South West Local Health Integration Network
Board of Directors' Meeting
Tuesday July 17, 2018, 1:30 pm to 5:00 pm
South West LHIN - London Oxford Street - 356 Oxford Street West - Trillium East/West Room

AGENDA				
Item	**Agenda Item**	**Lead**	**Expected Outcome**	**Time**
1.0 COVENING THE MEETING				
1.0	**Call to Order, Recognition of Quorum**	Chair		1:30
1.1	**Approval of Agenda**	Chair	Decision	1:30-1:32
1.2	**Declaration of Conflict of Interest**			
2.0 APPROVAL OF MINUTES				
	2.1 June 26, 2018 – South West LHIN Board of Directors Meeting	Chair	Decision	1:32-1:35
	2.2 July 5, 2018 – South West LHIN Special Meeting of the Board	Chair	Decision	
3.0 PATIENT STORY/PRESENTATIONs				
	3.1 Quality Award Winners		Information	1:35-1:55
	3.2 Community Paramedicine Program	D Ladouceur	Information	1:55-2:10
4.0 APPROVAL of CONSENT AGENDA				
	Approval of Consent Agenda			2:10-2:20
	4.1 2018/19 Quarter 1 Broader Public Sector Accountability Act Attestation	CEO	Decision	
	4.2 2018/19 Quarter 1Transfer Payments, LHIN CEO Delegation of Authority Report	CEO	Information	
	4.3 April 27, 2018 Governance & Nominations Minutes	Committee Chair	Information	
	4.4 May 15 2018 Governance & Nominations Minutes	Committee Chair	Information	
	4.5 May 18, 2018 Governance & Nominations Minutes	Committee Chair	Information	
	4.6 June 28, 2018 Governance & Nominations Committee Minutes	Committee Chair	Information	
	4.7 Health Service Provider 2017/18 Q4 Report	M Brintnell	Information	
	4.8 Canadian Mental Health Association(CMHA) Elgin Update	M Brintnell	Information	
	4.9 Annual Provincial Stroke Report Card	J Fear	Information	
	4.10 Board Committee Reports	Committee Chair	Information	
	4.11 Board Director Reports	Directors	Information	
5.0 DECISION ITEMS				
	5.1 Community Support Services Base Funding Increase	M Brintnell	Decision	2:20-2:50
	5.2 Governance Policy Harmonization	Committee Chair	Decision	
	5.3 Terms of Reference Indigenous Working Group	Committee Chair	Decision	
	5.4 Board Committee Appointment	Committee Chair		
6.0 FOCUSSED DISCUSSION ITEMS				
	6.1 May 2018 Financial Update	H Anderson	Information	2:50-3:50
	6.2 Integrated Health Service Plan and Strategic Plan	S McCutcheon	Discussion	
	6.3 Sub-Region Governance Planning	R Sapsford	Discussion	
BREAK				3:50-4:00
7.0 CLOSED SESSION				
	7.1 Closed Session	Chair	Decision	4:00-5:00
8.0 FUTURE MEETINGS/EVENTS				
	South West LHIN Board of Directors Meeting, Tuesday September 25, 2018, Owen Sound Office, 1415 First Avenue West, Suite 3009, Georgian North/South Rooms			
9.0	**Adjournment**	Chair	Decision	5:00

South West LHIN Board of Directors' Meeting

Board of Directors' Meeting
Tuesday June 26, 2018
South West LHIN, Woodstock Office, 1147 Dundas Street, Community Eats/West Rooms

Minutes

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

Regrets: Lori Van Opstal, Board Chair

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

Stacey Griffin, Executive Office Coordinator (Recorder)

1.0 Call to Order – Welcome and Introductions

The Vice Chair Linda Ballantyne called the meeting to order at 1:30 pm. There was quorum and 16 members of the public, which included health service providers, were in attendance for parts of the meeting.

1.1. Approval of Agenda

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

THAT the Board of Directors' meeting agenda for June 26, 2018, be approved as presented. A closed session will be held.

CARRIED

1.2 Declaration of Conflict of Interest
No conflicts were declared

2.0 Approval of Minutes
2.1 May 3, 2018 South West LHIN Special Meeting of the Board of Directors

MOVED BY: Cynthia St John
SECONDED BY: Jean-Marc Boisvenue

THAT the May 3, 2018 South West LHIN Special Meeting of the Board of Directors' minutes be approved as presented.

CARRIED

2.2 May 15, 2018 South West LHIN Board of Directors Meeting

MOVED BY: Allan MacKay
SECONDED BY: Myrna Fisk

THAT the May 15, 2018 South West LHIN Board of Directors' meeting minutes be approved as presented.

CARRIED

3.0 Board Delegation – Community Support Services Council
The Board heard from Barry Fellinger, Chair of the South West Community Support Services Council who presented the sectors vision, mandate and current membership of the Council. A copy of the speaking notes from the presentation are attached to the minutes as an Appendix A.

4.0 Patient Story /Presentation
4.1 Patient Family Advisory Committee (PFAC)
The Patient and Family Advisory Committee PFAC was launched on October 18, 2017, the committee advises, collaborates and co-designs with the LHIN on policies, practices, strategies, planning, and delivery of patient and family centred care and was created to support the development of the LHIN Patient Engagement Plan. Two patient/family members from each integration table sit on the committee. Patient and Family Advisory Committee (PFAC) Co-Chairs, Nadia Tahir and Barb-West Bartley described their own experience journey and provided highlights of what will be different in the next year as the committee begins to implement the patient engagement plan

5.0 Approval of Consent Agenda

MOVED BY: Myrna Fisk
SECONDED BY: Jim Sheppard

THAT the consent agenda items be received and approved as circulated in the agenda package. Agenda item 5.5 Enterprise Risk Management was removed from consent and added under discussion items as agenda item 7.4.

CARRIED

6.0 Decision Items
6.1 2017/18 Audited Financial Statements of the South West LHIN

MOVED BY: **Myrna Fisk**
SECONDED BY: **Leslie Showers**

THAT the South West LHIN Board approves the Audited Financial Statements for the year ended March 31, 2018, as recommended by the Audit Committee.

CARRIED

7.0 Focused Discussion
7.1 Integrated Health Service Plan (IHSP) and Strategic Plan

The Board heard from staff that the IHSP is our collective plan that builds on the accomplishments and initiatives from previous plans and identifies new and emerging strategies that will take place over the next 3 years. The IHSP will describe the priorities, approach, strategies, and proposed outcomes for the local health system over the three year period, while reconciling the work achieved over previous IHSPs, identifying successes, gaps and opportunities for the next phase of our health system transformation journey. The Strategic Plan will guide our ongoing systems approach to improving care internally and across the system. The draft IHSP is due to the Ministry of Health and Long-Term Care by the end of October 2018 and will come forward to the October 20, 2018 Board of Directors meeting. As requested by the Board of Directors, a Request for Proposal (RFP) was developed and Optimus SBR was chosen and will guide the South West LHIN through the development of both the IHSP and Strategic Plan. A formal kickoff session was held on June 25, 2018 with the South West LHIN Leadership team.

7.2 March 2018 Financial Update

The Board was provided with a summary of changes to the projections for the current 2018/19 fiscal year and highlighted:

- As previously reported, a new funding letter had been received for $15.4M. The funding is to allocate $11.4M to expand home care services, $2.5M to increase contract rates for home care services, and $1.5M to support sustainability of community services. It is important to note that the Ministry has only committed to 60% of this funding with the remaining 40% subject to appropriation from the Ontario Legislature.
- Analysis of purchased services indicates that they continue to be impacted by the PSW staffing shortage and are trending below budget. We are currently forecasting a surplus of $6.2M due to this trend. This results in $17.6M available for home care expansion when combined with the $11.4M in additional funding noted above. Refer to the chart below for a comparison of 2017/18 actual purchased services to 2018/19 projected purchased services. This projection does not include any of the new funding. Plans will be brought forward in the coming months.
- The transfer of the special needs strategy to Ministry of Children and Youth Services has been revised, and is currently expected to be Quarter 2 of 2017/18 at the earliest.
- Compensation is currently trending above historical vacancy rates. We have accounted for a 1.4% vacancy rate in the budget. The trend is closer to 4%. If vacancy rates continue in this manner it would add approximately $2M to the surplus.
- There is not yet an indication on whether other expenses are deviating from the budgeted amounts.

7.3 Quality Committee Update

The Board heard from the Committee Chair that the Quality Committee over the next 6 to 12 month's will focus on patient relations (complaints, stories, ethics, risk management), and accreditation.
The dates of December 3 to December 6, 2018 have been confirmed for the 2018 accreditation primer survey. The South West LHIN will be surveyed by four surveyors including a patient with lived experience in the home and community care sector. The Governance Functioning Tool will be introduced to the Governance & Nominations Committee in late June with a recommendation from the Quality Committee that the tool be used to further board development work.

7.4 Enterprise Risk Management (ERM) – Board Committee Focus

The Vice Chair advised that Enterprise Risk Management was reviewed at the Quality Committee and the discussed that the Board has the final oversight of Enterprise Risk Management but discussed options of an alternate Board Committee having more oversight. The Board reviewed options and confirmed that the Audit Committee would take on the oversight role but each committee would have elements on their agenda.

MOVED BY: Myrna Fisk
SECONDED BY: Jim Sheppard

THAT the South West LHIN Board of Directors approves that in Consultation with other committees as needed that the Audit Committee will take on the Enterprise Risk Management assessment, management and oversight role and that the Audit Committee will review and revise their Committee Terms of Reference and work plan to reflect the oversight role.

CARRIED

**The Board took a short break from 3:12 pm to 3:20 pm

8.0 Closed Session

MOVED BY: Myrna Fisk
SECONDED BY: Wilf Riecker

THAT the Board of Directors move into a closed session at 3:20 pm pursuant to s. 9(5)(a)(g)(h) of the Local Health System Integration Act, 2006

CARRIED

LHIN staff member Ron Sapsford attended the session and LHIN staff member Stacey Griffin was permitted to attend for parts of the meeting and left the meeting at 3:25pm.

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

THAT the South West LHIN Board of Directors rise from closed session at 4:20 pm and returned to open session. The Vice Chair reported that the Board discussed the CEO Executive Search and were provided an update from the Interim CEO.

CARRIED

9.0 Dates and Location of Next Meeting

The next regular meeting of the South West LHIN Board of Directors Meeting will be held on Tuesday July 17, 2018, 1:00 pm to 5:00 pm, at the South Wet LHIN London office, 356 Oxford Street West, Trillium East and West Rooms

10.0 Adjournment

MOVED BY: **Wilf Riecker**
SECONDED BY: **Aniko Varpalotai**

THAT the South West LHIN Board of Directors adjourned the meeting at 4:20 pm

APPROVED: _____
Andrew Chunilall, Acting Board Chair

Date:_____

Appendix A:

SOUTHWEST COMMUNITY SUPPORT SERVICES COUNCIL
FINAL SCRIPT FOR LHIN BOARD PRESENTATION JUNE 26th 2018 1:30 p.m.

Slide 1
Good afternoon. My name is Barry Fellinger and I currently serve as Chair of the South West Community Support Services Council or CSS Council for short and as such it is my privilege to present to you on behalf of the South West CSS sector. You have already received in your board package the sector vision, mandate and current membership of the Council.

Slide 2, 3
Our presentation will follow the themes of who we are, who we are not, innovations and partnerships, our challenges, and then close with 2 key requests for your consideration as well as a brief time for questions. In spite of both historical and current human resource and financial challenges, the CSS sector proudly continues to provide support to those in need of our services and we would like to share some of those successes with you this afternoon.

Slide 4
Meet Mike ! Mike and his wife Linda's lives took a tragic turn in 2004 and 2010, when Mike suffered from a heart attack and two strokes. The incidents left him paralyzed on the left side of his body and without the ability to speak. The road to recovery was a long one, but he and Linda took the journey together. Mike writes Linda was told to just put me in a home and forget about me, that it would be the best thing for me. She refused and just hearing that made me want to fight to get better . We found a CSS agency to help us and have never looked back. They worked with me daily to help not only with my bathing and meals, they worked at the table with me helping with my speech and even writing. Due to their incredible support I've become an advocate to help others find out their possibilities and that barriers are there only to be blown out of the water. Mike is currently on the board of a CSS organization and also participates in some provincial committees. Mike is here today and has agreed to answer any questions you might have for him at the end of the presentation.

