergency Department (ED) use for conditions best treated in primary health care settings, and reducing the rate at which

people are hospitalized for ambulatory care sensitive conditions (ACSC) that could be managed in the community represent three components that quantify costs that can be avoided – or value that can be realized — if improvements are made. Over three years, we aim to realize $11.7 million. To-date, worse-than-targeted rates for re-admissions, hospitalizations for ACSC, and unnecessary ED use translate into a *cumulative* $4.2 million unnecessarily spent in the first five quarters of our IHSP 2016-19 to support these re-admissions, hospitalizations for ACSC, and ED visits, even despite occasional quarters where performance has been better than baseline.

PART 2: GOALS AND ACTION PLANS

Goal (s)

As aligned with our Integrated Health Service Plan 2016-19, the following are the goals identified for our priority - **Improve the Patient and Family Experience across the Health System.**

Ensure primary health care is strengthened and integrated with the broader health care system aligned with a sub-region focus.

- Establish and strengthen primary care alliances in all sub-regions.
- Actively develop sub-region clinical leadership.
- Implement recommendations to support equitable access to primary care, and support for transitions of care for individuals most impacted by the social determinants of health.

Strengthen mental health and addictions coordination and collaboration of services with other partners.

- Reduce variation in admitting and discharge practices.
- Redesign of Mental Health and Addiction Case Management.
- Mental Health and Addiction Crisis Services – Redesign.
- Develop the strategy to integrate Mental Health & Addictions community providers within sub-regions.

Provide culturally and linguistically appropriate care for Indigenous and Francophone people.

- Implement the South West LHIN Indigenous Road Map.
- Improve access to health services in French starting with Home and Community Care, Mental Health & Addictions and Primary Care.

Advance integration to achieve seamless transitions of care for individuals with complex needs.

- Develop an Individuals with Complex Needs Strategy with a particular focus on individuals who are frail.
- Accelerate the adoption of coordinated care planning
- Spread Connecting Care to Home pathway.
- Increase our ability to support people to die in their place of choice.
- Implement sub-region focused strategies to maintain access and flow and optimize bed capacity.
- Implement an integrated Assess & Restore pathway and secondary level supports.
- Optimize community support services as part of the continuum of care.

Quantify capacity needs of Home and Community Care and Long-Term Care to support proactive plans to enhance services and supports

- Develop a dementia capacity plan aligned with the regional Dementia Strategy.
- Quantify Long-Term Care capacity needs and work collaboratively with the ministry, Long-Term Care homes and communities to develop plans to meet identified gaps.

Improve access to specialist care

- Implement Central Intake and Assessment with a focus on the musculoskeletal (MSK) pathway supported by eReferral.

Government Priorities:

The South West LHIN's strategic priority of ***Improving the Patient Experience across the Health System,*** the above noted goals, as well as the action plans to support the achievement of these goals are consistent with the provincial government and the South West LHIN priorities as reflected in:

- Premier Kathleen Wynne's Mandate Letters 2017-18 to the Ministry of Health and Long-Term Care and Associate Minister of Health and Long Term Care.
- Aging with Confidence: Ontario's Action Plan for Seniors.
- Patients First: Action Plan for Health Care 2015.
- Patients First: A Roadmap to Strengthen Home and Community Care.
- Ontario's Dementia Strategy.
- Living Longer, Living Well: Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to inform a Seniors Strategy for Ontario. Dr. Samir Sinha, December 20, 2012
- Open Minds, Health Minds: Ontario's Comprehensive Mental Health and Addictions Strategy.