Slides 5-8
Mike is only one example of how services provided by Southwest CSS agencies keep people at home and out of institutions like Long Term Care, hospital, shelters, or correctional facilities. CSS agencies service diverse populations including younger medically fragile adults, people with disabilities, seniors, newcomers as well as individuals from the Mennonite, Indigenous, Francophone, and LGBTQ2 communities. People and their families are supported in their own homes with a wide range of services from lower intensity early interventions, be they exercise programs to assist with falls prevention, volunteer visiting, telephone checks, transportation, blood pressure clinics, accompanying people to medical appointments or higher intensity longer term supports like Assisted Living, Adult Day Programs and palliative care services.

Slides 9-10
CSS history and culture is and continues to be grounded in local communities reflecting local needs and involving individuals, families, friends and all those impacted by our services. CSS agencies are typically locally governed, rooted in local communities and have a long history of working together, collaborating across multiple sectors and developing unique solutions to address problematic situations clients and families may be facing.

Slides 11-13
The CSS sector provides supportive care to stay at home and alleviate crisis in a proactive way preventing the need for more costly health care alternatives. Through the provision of continuous support we are able to help people maintain their level of health at home. The diversity of services offered by the sector is our unique strength allowing CSS providers to tailor programs to meet the individualized needs of our clients. Additional CSS services include rehab for Acquired Brain Injury, PSW support, Volunteer Services, Meals on Wheels, and Congregate Dining to name a few.

Slides 14-16
Many CSS agencies also receive funding from other Ministries or sources like United Way. Most fund raise to keep programs running or provide client subsidy as we are one of the only healthcare services required to charge fees. Both the LHIN and our other funding sources assist our services to focus on health promotion, prevention, management of chronic illness, and overall wellbeing through addressing both physical health needs as well as the broader social determinants of health and wellness. As service providers on the front line we recognize that there would be many more crises and expensive healthcare situations without our services in place. For example some clients have been receiving services for over 40 years. People have the opportunity to live their lives the best they possibly can through the services CSS provides, supporting people to be independent, contributing members of their communities by enabling them to remain well, and at home, through empowerment and by supporting wellness and self-management ; thereby avoiding high-priced, potentially inappropriate, crisis-driven healthcare services. The reality is that CSS has been doing Patients First for a long time.

Slide 17
WHO WE ARE NOT: Often, particularly with the general public and sometimes even other providers, there is confusion about the distinction between Community Support Services and the former CCAC /Homecare or now LHIN Home and Community Care services. CSS agencies do regularly receive referrals from Care Coordinators and partner with Home and Community Care on behalf of mutual clients.

However this chart provides a brief overview of some of the major differences between the two. Unlike LHIN Home Care, CSS is not a clinical brokerage model, CSS agencies use their own volunteers or paid staff to provide all services and where there is no expectation of fund raising for Home Care, there is that expectation for CSS.

One common misunderstanding is that new funding investments to Home and Community Care also means funding increases to CSS budgets. As I am sure you are aware this is not accurate, as Community Support Services and Home and Community Care are two distinct sectors.

Slide 18-19
We would also like to share with you about some of our current Innovations and Partnerships. One of the recommendations coming out of the LHIN"s Access to Care work was a flex fund, which is administered by the CSS Council. $227,250 is provided each year by the LHIN to address financial challenges individuals may be experiencing thus allowing them to stay healthy and well in their own homes rather than having to move to more expensive parts of the health care system like Long Term Care.

Slide 20
Last year the entire fund was used and approvals included installation of ceiling lift tracks, hospital beds, interim PSW transition support to a range of others that kept people living healthy and safely in their homes. As an example of this good work, in the information you received in your board package is the account of a woman of 84 years, one of many people, who have benefited from the fund.

CSS agencies are active partners in their communities, participating in the Lead Agency centralized access initiative, Health Links and other community tables continuing to educate and inform Primary Care and partners both within and outside of the Health Care system about what CSS can provide to patients and clients, consistently complementing and partnering with primary care and other providers.

Slide 21
The CSS Sector does face some major challenges so we are going to take a few moments to elaborate on those.

Slide 22-26
Volunteers play an important role, as Board members, but also as fundraisers and for many agencies through their time in direct service provision in meals on wheels, volunteer visiting, transportation services and so on. LHIN wide the value of volunteer support amounts to over $ 5 million annually. The challenge is that we now have an aging population of volunteers and it is becoming increasingly difficult to recruit new ones. While our agencies are thankful for our volunteers and the generous gift of time and effort they bring, continuing to rely on them in order to keep programs running rather than using paid staff is not viable in the long term.

The same is true of fund raising. Across our LHIN CSS fund raises over 4 million to help provide necessary services, but this is also not endlessly sustainable. Competition for fund raising dollars is extensive and fund raising takes a massive amount of staff time and effort - time that would be better spent in direct service rather than trying to secure donors to keep programs or buildings running. Fund raising, while helpful for one time projects or capital expenses, is not the best approach to fund salaries, benefits, and regular operating expenses. While every fund raised dollar helps it is clearly not the ideal way to secure annualized funding for such an integral part of the healthcare system. Combining fund raising and volunteer hours totals over $9 million which translates into a large array of services provided by CSS agencies across our LHIN.

Slide 27-30
CSS agencies deal with both financial and human resource challenges due to working with limited salary and benefit dollars, which also seriously impacts the ability to recruit and retain staff. Low wages often result in good staff moving on to higher paying positions in other better funded health care sectors. CSS is unable to compete with offers of greater salaries, benefits and even pensions- which are sometimes totally lacking in CSS agencies, and importantly equitable pay which CSS is unable to offer compared to other healthcare organizations.

The CSS sector is also challenged and constrained by decisions that are made at higher levels both Ministry and legislatively driven. The PSW wage increase while long overdue threw off internal equity for many agencies; in some cases the wage enhancement resulted in PSWs

making higher wages than their supervisors, with those agencies having to address this wage compression out of their existing funding.

Legislative changes such as Pay Equity and more recently Bill 148 can significantly affect non-profit organizations and often the only way to offset those financial impacts is to reallocate funds within existing dollars since we are required to have balanced budgets. CSS agencies are creative and do adjust to compensate but that can have ramifications for our clients. For example raising the cost of Meals on Wheels or mileage costs for transportation can be done, but we are supporting what is often a vulnerable population on fixed incomes and some of these financial decisions could result in serious consequences for our clients, setting up more barriers for them instead of less. Although we have managed, the reality is that in some cases services have been eroded or are being diminished and the support that people need to stay at home is being undermined.

Slides 31-38

The sector very much appreciated the 1% base budget increase received 7 years ago in 2011 from this LHIN. However operating costs continue to escalate: rent, transportation, utilities, insurance, equipment, IT, union contracts, to list a few. This does not come without an impact, to staff, to services, and unfortunately to clients.

Seven years later we are still doing our best to support our clients with limited resources and maximum effort, but it comes with a cost and a toll. Repeatedly moving budget lines every year to compensate for rising operating costs in order to achieve balanced budgets is a constant and growing challenge. Very soon this will no longer be possible and more agencies will have to declare deficits at year end.

What we need are base budget increases to operating and salary and benefit lines to cover the cost of doing business and to assist with staff recruitment and retention to meet the growing demand of individuals who require CSS services in order to live healthy and well in their own homes with necessary supports.

Some CSS agencies struggling to provide services to meet their mandate and their MSAAs already reduce targets and add to wait lists as they do not have the capacity take on any new clients. Over time this has translated into an incremental reduction of services due to budgets that do not reflect current costs.

One agency for example has 500 people on their wait list. Some are now laying off staff, cutting services and reducing training to all but that which is mandatory and legislated. If the current state continues CSS organizations will not be able to keep pace and the alternatives for those in need may be LTC, waiting in ALC beds in hospitals or repeatedly showing up in Emergency rooms in crisis, all of which have a more costly impact on the healthcare system.

We would point out that Home and Community Care, hospitals and Long Term Care sectors have all received some level of budget increases over the last seven years while CSS, a crucial partner providing backbone support to the health care system, has not experienced the same benefit. We believe a significant base budget increase is necessary to stabilize our sector, maintain and expand service levels and service quality, enabling CSS to continue to meet the growing demand for the services we provide as a vital partner in the health care system.

Slide 39
This summarizes a number of the very real and worrisome challenges CSS agencies face on a regular basis. Now let me introduce you to someone who has benefited from the work of a CSS organization but who also knows very well what her life would like without that support.

Slide 40
Angie Ryan seen here, has given us permission to use her name and her story to answer these two questions: If not us then who? If no CSS then what? She was a nurse but her disability, Frederick's ataxia so affected her life that at one point she was in a long term care facility in a locked ward because it was thought to be the only place that could provide the level of personal support she needed. That is not the case now however :

Speaking of the CSS agency from whom she now receives support, Angie writes I am grateful that I have them and for their outreach community support program because this has allowed me to live independently in my own home, allowing me to give back to my community. They support me with all of my daily living needs. Plus they have an "on call"service during the day and at night. Without this support I believe I would be living in a Nursing Home.(I'm involved with my community by being part of the agency's Comsumer Advisory Council and my church's Parish Pastrol Council).

CSS agencies do not hesitate to challenge the status quo, pride ourselves on being innovative and courageous, seeking out the best client-centred solutions and options for those we serve with respect, integrity and compassion.

Thinking about Angie's story and what her life may have looked like without CSS support provides some perspective on the questions, If not us then Who? If no CSS, then What? What will happen to the individuals currently receiving and all the people waiting for services if CSS agencies are no longer sustainable because budgets cannot keep pace with rising costs and good staff keep moving to higher paid positions elsewhere? What kind of crises will we see in the community beyond what we are already seeing? These are questions our sector is constantly asking itself and we are not convinced we like the answers.

CSS is proud of our record of supporting people and we would like to continue to offer that moving forward-but without significant annualized financial investment to the sector we are not sure what that may look like. With the right resources in place on an ongoing basis CSS agencies can continue to be part of the solution within the health care system- If not us then who? Like Angie, we would rather not find out

Slide 41
We have 2 requests for you to consider as we leave you today, we simply ask that the LHIN be courageous, innovative and compassionate in your decisions and responses related to these asks.

#1 On behalf of the sector we would request that serious consideration be given to providing sustainability funding to stabilize the sector through at minimum, a 5% base budget increase, not only a targeted increase, for new units of service. Since costs have gone up over 7% due to inflation over the past five years this is essential for the sector to continue to thrive and function in our expected role as a key partner in the healthcare system . We ask that this base budget increase be fair and equitable to the sector across the board and be followed with annualized increases in line with inflation. It is worth noting that in support of health sector transformation and Patients First, agencies have taken on additional programs and services but in most cases with no accompanying increase to administrative budgets.

We also ask that every time the Home and Community Care sector receives a funding investment, CSS organizations as equitable and essential partners in the healthcare system should also receive a fair and equitable funding allocation.

#2 Secondly, after hearing our presentation, and especially the stories and seeing the faces of those who have received and benefited from the types of services CSS agencies provide, keeping them healthy and safe in their own homes mitigating the use of more costly healthcare system alternatives we ask that thoughtful reflection be given to the questions-if not us then who? If no CSS then what? In light of those questions we would ask that the SW LHIN through its continued support enable the CSS sector to stabilize, grow and meet the current, ongoing and future demand of people requiring the diversity of community support services that will keep them healthy, well and safe at home and in their communities.

Slide 42
Thank you in advance for your consideration of these two asks.

Slide 43-44
Thank you again for this opportunity to present to you on Community Support Services this afternoon. We trust you found it informative, inspirational, and thought-provoking. And we now have some time to respond to questions.

South West LHIN Board of Directors' Meeting

Special Meeting of the Board of Directors
Thursday July 5, 2018 Teleconference

Minutes

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

Regrets: Myrna Fisk, Board Director
Leslie Showers, Board Director
Lori Van Opstal, Board Chair

Staff: Ron Sapsford, Interim Chief Executive Officer
Stacey Griffin, Executive Office Coordinator (Recorder)

1.0 Call to Order – Welcome and Introductions

The Acting Board Chair called the meeting held by teleconference to order at 8:00 am. There was quorum and no members of the public were in attendance for the meeting.

1.1. Approval of Agenda

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

THAT the Board of Directors' meeting agenda for July 5, 2018, be approved as presented. A closed session will be held

CARRIED

1.2 Declaration of Conflict of Interest

No conflicts were declared

2.0 Moving into Closed Session

MOVED BY: Jean-Marc Boisvenue
SECONDED BY: Cynthia St. John

THAT the Board of Directors move into a closed session at 5:03pm pursuant to s. 9(5)(a)(g)(h) of the Local Health System Integration Act, 2006

CARRIED

LHIN staff members Ron Sapsford and Stacey Griffin were permitted to attend for parts of the meeting.

MOVED BY: Allan Mackay
SECONDED BY: Wilf Riecker

THAT the South West LHIN Board of Directors rise from closed session at 8:25 am and returned to open session.

CARRIED

3.0 Report in Open Session

The Acting Board Chair reported in open session that the South West LHIN Board of Directors reviewed and approved the Board CEO Search Committee Terms of Reference as circulated, including the Search Committee membership. Ron Sapsford, Interim CEO provided an update on discussions related to retaining an Executive Search Firm to assist the Board CEO Search Committee.

4.0 Dates and Location of Next Meeting

The next South West LHIN Board of Directors Meeting will be held on July 17, 2018, from 1:30 pm to 5:00 pm at the South West LHIN, 356 Oxford Street West, London – Trillium Rooms East and West

5.0 Adjournment

MOVED BY: Glenn Forrest
SECONDED BY: Jim Sheppard

THAT the South West LHIN Board of Directors meeting adjourn at 8:27 am.

APPROVED: _____
Andrew Chunilall, Acting Board Chair

Date:_____

Report to the Board of Directors

South West LHIN Quality Award Winners

Meeting Date: **July 17, 2018**

Submitted By: **Andrew Chunilall, Acting Board Chair**

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

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

On May 14, 2018 the South West LHIN cancelled the Quality Symposium, scheduled for May 31, 2018, as it fell within the writ of election period. As a result, we did not present the Quality Awards to the two winners: South West Health Links for the Large Project, and Canadian Mental Health Association (CMHA) Middlesex for the Small/Medium Project

The Quality Awards program was first introduced in 2011 to recognize health system partners that achieve performance excellence through a sustainable quality improvement initiative. To be eligible for an award, initiatives must demonstrate sustainable system change and involve two or more organizations or agencies, at least one of which is LHIN-funded.

The Large Project award is typically for LHIN-wide initiatives with greater complexity, involving multiple stakeholders and are usually funded projects. The Small/Medium Project award is for smaller quality improvement projects that address local problems, involve fewer stakeholders and are often carried out with the resources of the participating organizations.

Large Project Award – South West Health Links Approach to Coordinated Care Planning

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

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

Small/Medium Project Award – CMHA Middlesex's Improving Access to Mental Health Services

Seeking treatment is often a big step for someone dealing with a mental health problem. However, access to services often starts with an assessment, followed by a long wait. This project aimed to decrease avoidable wait times to case management services in London offered through CMHA Middlesex to service initiation (this includes referral to assessment and assessment to service initiation) to under 14 days. This project reduced wait times for service, improved the client experience and ensured continuity of care.

Agenda item 4.1

Report to the Board of Directors

2018/19 Quarter 1 Broader Public Sector Accountability Act Attestation

Meeting Date:	**July 17, 2018**
Submitted By:	**Ron Sapsford, Interim Chief Executive Officer**
Submitted To:	☒ **Board of Directors** ☐ **Board Committee**
Purpose:	☐ **Information Only** ☒ **Decision**

ATTESTATION
Prepared in accordance with section 14 of the *Broader Public Sector Accountability Act, 2010* (BPSAA)

TO: **South West LHIN Board**
FROM: **Ron Sapsford, Interim CEO**
Date: **July 17, 2018**
RE: **2018/19, Quarter 1, April 1, 2018 to June 30, 2018**

On behalf of the **South West LHIN** I attest to:

- the completion and accuracy of reports required of the LHIN, pursuant to section 5 of the BPSAA, on the use of consultants;
- the LHIN's compliance with the prohibition, in section 4 of the BPSAA, on engaging lobbyist services using public funds;
- the LHIN's compliance with all of its obligations under applicable directives issued by the Management Board of Cabinet;
- the LHIN's compliance with its obligations under the Memorandum of Understanding with the Ministry of Health and Long-Term Care; and
- the LHIN's compliance with its obligations under the Ministry LHIN Accountability Agreement/Ministry LHIN Performance Agreement in effect,

during the Applicable Period.

In making this attestation, I have exercised care and diligence that would reasonably be expected of a Chief Executive Officer in these circumstances, including making due inquiries of LHIN staff that have knowledge of these matters.

I further certify that any material exceptions to this attestation are documented in the attached

Schedule A.

Dated at London, Ontario this July 17, 2018

Ron Sapsford, Interim CEO, South West Local Health Integration Network

I certify that this attestation has been approved by the Board of the **South West LHIN** on July 17, 2018

Andrew Chunilall, Acting Board Chair, South West Local Health Integration Network

ATTESTATION

Prepared in accordance with section 14 of the *Broader Public Sector Accountability Act, 2010* (BPSAA)

SCHEDULE A
South West Local Health Integration Network

For the Applicable Period: 2018/19, Quarter 1, April 1, 2018 to June 30, 2018

1. MEMORANDUM OF UNDERSTANDING

Non-Compliance.

The LHIN has determined that the terms and conditions on which all fourteen LHINs acquired insurance breach the LHINs' obligations under LHSIA, the Financial Administration Act, the MOU and possibly the MLAA. In the context of Bill 41, P*atients First Act 2016*, receiving Royal Assent, which will significantly impact the LHIN's insurance needs, the LHIN is maintaining the status quo and, when appropriate will take such steps as may be agreed among the all fourteen LHINs and the Crown in regard to this matter.

2. MINISTRY LHIN ACCOUNTABILITY AGREEMENT/MINISTRY LHIN PERFORMANCE AGREEMENT
   - No known exceptions

3. COMPLETION AND ACCURACY OF REPORTS REQUIRED PURSUANT TO SECTION 5 OF THE BPSAA
   - No known exceptions

4. PROHIBITION ON ENGAGING LOBBYIST SERVICES USING PUBLIC FUNDS PURSUANT TO SECTION
   - No known exceptions

5. COMPLIANCE WITH APPLICABLE DIRECTIVES ISSUED BY MANAGEMENT BOARD OF CABINET
   a. OPS PROCUREMENT DIRECTIVE
      - ONE (1) known exception: Board of Directors use of a consultant <$3000 to provide corporate governance advisory services related to CEO succession planning; single-sourced.

   b. OPS TRAVEL, MEAL AND HOSPITALITY EXPENSES DIRECTIVE
      - No known exceptions

   c. OPS PERQUISITES DIRECTIVE
      - No known exceptions

Report to the Board of Directors

South West LHIN CEO Delegation of Authority – Transfer Payments 2018/19 Quarter 1 Report

Meeting Date: **July 17, 2018**

Submitted By: **Ron Sapsford, Interim Chief Executive Officer**

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

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

Purpose

The purpose of this report is to provide an update on 2018/19 Quarter 1 (April 1, 2018 to June 30, 2018) approvals triggered by the CEO through the South West LHIN Delegation of Authority for Funding, Accountability Agreements, and Routine Reports policy. *The South West LHIN Co-CEO's exercised delegation provisions on the items noted below.*

Item	Item Description	Health Service Provider	Funding B=Base OT=One-Time
	NIL Report		
Funding is for 2018/19 unless otherwise indicated above.			

South West LHIN Governance & Nominations Committee
Friday, April 27, 2018, 9:00 am to 12:00 pm
South West LHIN, 201 Queens Ave, Suite 700, Main Boardroom, London

Minutes

Approved – June 28, 2018

Present: Cynthia St. John, Committee Co-Chair and Board Director
Aniko Varpalotai, Committee Co-Chair and Board Director
Jean-Marc Boisvenue, Board Director
Andrew Chunilall, Acting Board Chair *(arrived at 10:30 am)*
Wilf Riecker, Board Director
Leslie Showers, Board Director

Guests: Linda Ballantyne, Vice Chair
Myrna Fisk, Board Director
Glenn Forrest, Board Director *(by teleconference)*
Allan MacKay, Board Director *(by teleconference)*
Jim Sheppard, Board Director *(by teleconference*)
Lori Van Opstal, Board Chair *(by teleconference)*

Staff: 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 London Downtown Office at 9 am on Friday April 27, 2018.

The meeting was called to order at 9:00 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: Leslie Showers
SECONDED BY: Wilf Riecker

THAT the Governance & Nominations Committee meeting agenda for April 27 2018, be approved as presented. A closed session will be held.

CARRIED

4. Closed Session

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

THAT the Governance & Nominations Committee move into a closed session at 9:00 am pursuant to s. 9(5)(a)(g)and (h) of the *Local Health System Integration Act, 2006.*

CARRIED

LHIN staff members Stacey Griffin and Marilyn Robbins left the meeting at 9:01 am.

MOVED BY: Leslie Showers
SECONDED BY: Wilf Riecker

THAT the Governance & Nominations Committee rise from closed session at 12:14 pm and return to open session. The Governance & Nominations Committee Co-Chairs reported that the Committee discussed governance matters.

CARRIED

5. Approval of Minutes
Review of the February 27, 2018 meeting minutes was deferred to the next committee meeting.

6. Board Advancement Workshops – Next Steps
Item was deferred to next committee meeting.

7. Update: Sub-region Board-to-Board Reference Groups
Item was deferred to next committee meeting.

8. Indigenous Work Group
Item was deferred to next committee meeting.

9. Appointment to Board Committees
Item was deferred to next committee meeting.

10. Governance Policy Review & Recommendations
Item was deferred to next committee meeting.

11. Adjournment

MOVED BY: Wilf Riecker
SECONDED BY: Leslie Showers

THAT the Governance & Nominations Committee adjourn at 12:15 pm.

CARRIED

APPROVED: _____
Aniko Varpalotai, Co-Chair
Governance & Nominations Committee

DATE: _____

South West LHIN Governance & Nominations Committee
Tuesday, May 15, 2018, 10:30 am to 11:50 am
South West LHIN, 201 Queens Ave, Suite 700, Main Boardroom, London

Minutes

Approved – June 28, 2018

Present: Cynthia St. John, Committee Co-Chair and Board Director
Aniko Varpalotai, Committee Co-Chair and Board Director
Jean-Marc Boisvenue, Board Director
Andrew Chunilall, Acting Board Chair
Wilf Riecker, Board Director
Leslie Showers, Board Director

Guests: Linda Ballantyne, Vice Chair
Myrna Fisk, Board Director
Jim Sheppard, Board Director
Lori Van Opstal, Board Chair

Staff: 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 London Downtown Office at 10:30 am on Tuesday, May 15, 2018.

The meeting was called to order at 10:30 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: Jean-Marc Boisvenue
SECONDED BY: Leslie Showers

THAT the Governance & Nominations Committee meeting agenda for May 15 2018, be approved as presented. A closed session will be held.

CARRIED

4. Approval of Minutes

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

THAT the minutes of the February 27, 2018 meeting of the Governance & Nominations Committee be approved as presented.

CARRIED

5. Closed Session

MOVED BY: Wilf Riecker
SECONDED BY: Leslie Showers

THAT the Governance & Nominations Committee move into a closed session at 10:35 am pursuant to s. 9(5)(a) and (g) of the *Local Health System Integration Act, 2006.*

CARRIED

LHIN staff members Stacey Griffin and Marilyn Robbins left the meeting at 10:35 am.

MOVED BY: Wilf Riecker
SECONDED BY: Leslie Showers

THAT the South West LHIN Governance & Nominations Committee of the Board rise from closed session at 11:50 am and return to open session. The Governance & Nominations Committee Co-Chairs reported that the Committee discussed governance matters in closed session.

CARRIED

6. Adjournment

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

THAT the Governance & Nominations Committee adjourn at 11:52 am.

CARRIED

APPROVED: _____
Aniko Varpalotai, Co-Chair
Governance & Nominations Committee

DATE: _____

South West LHIN Governance & Nominations Committee
Friday, May 18, 2018, 4 to 5 pm
Teleconference

Minutes
Approved – June 28, 2018

Present: Cynthia St. John, Committee Co-Chair and Board Director
Aniko Varpalotai, Committee Co-Chair and Board Director
Jean-Marc Boisvenue, Board Director
Wilf Riecker, Board Director
Leslie Showers, Board Director

Regrets: Andrew Chunilall, Acting Board Chair

Staff: 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 via teleconference on Friday, May 18, 2018.

The meeting was called to order at 4 pm. 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
The only item of business was the planning of an urgent board governance retreat.

4. Board Governance Retreat Planning
Committee Co-Chair, Cynthia St. John introduced the discussion by re-capping the direction given at Tuesday's board meeting for the Governance & Nominations Committee to arrange for a board retreat/development day considering urgency, availability, facilitation services, and procurement processes.

Committee Co-Chair, Aniko Varpalotai reported that following the May 15 board meeting, she and Cynthia contacted Lyn McDonell who had been contracted for some board development work in April that was cancelled. After providing Lyn with the background on current issues and the work recently undertaken with Dr. Richard Leblanc it was suggested that the board contract both Lyn and Richard

for the upcoming retreat as they have complementary skills and styles. Aniko and Cynthia have confirmed that Richard and Lyn are willing to work together to develop and deliver the board retreat and that both are available on May 31, a date suggested due to the cancellation of the Quality Symposium. Richard would focus on the process piece related to governance policies and practices, while Lyn would focus on relationship building and trust. It was noted that both have some familiarity with the board and have warranted and/or provided signed confidentiality agreements.

Committee members responded with their overall support for the proposed approach outlined by the Committee Co-Chairs.

ACTION: Committee Co-Chairs to get a proposal from Lyn and/or Richard for the one-day retreat.

ACTION: Stacey Griffin to connect with finance staff for instruction on properly procuring Lyn and Richard's services.

5. Adjournment

The meeting adjourned at 5 pm. The next regular meeting is scheduled for Thursday June 28, 2018 at 9:00 am.

APPROVED: _____

Aniko Varpalotai, Co-Chair
Governance & Nominations Committee

DATE: _____

South West LHIN
Governance & Nominations Committee
Thursday, June 28, 2018

Minutes
DRAFT

Present: Cynthia St. John, Committee Co-Chair and Board Director
Aniko Varpalotai, Committee Co-Chair and Board Director
Jean-Marc Boisvenue, Board Director
Andrew Chunilall, Acting Board Chair
Wilf Riecker, Board Director
Leslie Showers, Board Director

Guests: Linda Ballantyne, Board Director
Myrna Fisk, Board Director

Staff: Ron Sapsford, Interim CEO
Hilary Anderson, Vice President, Corporate Services
Mark Brintnell, Vice President, Quality, Performance and Accountability
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 Thursday, June 28, 2018.

Committee Co-Chair, Aniko Varpalotai called the meeting to order at 9:04 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
In reviewing the draft agenda, Committee Co-Chair, Aniko Varpalotai noted the following…

- Enterprise Risk Management to be added to the list of education session topics to be considered under *Item 5 Board Education/Development;*
- Members for the CEO Search Committee will be proposed for recommendation to the Board under *Item 6 CEO Search Committee Terms of Reference; and*
- Next steps for board meeting evaluations and board monitor reports will be considered under *Item 10 Accreditation – Governance Committee Role*.

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

TO adopt the agenda for the June 28, 2018 meeting of the Governance and Nominations Committee.

CARRIED

4. Approval of Minutes

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

THAT the minutes of the April 27, May 15, and May 18, 2018 meetings of the South West LHIN Governance & Nominations Committee be approved as circulated.

CARRIED

5. Board Education/Development

Retreat Debrief

Committee Co-Chair, Aniko Varpalotai instructed that this debrief will be restricted to policy-related discussion. Members were invited to request a closed session for any other discussion related to the retreat. Aniko reported that the retreat facilitator, Lyn McDonell has suggested a follow-up session be scheduled in 3 to 5 months and will be checking-in with the Governance & Nominations Committee Co-Chairs.

ACTIONS: The following action items were agreed to…

1) Establish a CEO Search Committee Terms of Reference
2) Governance policy work…
    - create a leave of absence policy for the board chair position
    - review and enhance the board's code of conduct policy
    - review of conflict of interest and confidentiality policies
    - review/revision of position descriptions for board chair, vice chair(s), and committee chairs
    - review the CEO succession policy
    - review Terms of Reference for CEO Performance Review Task Force
    - consider a policy on non-member attendance at board committee meetings
3) Retreat follow-up with Lyn and review of evaluation work to date.

Education Session (generative topics)

Interim CEO, Ron Sapsford asked the committee about board meeting time spent on education versus generative and described his view of generative discussion and how generative could be structured and supported. He suggested the following topics as examples for generative - statutory role of the LHIN and accountability (freedoms/restrictions), Ministry relationships – how to view your role in relation to Toronto and also to the citizens of the South West, sub-regions, London Health Sciences Centre (LHSC), teaching hospitals.

The group considered the board's typical agendas and reflected on recent meetings, and discussed how to ensure a generative component along with their strategic and fiduciary responsibilities.

It was agreed that a refresh on how to have a generative discussion would be helpful to the board and to survey board members on topics of interest. Ron emphasized that the topics need to be owned and prioritized by the board, not staff.

6. CEO Search Committee Terms of Reference

The committee reviewed the draft Terms of Reference for a CEO Search Committee as included in the meeting materials and requested the following amendments…

- Under *Conflicts of Interest* include that board directors and/or search committee members will not initiate contact with any candidate(s) and in turn if contacted by any candidate(s) board directors and/or search committee members will refer the candidate(s) to the committee chair and/or the executive search firm. To this point, Interim CEO, Ron Sapsford reported that he won't participate in any dialogue with candidates and will instead refer them to the executive search firm.

- Clarify references to the Committee Chair as opposed to Chair throughout the document.

- Under *Mandate* include that at such time the board by motion selects a finalist candidate that the CEO Search Committee resumes their work with the executive search firm to conduct hiring negotiations with the selected candidate.

The committee considered the negotiation process with Ron suggesting that the CEO Search Committee would provide its position to the executive search firm to handle the negotiations. The CEO Search Committee's position would be based on parameters confirmed by the board. It was noted that the CEO Compensation Framework for all LHINs is still draft and that staff would be available to prepare some guidelines/parameters for the hiring negotiation position. It was also suggested that all reference checks be completed before recommending finalist candidates for the board's consideration and that all board members receive a package comprised of the candidates resumes and the committee's search/selection materials. It was agreed that the CEO Search Committee would make a recommendation to the board on the key elements of the employment contract for a new CEO apart from their recommendation of a finalist candidate.

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

THAT the Terms of Reference for a Chief Executive Officer (CEO) Search Committee be recommended in principle with the amended version to follow for review prior to submitting to the South West LHIN Board of Directors for consideration/approval.

CARRIED

Committee Membership

The Governance & Nominations Committee Co-Chairs proposed a slate of members for the CEO Search Committee to be recommended to the board noting their consideration of diversity, experience, and skills. The co-chairs confirmed that each of those recommended has agreed to stand for appointment

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

THAT Andrew Chunilall, Myrna Fisk, Cynthia St. John, Wilf Riecker, Glenn Forrest, and Jim Sheppard be recommended to the South West LHIN Board of Directors for appointment to the CEO Search Committee.

CARRIED

Executive Search Firm

The group discussed next steps to confirm an executive search firm considering the merits and challenges of continuing with the previously contracted firm versus securing a new firm. Procurement policy requirements were noted. It was agreed to continue this discussion with the full board of directors.

7. Sub-region Board-to-Board Reference Groups

Leslie Showers, Board Member and Chair of the South West LHIN Board-to-Board Reference Group introduced discussion on the initiative to establish Sub-region Board-to-Board Reference Groups and the board's vision for sub-region development and service delivery. Leslie provided a brief overview of the work to date speaking to sub-region purpose, Sub-region Integration Tables (SRITs), the patient journey, the role of governors in providing advisory support for sub-region improvement, recruitment efforts and results to date. Leslie reported on discussions held with the South West LHIN Board-to-Board Reference Group about the merits and challenges of establishing sub-region groups and the on-going struggle to clearly articulate the role, purpose, and process. Proposed next steps involve establishing teams to conduct ½ hour teleconference interviews with each of the applicants for the Grey Bruce, Huron Perth, and London Middlesex sub-regions. The goal is to bring a membership recommendation to the board in the fall for those groups to launch in November. Additional interest is being sought from the Elgin and Oxford sub-regions before proceeding with interviews.

Leslie asked the group to respond as far as their understanding of and feelings about the sub-region initiative as it's essential to its success that the LHIN Board understands and participates in the vision.

Comments included…

- Governors/applicants are busy and want to come together for the purpose of making real change. They are seeking serious influence, and decision-making authority is desired.
- We need brave people to enhance the system. We need to be firmly planted in this to push organizations to change.

- This is an important discussion for the board. What is our LHINs mandate for sub-regions? Where are the SRITs at? Are we an example for integration? Does the new government have the same focus on sub-regions?
- Patients and their families need an integrated system or at least some alignment in decision-making from organization to organization.
- Is there confusion between these groups and the SRITs? Would it be more efficient to have some board members at the SRITs?
- We need to be clear on what we envision.
- HSPs are struggling to find board members.
- The goal is to achieve better connectivity and networking of HSP boards throughout the LHIN to provide for the exchange of improvement ideas.
- What is our intent for these groups? Are we considering decentralizing some of the decision-making?
- Should we revisit the South West LHIN Board-to-Board Reference Group as it currently exists?
- If not enough interest for a group in each sub-region maybe five is too many.
- The board needs to be crystal clear as to the goal – is it a network? Is it about how decisions are made at the sub-region level? To advise or to govern?
- We need to remember that individual board members have fiduciary responsibilities first to their respective health service provider or partner organization.

ACTION: The July 17 meeting of the South West LHIN Board of Directors will include a generative discussion on sub-regions.

8. Indigenous Community Engagement

Aniko Varpalotai, Governance & Nominations Committee Co-Chair introduced discussion on the board's role in addressing Indigenous health issues, the board's relationship challenges with the Indigenous communities, and related outstanding items. Aniko reported that the draft Terms of Reference for an Indigenous Work Group included in the meeting materials were developed as a means to get traction on these items.

The group discussed the role of the Chiefs and of the Indigenous Health Committee. They considered the LHIN's relationship to each along with the role of the board and of the proposed work group. It was agreed to amend the draft terms of reference to have the work group link to other board committees as appropriate rather than the Quality Committee exclusively. It was also agreed to evaluate the effectiveness of the work group after one year.

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

To recommend that the South West LHIN Board of Directors approve the Terms of Reference for an Indigenous Work Group as amended.

CARRIED

9. Policy Review & Recommendations

Cynthia St. John, Governance & Nominations Committee Co-Chair led the committee's review of the following board governance policies…

A-10 Reimbursement of Expenses
E-1 Risk Management
E-2 Asset Protection
E-4 Operating/Business Plan
E-5 Financial Condition
NEW: Monitoring of Financial Indicators
E-6 Delegation of Authority for Funding, Accountability Agreements, Plans and Routine Reports
NEW: LHIN Board Treasurer – Role Description
A-4d LHIN Board Secretary – Role Description
D-1 Board Spokespeople & Media

ACTIONS:

1. The following policies to be forwarded to the Audit Committee for input prior to being further considered for recommendation to the Board.
   A-10 Reimbursement of Expenses
   E-1 Risk Management
   E-2 Asset Protection
   E-5 Financial Condition
   NEW: Monitoring of Financial Indicators
   NEW: LHIN Board Treasurer – Role Description

2. Governance Policy *E-6 Delegation of Authority for Funding, Accountability Agreements, Plans and Routine Reports* to be deleted from the *Governance Policy Manual* in view of the operation's extensive *Delegation of Authority Policy* approved by the Board on October 18, 2017and available on the Board Portal for reference.

No changes were recommended after reviewing *A-4d LHIN Board Secretary – Role Description.*

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

TO recommend to the South West LHIN Board of Directors that Governance Policies *E-4 Operating/Business Plan* and *D-1 Board Spokespeople & Media* be amended as attached.

CARRIED

Hilary Anderson, Ron Sapsford, and Andrew Chunilall departed the meeting.

10. Accreditation – Governance Committee Role

Mark Brintnell, Vice President, Quality, Performance and Accountability provided a brief overview of the accreditation process and plans for surveyors to be onsite in December to review survey results and to look at what the board is doing to address gaps and issues.

Accreditation Canada's *Governance Functioning Tool* was included in the meeting materials. While the Quality Committee is driving the accreditation process on behalf of the board it was agreed that the Governance & Nominations Committee would be responsible for the completion of this optional tool recognizing the opportunity for the results to inform plans for board development and education, and it's potential to support on-going evaluation and monitoring of board performance.

Mark confirmed that staff will administer the survey and have access to the results. He proposed that the tool be completed in September with the results summary to be shared with the committee for an action plan to be developed for the board's consideration.

MOVED BY: Leslie Showers
SECONDED BY: Wilf Riecker

TO administer Accreditation Canada's *Governance Functioning Tool* in September 2018 with each board member completing the survey, and the committee developing an action plan based on the results summary for consideration by the board in both meeting accreditation requirements and board performance going forward.

CARRIED

Evaluation

Aniko Varpalotai, Governance & Nominations Committee Co-Chair reported that the board meeting monitor role was suspended at the last meeting but that the paper-based meeting evaluations have continued. The committee was asked to consider how they wish to proceed with evaluations.

Comments included…

- Need to focus on meeting achievements rather than logistics. For example, did we engage all board members in discussion? Did we have generative? Did we advance our position? Evolve the general process.
- Support for a more thorough survey monkey evaluation after each meeting and measurable over time.
- The pan-LHIN evaluation administered by Deloitte is not happening this year. Many LHINs are using the Accreditation Canada process so perhaps there is an opportunity for LHIN Board and CEO leadership to support this approach going forward. May require an alternative to Deloitte's peer review process.

Mark offered staff support in developing meeting evaluations that connect to the *Governance Functioning Tool*. It was suggested that the monthly meeting evaluations include open-ended questions along with questions measurable over time, and that the evaluation summaries should be reviewed and discussed.

ACTION: Quality, Performance & Accountability staff to develop new board meeting evaluations. Monitor reporting will be suspended until further notice.

11. Appointment to Committees – Jim Sheppard

MOVED BY: Wilf Riecker
SECONDED BY: Leslie Showers

TO recommend to the South West LHIN Board of Directors the appointment of Jim Sheppard to the Audit Committee and the Quality Committee effective immediately.

CARRIED

12. Adjournment

The meeting adjourned at 11:53 am. The next meeting is scheduled for Friday, September 28 at 9 am.

APPROVED: _____
Aniko Varpalotai, Co-Chair
Governance & Nominations Committee

DATE: _____

Title: **Operating/Business Plan**	Policy Number: E-4
Approved: January 25, 2012 Approved: May 19, 2015 Pending: July 17, 2018	Revised: November 2011 Reviewed: November 27, 2013 Revised: April 21, 2015 Reviewed: June 28, 2018

An Annual Business Plan (ABP) will be approved by the board for submission to the Ministry of Health and Long-Term Care as required by Ministry directives.

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 ~~Performance~~ Accountability Agreement (~~MPLA~~MLAA), in addition to government directives such as the Agency Establishment and Accountability Directive (AEAD).
- AEAD requires all agencies to produce a business plan annually that includes the organization's mandate, strategic directions, current and future programs, resources required, risk assessment and mitigation strategies, environmental scan, staff numbers and compensation, performance measures and 3 year targets, financial budget over 3 years, implementation plan and communication plan.
- LHSIA requires LHINs to produce an annual "plan for spending the funding that the network receives…., which spending shall be in accordance with the appropriation from which the Minister has provided the funding to the network" (LHSIA 2006, c.4, s. 18 (18)). French Language Services and the needs of First Nations and ~~Aboriginal~~ Indigenous peoples must also be included in the plan.
- ABPs are to align with the ministry's Action Plan for Health and each LHIN's IHSP.

Annual Business Plan Development Phases:

- **Phase I –** Gather information related to Ministry of Health and Long Term Care (MOHLTC) expectations, determine internal approach to complete, create timeline, determine expectations of final ABP document
- **Phase II –** Confirm approach and expectations; engage Board and staff
- **Phase III –** Create and distribute status of annual ABP deliverables for Board
- **Phase IV –** Create and distribute the preliminary draft ABP for Board review and discussion. A board-approved draft is then submitted to the Ministry for review.
- **Phase V –** Receive Ministry Response, revise as required and submit final version for Board consideration. Pending board-approval the final ABP is returned to the Ministry with updated Financials. The Minister's final approval is expected within 120 days of the annual provincial budget announcement.

Title: **Board Spokespeople & Media**	Policy Number: D-1
Approved: January 25, 2012 Approved: May 20, 2014 Pending: July 17, 2018	Revised: November 2011 Revised: April 15, 2014 Reviewed: June 21, 2016 Reviewed: June 28, 2018

The South West LHIN Chief Executive Officer (CEO), and Board Chair or their designates will each serve as the South West LHIN's official spokesperson and have the authority to make statements to the media on behalf of the organization.

- News media contact, responses and public discussion of the LHIN's affairs are only made through the board's official spokespersons. Directors should refer any media enquiry to the communications staff where possible, so the appropriate spokesperson can answer.

- Board directors should not speak or make representations on behalf of the South West LHIN board unless authorized by the Board Chair. When so authorized, the board member's presentation must be consistent with accepted positions and policies of the board.

- South West LHIN communication staff serve as the primary contacts for all media queries. All media calls are routed to the communication staff for assessment, referral to the appropriate spokesperson, and briefing preparation as required. Current contact information attached.

- Board of directors can communicate with the public if approved by the Chair.

- In the event a Board Member is approached in the community by a member of the public, by a patient, by a community agency, or a staff person of the LHIN, the Board Member's role is to:

-

    1. act as listener for a very short time;
    2. remain neutral and non-committal; and
    3. refer concerns to the Chief Executive Officer.

- The Director of Communications ~~and Community Engagement~~ will complete a full Communications and Community Engagement Plan to be reviewed by the board on an annual basis.

~~*Attached: Communications staff contact information.*~~

COMMUNICATIONS STAFF CONTACT INFORMATION & PROCESS:

Effective January 3, 2017

If you are contacted by media please advise that a response to their enquiry will be provided as soon as possible and forward the enquiry to the communications team (feel free to contact any communications team member or, if emailing, copy the full team). Please provide any details you have including the name/contact info for the media representative, nature of the enquiry, timing/deadlines, etc.

Ashley Jackson – Director of Communications & Community Engagement
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Report to the Board of Directors

Health Service Provider 2017/18 Quarter 4 Report and Non-Discretionary Funding Provided to the LHIN

Meeting Date: **July 17, 2018**

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

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

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

Purpose

The purpose of 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 fourth quarter (Q4) performance. Non-discretionary (directed) funding provided to the LHIN in the fourth quarter is also summarized.

Hospital Sector

Performance Highlights and Actions to Improve[1,2]

- Despite increases in Emergency Department (ED) volumes, Q4 ED waits are within allowable performance corridors for patients with complex conditions, except, London Health Sciences Centre (LHSC) and Stratford General Hospital (SGH). LHSC, SGH, Alexandra Hospital and Tillsonburg District Memorial Hospital experienced wait times beyond corridor for patients with minor/uncomplicated conditions in Q4.

    - *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; GBHS met the substance abuse revisit target but failed to meet the mental health target, LHSC met the mental health revisit target but was below the substance abuse revisit target in Q4.

    - *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.*

- ALC Rate: when all bed types are considered, the South West LHIN rate of 12% is 3rd best in the province with 8 of 17 hospitals meeting their local ALC targets. Four of five hospitals with Coordinated Access have rehab-appropriate patients in rehab beds but only five 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. All hospitals are meeting their local H-SAA targets for MRI and CT wait times. Most LHINs are not meeting the clinical access target provincial standard for CT/MRI wait times, the SW LHIN combined wait time result is 85% for CT – provincial target 90%, and 53% for MRI - provincial target 90%.

    - *LHIN interventions to improve MRI: Regional Medical Imaging Integrated Care Project; MRI Performance Improvement Program (PIP) Scorecard; additional one-time MRI funding provided as part of the 2018/19 hospital funding increase.*

- Four 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; QBP growth funding and Priority for Investment (PFI) for additional volumes in the latter half of 2017/18.*

- Four of 18 hospitals experienced a higher rate of readmissions than expected for the period of January through March of 2018 (an improvement over eight over target in Q3). 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 ongoing at LHSC with the potential to spread to other sites; 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

- Two hospitals reported total margin deficits at the end of 2017/18: Alexandra Marine and General (AMGH) - $893,230 (3.6% Revenue) and Tillsonburg District Memorial Hospital (TDMH) - $107,560 (0.38% Revenue). AMGH's deficit projection is primarily driven by one-time events. TDMH's deficit is primarily related to unplanned pay equity costs; a deficit is also being projected for next year; the hospital has sufficient working capital to absorb the deficit(s) and work to return to a balanced positon is underway. Grey Bruce Health Services and Strathroy Middlesex General Hospital had budget waivers for 2017/18 but ended the year with modest surpluses. All deficit positions remain the sole financial responsibility of the hospital corporation.

Community Sector

Performance Highlights and Actions to Improve

- 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; four of five were within performance corridors for this measure.

- LHIN Home & Community Care waits were longer than targeted when initiating service from the community setting. The results for initiating service from hospitals was within corridor but below target, as were the results for percent nursing visits within five days and percent PSW visits within five days.

Financial Highlights

- 98% of Community Support Services (CSS), 100% of Community Health Centres (CHC), and 85% of Community Mental Health (CMH) HSP's ended the year with balanced budgets. LHIN staff are working with HSP's to avoid or mitigate any impact at the client level. All deficit positions remain the sole financial responsibility of the HSP.

Long-Term Care Sector

Performance Highlights and Actions to Improve

- Fourth quarter results for the local performance obligations for long-term care homes indicate that 92% of homes are meeting the requirement to report on residents with responsive behaviours who have been discharged from the homes (with rationale). Long Term Care Homes were also 92% compliant with 1:1 staffing provisions introduced to help support residents with responsive behaviours to remain in their long-term care homes. These measures were introduced in 2016/17 to better reflect 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 Q4 results 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 the 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 Q4 2017/18.

Attachments:

Appendix 1 – Q4 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 Q4 2017/18.

Appendix 1 - Q4 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*	Dimen-sion wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimen-sion wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimen-sion wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimen-sion wt avg	Analysis & Performance Management	M-SAA Indicator	% of HSPs at Target*	Dimen-sion wt avg	Analysis & Performance Management	L-SAA Indicator	% of HSPs at Target*	Dimen-sion wt avg	Analysis & Performance Management
Access	90P ED LOS complex	85%	77%	Performance in ED waits retreated from Q3 improvement; volumes remain high. LHSC continues to be challenged by long waits. P4R plans and Knowledge Transfer underway.	90P Wait from Hospital	100%	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	80%		Improvements seen in achieving panel size targets even with increasingly more aggressive targets.	Coord-inated Access (% GAIN screened)	N/A		N/A				
	90P ED LOS minor/ uncomplic.	69%			90P Wait from Community	0%																		
	Coord-inated Access (% GAIN screened)	N/A			% Nursing Visit Within 5d	100%																		
					% PSW Visit Within 5d	100%																		
Diagnostics Access	MRI-- % P2,3,4 within target	100%	100%	Despite missing clinical wait time targets for MRI and CT in some instances, hospitals are meeting HSAA targets.									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	50%	42%	Access to both knee and hip surgery remained well below target in Q4 but compliance improved over Q3. Open wait list clean-up, enhanced volumes, central intake, and sharing surgeon wait times all aim to improve.																				
	Knee-- % P2,3,4 within target	33%																						
Safe & Effective	C. diff	44%	56%	r C. diff compliance rate declined from Q3.									Influenza	100%	100%	All CHCs within performance corridors for best practice measures.								
	Stroke/ TIA adm to Stroke Unit	75%		(LOCAL) 3 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		50%	see below (73%)	(LOCAL) GBHS continues to experience exceptional challenges with mental health ED revisits in Q4.																				
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 Q4 but not LHSC.																				

Appendix 1 - Q4 2017/18 Service Accountability Agreement Review: Performance Outcomes, Financial & Service Activity Perspectives

Readmissions within 30 days	78%		Rates of readmissions for 14 of 18 hospitals were within expected rates.					

Appendix 1 - Q4 2017/18 Service Accountability Agreement Review: Performance Outcomes, Financial & Service Activity Perspectives

System Perspective & Integration (cont.)

SAA Indicator	Hospitals % of HSPs at Target*	Hospitals Dimension wt avg	Hospitals Analysis & Performance Management	LHIN Home & Community Care M-SAA Indicator	LHIN Home & Community Care % of HSPs at Target*	LHIN Home & Community Care Dimension wt avg	LHIN Home & Community Care Analysis & Performance Management	Community Support Services (CSS) M-SAA Indicator	CSS % of HSPs at Target*	CSS Dimension wt avg	CSS Analysis & Performance Management	Community Health Centres (CHC) M-SAA Indicator	CHC % of HSPs at Target*	CHC Dimension wt avg	CHC Analysis & Performance Management	Community Mental Health & Addictions (CMH&A) M-SAA Indicator	CMH&A % of HSPs at Target*	CMH&A Dimension wt avg	CMH&A Analysis & Performance Management	Long-Term Care Homes L-SAA Indicator	LTC % of HSPs at Target*	LTC Dimension wt avg	LTC Analysis & Performance Management
% Eligible Pts in Rehab	80%	73%	(LOCAL) 4 of 5 hospitals with Coordinated Access had rehab-appropriate patients in rehab beds and only 5 of 10 met CCC eligibility targets for CCC beds.	0%	71%		(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	50%			0%																			
ALC Rate	53%		9 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	100%		(LOCAL)	100%			(LOCAL)	100%	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.	100%	100%														
% ALC Days (Acute)				100%			The overall LHIN % ALC Days remained the 3rd lowest among Ontario LHINs for Q4 (most recent data).																
Residents with Responsive Behaviours Discharged from LTC																				92%			(LOCAL)
1:1 Staffing Implemented for Residents with Responsive Behaviours																				92%			(LOCAL)

Organizational Health

	H-SAA Indicator	Hospitals % of HSPs at Target*	Hospitals Dimension wt avg	Hospitals Analysis & Performance Management	LHIN Home & Community Care M-SAA Indicator	LHIN Home & Community Care % of HSPs at Target*	LHIN Home & Community Care Dimension wt avg	LHIN Home & Community Care Analysis & Performance Management	CSS M-SAA Indicator	CSS % of HSPs at Target*	CSS Dimension wt avg	CSS Analysis & Performance Management	CHC M-SAA Indicator	CHC % of HSPs at Target*	CHC Dimension wt avg	CHC Analysis & Performance Management	CMH&A M-SAA Indicator	CMH&A % of HSPs at Target*	CMH&A Dimension wt avg	CMH&A Analysis & Performance Management	LTC L-SAA Indicator	LTC % of HSPs at Target*	LTC Dimension wt avg	LTC Analysis & Performance Management
Total Margin	Total Margin %	90%	90%	Two hospitals ended the year in a deficit position	Total Margin %	100%	100%	Year-end balanced position; enhanced targeted funding received for Levels of Care and Respite	Total Margin %	98%	96%	98% HSPs are projecting year-end balanced positions after allowing for Fund Type 3.	Total Margin %	100%	88%		Total Margin %	85%	86%	Four HSPs reported deficits at year-end.				
Balanced Budget	Fund Type 1 Balanced Budget	90%			Fund Type 2 Balanced Budget	100%			Fund Type 2 Balanced Budget	94%			Fund Type 2 Balanced Budget	100%				88%						
Sector-Specific	Current Ratio (YE)	90%			% Spent on Admin	100%			% Spent on Admin	96%			% Spent on Admin	100%			% Spent on Admin	81%						
													Retention Rate	80%										

Appendix 1 - Q4 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	95%	86%	Hospitals are generally projecting to meet service activity targets. The CCC variances are not unexpected as hospitals adjust to bed reallocations and occupancy challeges that persist in some sites.	Indiv. Served	100%	67%	School visits are under due to decreased school therapies authorized in order to balance to the school restricted budget - variance masked by other functional centres; Hours of care under - PSW shortage	Indiv. Served	74%	71%	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 .	Indiv. Served	80%	84%	As CHCs are able to recruit and retain staff, practices can expand (patients and staffing) and improvements have been maintained in individuals served, visits, and access.	Indiv. Served	84%	67%	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	71%			Visits F2F, phone, cont.out	100%			Visits F2F, phone, cont.out	53%			Visits F2F, phone, cont.out	100%			Visits F2F, phone, cont.out	50%					
	Weighted Visits: DS	88%			Hours of Care	0%			Hours of Care	50%			Hours of Care	n/a			Hours of Care	n/a					
	Weighted Cases: ED	75%							Attendance Days (F2F)	67%			Attendance Days (F2F)	100%			Attendance Days (F2F)	63%					
	Visits: ED & Urg Care	100%							IP/Res Days	60%			IP/Res Days	0%			IP/Res Days	80%					
	Days: IP MH	100%							Group Participant Attendan	67%			Group Participant Attendan	100%			Group Participant Attendan	63%					
	Days: IP Rehab	88%							Not Uniquely ID'd Svc Rec	75%			Not Uniquely ID'd Svc Rec	100%			Not Uniquely ID'd Svc Rec	60%					
	Weighted Cases: IP Acute	74%							Group Sessions	80%			Group Sessions	100%			Group Sessions	75%					
									Meals Delivered	56%			Service Provider Interactions	100%			Service Provider Interactions	50%					
													Meals Delivered	n/a			Mental Health Sessions	67%					
					Variance-Forecast: Actual Svcs	100%			Variance-Forecast: Actual Svcs	71%			Variance-Forecast: Actual Svcs	80%			Variance-Forecast: Actual Svcs	71%					
Total # of Providers:	20				1				51				5				27				77		

Appendix 1 - Q4 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.

Non-Discretionary (Ministry Directed) 2017/18 Quarter 4 Culmulative Ministry-LHIN Accountability Agreement (MLAA) Funding

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	Hospitals	Onetime	$226,800		Q2
Dehavioural Supports Ontario - Specialized Staffing Initiatives	Long Term Care Homes	Base		$705,735	Q2
Recruitment and Retention Primary Care	Community Health Centres	Base		$770,900	Q3
New Forensic Housing units Short term transitional care models	Community Mental Health and Addiction	Base		$95,000	Q3
Recruitment and Retention Primary Care	Hospitals	Base		$120,600	Q3
Neonatal Intensive Care Unit Capacity	Hospitals	Onetime	$250,000		Q3
Indigenous Mental Health and Addictions Programs	Community Mental Health	Onetime	$142,100		Q4
Enhancement of Forensic Services	Hospitals	Base		$604,800	Q4
Post Construction Operating Plan (PCOP)	Hospitals	Base		$1,005,900	Q4
Long Term Care Home Financial Stability and Operations Improvement	Long Term Care Homes	Onetime	$290,000		Q4
Fair Workplaces, Better Jobs Act 2017 - Transition Costs	Community Support Services/Community Mental Health/Service Provider Organizations	Onetime	$1,283,900		Q4
Total			**$13,120,784**	**$39,215,331**	

*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 4.8

Report to the Board of Directors

Canadian Mental Health Association - Elgin Update

Meeting Date: **July 17, 2018**

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

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

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

Purpose

The purpose of this report is to provide the LHIN Board with a brief update on the progress achieved following the appointment of a Supervisor at CMHA Elgin.

Current Status

On May 3, 2018, the LHIN Board appointed Ms. Sandy Whittall (SW) as Supervisor for CMHA Elgin. The appointment is effective until September 30, 2018. This appointment followed a third-party investigation into issues of governance and management oversight, as well as operations, financial management and workplace environment. Since the appointment of SW the organization appears to have stabilized. The following activities have occurred:

Governance and Management:

- The Board of Directors was maintained in an advisory capacity to ensure the members understood the steps that were occurring within the organization post appointment of the Supervisor.
- The Executive Director is no longer with the organization.

Operations and Financial Management:

- At the time of the appointment of the Supervisor, CMHA Elgin did not have an acceptable balanced/sustainable operating plan. Work has been underway between SW/team and the LHIN on a 'zero-based budget' which should translate into a balanced and sustainable operating plan. This work includes ensuring value for all funding spent.
- Although an organization-wide strategic planning process is not being launched, work is underway to look at each program and service to ensure client needs are being met and connections with provider partners are occurring.
- Work on policies and procedures continues.

Workplace Environment:

- SW's first order of business was to meet with the management team and front-line staff and to establish a regular written communication channel to share information and keep all staff up-to-date on activities within the organization.

- Staff sessions have been arranged (with an outside provider) to afford staff the opportunity to de-brief and discuss past challenges in the workplace and opportunities moving forward.
- The communication steps extend to Union representatives and it appears a positive dialogue is now occurring.

Next Steps
Discussions are underway about how best to continue to strengthen mental health and addictions services in Elgin County. Further updates will be shared with the LHIN Board

End

Agenda item 4.9

Report to the Board of Directors

Annual Provincial Stroke Report Card

Meeting Date: **July 17, 2018**

Submitted By: **Jana Fear, Health System Planner, South West LHIN**

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

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

Purpose

The purpose of this report is to provide the South West LHIN Board of Directors with highlights from the 8th Annual Provincial and LHIN Stroke Report Card.

2016/17 Annual Stroke Report Card

On June 19, 2018, CorHealth Ontario released the 8th Annual Provincial and LHIN Stroke Report Cards that grade the delivery of stroke care and services provincially and for each of Ontario's 14 LHINs. The report cards compare the level of access and treatment of people who suffer strokes, demonstrating the impact of regional efforts to improve the quality of stroke care across the province, and will be used to review gaps and identify solutions that will further enhance the stroke care system.

South West LHIN Performance

It is important to note that, although the report cards are being released in 2018, the data represented are from 2016/17. At that time, not all of the impact from the realignment of stroke services in the South West LHIN, started in 2016/17, would have been realized. Improvements will continue to be seen in future report cards.

Acceptable or exemplary performance was demonstrated in the South West LHIN on 11 of the 16 indicators. Key areas of progress include:

- Three acute performance indicators have showed statistically significant improvement: access to and timeliness of thrombolysis (tPA) proportion of ischemic stroke patients who received tPA (indicators 6 and 7); and proportion of patients treated on a stroke inpatient unit (indicator 8).
- Three rehabilitation performance indicators showed statistically significant improvement: admission time to inpatient stroke rehabilitation (indicator 13); achievement for target length of

stay for inpatient rehabilitation (indicator 15); and functional outcome of patients receiving inpatient rehabilitation (indicator 16).

Areas for improvement include:

- Proportion of stroke/TIA patients who arrive at ED by ambulance (indicator 1) – Performance is below 50th percentile and not progressing.

- Median FIM Efficiency (indicator 16) – Performance is below 50th percentile but showed significant improvement from 3 year average.

- Proportion of ALC days to total length of stay in acute (indicator 10) – Performance is below 50th percentile and not progressing compared to 3 year average.

- Proportion of rehabilitation patients with severe stroke (indicator 18) – Performance is below the 50th percentile and is not progressing.

Appendix D contains a summary of associated current or planned activities to improve performance on these metrics.

The Stroke Report Card is one tool for providers to look for opportunities to make improvements. Our LHIN will continue to work with our health service providers to help ensure residents have access to high-quality stroke prevention and care.

Appendices

Appendix A: Ontario Stroke Report Card, 2016/17
Appendix B: South West LHIN Stroke Report Card, 2016/17
Appendix C: South West LHIN Stroke Progress Report, 2016/17
Appendix D: Interpretation of South West LHIN Stroke Report Card, 2016/17

Ontario Stroke Report Card, 2016/17

Local Health Integration Networks (LHINs)

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

● Progressing Well[1] ■ Progressing[2] ▲ Not Progressing[3] □ Limited Data

Indicator No.	Care Continuum Category	Indicator[4]	Ontario FY 2016/17 (2015/16)	Variance Across LHINs (Min–Max)	Provincial Benchmark[5]	High Performers[6]	
						Sub-LHIN/Facility	LHIN
1 ■	Public awareness and patient education	Proportion of stroke/TIA patients who arrived at the ED by ambulance.	59.2% (58.8%)	53.2 - 63.9%	65.9%	Essex Sub-LHIN	1, 11
2 ▲	Prevention of stroke	Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000 population).	1.3 (1.3)	1.1 - 1.8	1.2	Oakville Sub-LHIN	6, 8, 7, 11
3§ ■	Prevention of stroke	Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).	10.8 (11.1)	10.9 - 16.4	-	-	7
4 ■	Prevention of stroke	Proportion of ischemic stroke/TIA inpatients aged 65 and older with atrial fibrillation who filled a prescription for anticoagulant therapy within 90 days of discharge from acute care.	72.0% (71.3%)	64.9 - 78.7%	85.5%	Southeast Mississauga Sub-LHIN	None
5 ●	Prevention of stroke	Proportion of ischemic stroke inpatients who received carotid imaging.	82.2% (81.9%)	76.1 - 87.4%	92.4%	Bluewater Health, Sarnia	5
6 ●	Acute stroke management	Median door-to-needle time among patients who received acute thrombolytic therapy (tPA) (minutes). Target[7]: 30 minutes	47.0 (50.0)	35.0 - 125.5	33.0	The Ottawa Hospital, Civic	11
7§ ●	Acute stroke management	Proportion of ischemic stroke patients who received acute thrombolytic therapy (tPA). Target[7]: >12%	12.5% (12.3%)	8.9 - 15.5%	17.7%	Ottawa East Sub-LHIN	11, 10
8§ ●	Acute stroke management	Proportion of stroke/TIA patients treated on a stroke unit[8] at any time during their inpatient stay. Target[7]: >75%	45.6% (43.3%)	10.5 - 82.9%	80.6%	Urban Guelph Sub-LHIN	3, 10
9 ●	Prevention of stroke	Proportion of ischemic stroke/TIA patients discharged from the ED and referred to secondary prevention services.	77.3% (73.9%)	50.2 - 87.8%	95.1%	Hamilton Health Sciences Corp., Juravinski	None
10§ ▲	Acute stroke management	Proportion of ALC days to total length of stay in acute care.	30.7% (26.8%)	14.2 - 41.0%	8.2%	Bluewater Health, Sarnia	None
11§ ▲	Acute stroke management	Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation. Target[7]: >30%	35.2% (35.5%)	28.5 - 44.8%	47.8%	Chatham-Kent Sub-LHIN	1
12§ □	Stroke rehabilitation	Proportion of acute stroke (excluding TIA) patients with mild disability (AlphaFIM > 80) discharged home.	72.6% (71.8%)	62.0 - 92.2%	-	-	14, 3
13§ ▲	Stroke rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation.	9.0 (8.0)	6.0 - 15.0	5.0	Pembroke Regional Hospital	None
14§ □	Stroke rehabilitation	Median number of minutes per day of direct therapy received by inpatient stroke rehabilitation patients. Target[7]: 180 minutes/day	64.8 (60.0)	23.8 - 92.3	101.7	West Park Healthcare Centre	None
15§ ●	Stroke rehabilitation	Proportion of inpatient stroke rehabilitation patients achieving RPG active length of stay target.	66.4% (62.6%)	41.0 - 85.5%	85.4%	Providence Healthcare	3
16 ●	Stroke rehabilitation	Median FIM efficiency for moderate stroke in inpatient rehabilitation.	1.1 (1.1)	0.8 - 1.6	1.6	Grand River Hospital Corp., Freeport	3, 12
17 ●	Stroke rehabilitation	Mean number of CCAC visits provided to stroke patients on discharge from inpatient acute care or inpatient rehabilitation in 2015/16–2016/17.	8.2 (8.2)	5.1 - 15.7	12.4	Waterloo Wellington CCAC	3, 10
18§ ▲	Stroke rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe stroke (RPG 1100 or 1110).	41.2% (42.2%)	29.0 - 56.3%	58.7%	Lakeridge Health, Oshawa	3
19§ ■	Reintegration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	6.8% (6.3%)	2.5 - 10.8%	1.9%	Urban Guelph Sub-LHIN	None
20§ ●	Reintegration	Age- and sex-adjusted readmission rate at 30 days for patients with stroke/TIA for all diagnoses (per 100 patients). Target[7]: 10.0	7.0 (7.6)	5.3 - 11.2	-	-	10, 6

Hospital Service Accountability Agreement indicator, 2015/16 | - Data not available | § Contributes to QBP performance

[1] Statistically significant improvement.
[2] Performance improving but not statistically significant.
[3] No change or performance decline.
[4] Facility-based analysis (excluding indicators 1, 2, 4, 7, 8, 11 and 19) for patients aged 18 -108. Indicators are based on CIHI data. Low rates are desired for indicators 2, 3, 6, 10, 13, 19 and 20.
[5] Top benchmark achieved between 2014/15 and 2016/17. Benchmarks were calculated using the ABC methodology (Weissman et al. *J Eval Clin Pract* 1999; 5(3):269 -81) on sub-LHIN or facility data.
[6] Sub-LHIN/Facility: Highest performer among acute care institutions treating more than 100 stroke patients per year, rehabilitation facilities admitting more than 62 stroke patients per year, or sub -LHINs with at least 30 stroke patients per year. LHIN: Top two with exemplary performance.
[7] Targets based on international, national and provincial targets, please refer to full report for details.
[8] The revised definition was developed with the consensus of Ontario Stroke Network regional directors (February 2014). There were 16 stroke units in 2013/14, 21 in 2014/15, 28 in 2015/16 and 35 in 2016/17.

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Ontario Stroke Report Card, 2016/17:
South West Local Health Integration Network

● Exemplary performance[1] ■ Acceptable performance[2] ▲ Poor performance[3] ☐ Data not available or benchmark not available

Indicator No.	Care Continuum Category	Indicator[4]	LHIN FY 2016/17 (2015/16)	Variance Within LHIN[5] (Min–Max)	Provincial Benchmark[6]	High Performers[7]	
						Sub-LHIN/Facility	LHIN
1 ▲	Public awareness and patient education	Proportion of stroke/TIA patients who arrived at the ED by ambulance.	55.2% (58.7%)	46.1 - 63.5%	65.9%	Essex Sub-LHIN	1, 11
2 ■	Prevention of stroke	Annual age- and sex-adjusted inpatient admission rate for stroke/TIA (per 1,000 population).	1.4 (1.5)	1.4 - 2.1	1.2	Oakville Sub-LHIN	6, 8, 7, 11
3§ ☐	Prevention of stroke	Risk-adjusted stroke/TIA mortality rate at 30 days (per 100 patients).	11.7 (13.4)	0.0 - 22.3	-	-	7
4 ■	Prevention of stroke	Proportion of ischemic stroke/TIA inpatients aged 65 and older with atrial fibrillation who filled a prescription for anticoagulant therapy within 90 days of discharge from acute care.	76.1% (72.9%)	58.3 - 94.4%	85.5%	Southeast Mississauga Sub-LHIN	None
5 ■	Prevention of stroke	Proportion of ischemic stroke inpatients who received carotid imaging.	80.5% (80.6%)	33.3 - 100%	92.4%	Bluewater Health, Sarnia	5
6 ■	Acute stroke management	Median door-to-needle time among patients who received acute thrombolytic therapy (tPA) (minutes). Target[8]: 30 minutes	46.0 (50.0)	39.0 - 75.0	33.0	The Ottawa Hospital, Civic	11
7§ ●	Acute stroke management	Proportion of ischemic stroke patients who received acute thrombolytic therapy (tPA). Target[8]: >12%	15.1% (13.0%)	8.9 - 18.8%	17.7%	Ottawa East Sub-LHIN	11, 10
8§ ■	Acute stroke management	Proportion of stroke/TIA patients treated on a stroke unit[9] at any time during their inpatient stay. Target[8]: >75%	62.6% (51.5%)	35.1 - 84.6%	80.6%	Urban Guelph Sub-LHIN	3, 10
9 ■	Prevention of stroke	Proportion of ischemic stroke/TIA patients discharged from the ED and referred to secondary prevention services.	76.3% (75.3%)	14.3 - 96.2%	95.1%	Hamilton Health Sciences Corp., Juravinski	None
10§ ▲	Acute stroke management	Proportion of ALC days to total length of stay in acute care.	23.6% (20.8%)	0.0 - 55.4%	8.2%	Bluewater Health, Sarnia	None
11§ ■	Acute stroke management	Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation. Target[8]: >30%	34.3% (33.4%)	29.5 - 50.5%	47.8%	Chatham-Kent Sub-LHIN	1
12§ ☐	Stroke rehabilitation	Proportion of acute stroke (excluding TIA) patients with mild disability (AlphaFIM > 80) discharged home.	74.6% (73.3%)	0.0 - 81.4%	-	-	14, 3
13§ ■	Stroke rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation.	8.0 (9.0)	6.0 - 12.0	5.0	Pembroke Regional Hospital	None
14§ ■	Stroke rehabilitation	Median number of minutes per day of direct therapy received by inpatient stroke rehabilitation patients. Target[8]: 180 minutes/day	83.8 (71.1)	0.0 - 94.4	101.7	West Park Healthcare Centre	None
15§ ■	Stroke rehabilitation	Proportion of inpatient stroke rehabilitation patients achieving RPG active length of stay target.	76.0% (64.6%)	57.3 - 85.5%	85.4%	Providence Healthcare	3
16 ▲	Stroke rehabilitation	Median FIM efficiency for moderate stroke in inpatient rehabilitation.	1.0 (0.9)	0.9 - 1.8	1.6	Grand River Hospital Corp., Freeport	3, 12
17 ▲	Stroke rehabilitation	Mean number of CCAC visits provided to stroke patients on discharge from inpatient acute care or inpatient rehabilitation in 2015/16–2016/17.	5.6 (5.3)	-	12.4	Waterloo Wellington CCAC	3, 10
18§ ▲	Stroke rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe stroke (RPG 1100 or 1110).	40.4% (46.7%)	28.7 - 57.8%	58.7%	Lakeridge Health, Oshawa	3
19§ ■	Reintegration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	4.6% (4.4%)	1.5 - 7.3%	1.9%	Urban Guelph Sub-LHIN	None
20§ ☐	Reintegration	Age- and sex-adjusted readmission rate at 30 days for patients with stroke/TIA for all diagnoses (per 100 patients). Target[8]: 10.0	8.1 (7.5)	0.0 - 14.9	-	-	10, 6

Hospital Service Accountability Agreement indicator, 2015/16 - Data not available § Contributes to QBP performance

[1] Benchmark achieved or performance within 5% absolute/relative difference from the benchmark.
[2] Performance at or above the 50th percentile and greater than 5% absolute/relative difference from the benchmark.
[3] Performance below the 50th percentile.
[4] Facility-based analysis (excluding indicators 1, 2, 4, 7, 8, 11 and 19) for patients aged 18–108. Indicators are based on CIHI data. Low rates are desired for indicators 2, 3, 6, 10, 13, 19 and 20.
[5] Excludes sub-LHINs or facilities with fewer than six patients.
[6] Top benchmark achieved between 2014/15 and 2016/17. Benchmarks were calculated using the ABC methodology (Weissman et al. J Eval Clin Pract 1999; 5(3):269–81) on sub-LHIN or facility data.
[7] Sub-LHIN/Facility: Highest performer among acute care institutions treating more than 100 stroke patients per year, rehabilitation facilities admitting more than 62 stroke patients per year, or sub-LHINs with at least 30 stroke patients per year. LHIN: Top two with exemplary performance.
[8] Targets based on international, national and provincial targets, please refer to full report for details.
[9] The revised definition was developed with the consensus of Ontario Stroke Network regional directors (February 2014). There were 16 stroke units in 2013/14, 21 in 2014/15, 28 in 2015/16, and 35 in 2016/17.

CorHealth Ontario

Stroke Progress Report, 2016/17 compared to 2013/14-2015/16:
South West Local Health Integration Network

● Progressing Well[1] ■ Progressing[2] ▲ Not Progressing[3] ☐ Data not available

Indicator No.	Care Continuum Category	Indicator[4]	LHIN FY 2016/17 (Previous 3–Year Average)	Variance Within LHIN[5] 2016/17 (2013/14)		Greatest Improvement[6]	
				Min	Max	Sub–LHIN/Facility	LHIN
1 ▲	Public awareness and patient education	Proportion of stroke/TIA patients who arrived at the ED by ambulance.	55.2% (58.0%)	46.1% (49.5%)	63.5% (63.7%)	Tyendinaga, Napanee Sub-LHIN	11
2 ▲	Prevention of stroke	Annual age– and sex–adjusted inpatient admission rate for stroke/TIA (per 1,000 population).	1.4 (1.2)	1.4 (1.2)	2.1 (1.9)	Milton Sub-LHIN	None
3§ ●	Prevention of stroke	Risk–adjusted[7] stroke/TIA mortality rate at 30 days (per 100 patients).	9.7 (11.6)	0.0 (0.0)	24.2 (42.7)	-	10, 2
4 ■	Prevention of stroke	Proportion of ischemic stroke/TIA inpatients aged 65 and older with atrial fibrillation who filled a prescription for anticoagulant therapy within 90 days of discharge from acute care.	76.1% (70.7%)	58.3% (68.8%)	94.4% (76.5%)	Cochrane Sub-LHIN	6, 7
5 ●	Prevention of stroke	Proportion of ischemic stroke inpatients who received carotid imaging.	80.5% (75.9%)	33.3% (12.5%)	100% (86.8%)	Brockville General Hospital	10, 11
6 ●	Acute stroke management	Median door–to–needle time among patients who received acute thrombolytic therapy (tPA) (minutes). Target[8]: 30 minutes	46.0 (52.0)	39.0 (53.0)	75.0 (92.5)	Thunder Bay Regional Health Sciences Centre	14, 1
7§ ●	Acute stroke management	Proportion of ischemic stroke patients who received acute thrombolytic therapy (tPA). Target[8]: >12%	15.1% (11.8%)	8.9% (6.3%)	18.8% (13.0%)	Tyendinaga, Napanee Sub-LHIN	2, 1
8§ ●	Acute stroke management	Proportion of stroke/TIA patients treated on a stroke unit[9] at any time during their inpatient stay. Target[8]: >75%	62.6% (20.9%)	35.1% (0.0%)	84.6% (5.9%)	Thunder Bay City Sub-LHIN	14, 2
9 ●	Prevention of stroke	Proportion of ischemic stroke/TIA patients discharged from the ED and referred to secondary prevention services.	76.3% (68.0%)	14.3% (0.0%)	96.2% (86.1%)	North Bay Regional Health Centre	10, 1
10§ ▲	Acute stroke management	Proportion of ALC days to total length of stay in acute care.	23.6% (21.3%)	0.0% (0.0%)	55.4% (32.5%)	Trillium Health Partners, Credit Valley	None
11§ ▲	Acute stroke management	Proportion of acute stroke (excluding TIA) patients discharged from acute care and admitted to inpatient rehabilitation. Target[8]: >30%	34.3% (35.0%)	29.5% (32.7%)	50.5% (47.1%)	Timiskaming Sub-LHIN	None
12§ ☐	Stroke rehabilitation	Proportion of acute stroke (excluding TIA) patients with mild disability (AlphaFIM > 80) discharged home.	74.6% (-)	0.0% (-)	81.4% (-)	-	-
13§ ●	Stroke rehabilitation	Median number of days between stroke (excluding TIA) onset and admission to stroke inpatient rehabilitation.	8.0 (9.0)	6.0 (6.0)	12.0 (11.0)	Mackenzie Health	4, 14
14§ ☐	Stroke rehabilitation	Median number of minutes per day of direct therapy received by inpatient stroke rehabilitation patients. Target[8]: 180 minutes/day	83.8 (-)	0 (-)	94.4 (-)	-	-
15§ ●	Stroke rehabilitation	Proportion of inpatient stroke rehabilitation patients achieving RPG active length of stay target.	76.0% (57.8%)	57.3% (40.9%)	85.5% (70.1%)	Hotel Dieu Shaver	5, 12
16 ●	Stroke rehabilitation	Median FIM efficiency for moderate stroke in inpatient rehabilitation.	1.0 (0.8)	0.9 (0.7)	1.8 (1.1)	Trillium Health Partners, Credit Valley	5, 4, 6, 7
17 ■	Stroke rehabilitation	Mean number of CCAC visits provided to stroke patients on discharge from inpatient acute care or inpatient rehabilitation in 2015/16 - 2016/17.	5.6 (5.4)	-	-	Waterloo Wellington CCAC	3, 13
18§ ▲	Stroke rehabilitation	Proportion of patients admitted to inpatient rehabilitation with severe stroke (RPG 1100 or 1110).	40.4% (44.1%)	28.7% (33.3%)	57.8% (65.1%)	Grand River Hospital Corp., Freeport	11
19§ ■	Reintegration	Proportion of stroke/TIA patients discharged from acute care to LTC/CCC (excluding patients originating from LTC/CCC).	4.6% (5.4%)	1.5% (1.0%)	7.3% (13.2%)	Perth Sub-LHIN	11
20§ ▲	Reintegration	Age– and sex–adjusted[7] readmission rate at 30 days for patients with stroke/TIA for all diagnoses (per 100 patients). Target[8]: 10.0	8.6 (7.8)	0.0 (2.7)	15.3 (22.1)	-	12, 13

Hospital Service Accountability Agreement indicator, 2015/16 - Data not available § Contributes to QBP performance

[1] Statistically significant improvement.
[2] Performance improving but not statistically significant.
[3] No change or performance decline.
[4] Facility-based analysis (excluding indicators 1, 2, 4, 7, 8, 11 and 19) for patients aged 18–108. Indicators are based on CIHI data. Low rates are desired for indicators 2, 3, 6, 10, 13, 19 and 20.
[5] Excludes sub-LHINs or facilities with fewer than six patients.
[6] Sub-LHIN/Facility: Greatest improvement from 2013/14 among acute care institutions treating more than 100 stroke patients per year, rehabilitation facilities admitting more than 62 stroke patients per year, or sub-LHINs with at least 30 stroke patients per year. LHIN: Top two with greatest statistically significant improvement from 2013/14.
[7] The 2013/14-2016/17 LHIN rate is used in calculating the LHIN risk-adjusted rate.
[8] Targets based on international, national and provincial targets, please refer to full report for details.
[9] The revised definition was developed with the consensus of Ontario Stroke Network regional directors (February 2014). There were 16 stroke units in 2013/14, 21 in 2014/15, 28 in 2015/16, and 35 in 2016/17.

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Advancing cardiac, stroke and vascular care

Southwestern Stroke Network

Interpretation of LHIN Stroke Report Card - South West 2016/17

RD Contact Information

Doug Bickford, Regional Director - Southwestern Ontario Stroke Network, doug.bickford@lhsc.on.ca, (519) 685 8500 x 32214

Performance Overview

Acceptable or exemplary performance was demonstrated on 11 of 16 indicators. Statistically significant improvement was achieved on 9 of 18 indicators & the LHIN was recognized for greatest provincial improvement on indicators #3, 7, 8 & Perth region for #19.

Opportunities for LHIN and Stroke Network Collaboration:

In full partnership with the LHIN, the Southwestern Stroke Network continues to lead large system change via the Stroke Project for acute realignment and post hospital care including an 18/19 Early Supportive Discharge Pilot in Huron Perth. In 17/18 SWOSN also continued planning for Community Hubs, Stroke Prevention, Emergency Dept and Rehab Facilitators.

Areas of Progress:

Acute Stroke Management	3 of 5 acute indicators show statistically significant improvement (#6, 7, 8)
Stroke Rehabilitation	3 of 7 rehab indicators show significant improvement (#13, 15, 16)
Stroke Rehabilitation	Proportion of rehab inpts achieving RPG target LOS: 76% (16/17) vs 57.8%
Stroke Prevention	Stroke mortality significantly improved: 9.7% (16/17) vs 11.6% (3yr avg)

Areas for Improvement:	Associated Current or Planned Activities:
Access Proportion of stroke/TIA pts who arrive at ED by ambulance: 16/17 perf is below 50th percentile and not progressing. 16/17 Prov BM 65.9% SW 55.2%	Public awareness of FAST and local stroke system is an 18/19 SWOSN work plan priority. Opportunity to monitor access metrics in "real" time via the IDS Dashboard. Engaging partners: Heart & Stroke, EMS, South West Oversight Committee
Effectiveness Median FIM Efficiency: performance is below 50th percentile but 16/17 showed significant improvement from 3yr avg. Provincial Benchmark = 1.6 SW 1.0	Rehab FIM Efficiency is part of LHIN 16-19 IHSP Performance Measurement. Monitoring metrics in "real" time via IDS Dashboard. 18/19 Early Supportive Discharge Pilot will support access / flow in Huron Perth. UH/PKWD leading process improvement.
Appropriateness Proportion of ALC days to total LOS in acute is below 50th percentile and not progressing compared to 3yr avg. 16/17 Prov Benchmark: 8.2% SW: 23.6%	Stroke Project Phase II (including 18/19 Huron Perth ESD Pilot) supports hospital access / flow. University Hospital and Parkwood Institute has operationalized an Integrated Dashboard to support decision making. London Middlesex Oxford benefiting from Stroke Navigator (17/18).
Appropriateness Proportion of rehabilitation patients with severe stroke is below the 50th percentile and is not progressing. 16/17 Provincial Benchmark: 58.7% SW: 40.4%	SWOSN discussing severe stroke journey that includes CCC pathway. UH/PKWD implementing integrated scorecard & transitions work. HP ESD pilot for access.

Agenda item 4.10

Report to the Board of Directors

Board Committee Reports

Meeting Date: **July 17, 2018**

Submitted To: ☒ **Board of Directors**

Purpose: ☒ **Information Only**

Governance & Nominations Committee

The Governance Committee last met on Thursday, June 28. The draft minutes are included for acceptance in the consent section of the board's July 17 agenda and the recommendations contained therein are included in the decision items section of the meeting package. The items for the board's consideration include a Terms of Reference for Indigenous Work Group, governance policy amendments, and a committee appointment. The Governance & Nominations Committee is next scheduled to meet on Friday, September 28.

Quality Committee

The Quality Committee met on Tuesday, June 26. Committee Chair, Linda Ballantyne provided a brief verbal update at the board meeting that followed. She reported on the committee priorities of 1) patient relations (complaints, stories, ethics, risk management), and 2) accreditation. Regarding accreditation, December 3 to 6 has been confirmed for the 2018 accreditation primer survey. The South West LHIN will be surveyed by four surveyors including a patient with lived experience in the home and community care sector. All Quality Committee meeting materials are available on the portal including the 2012 Accreditation Report for any board member interested in more details. More reports to follow to ensure the Board's confidence in meeting the applicable accreditation standards. The Quality Committee is next scheduled to meet on Thursday, September 6, 2018.

Agenda item 4.11

Report to the Board of Directors

Board Director Reports

Meeting Date: **July 17, 2018**

Submitted To: ☒ **Board of Directors**

Purpose: ☒ **Information Only**

South West LHIN Board Directors reported attending the following events.

Linda Ballantyne

- June 26, 2018 – Quality Committee
- June 26, 2018 – Board of Directors Meeting - Woodstock
- June 28, 2018 – Governance Committee
- July 5, 2018 – Special Board Meeting Teleconference

Wilf Riecker

- June 11, 2018 - Audit Committee Meeting
- June 14, 2018 - Board of Directors Retreat
- June 19-20, 2018 – Achieving Excellence (HSSO) Conference
- June 26, 2018 – Board of Directors Meeting - Woodstock
- June 27, 2018 - Quality Committee
- June 29, 2018 - Governance Committee
- July 5, 2018 - Special Board Meeting Teleconference

Cynthia St. John

- June 25, 2018 – Governance committee planning
- June 28, 2018 - Governance committee meeting
- July 5, 2018 – Special Board Meeting Teleconference

Aniko Varpalotai

- June 25, 2018 – Governance committee planning
- June 28, 2018 - Governance committee meeting
- July 5, 2018 – Special Board Meeting Teleconference

Agenda item 5.1

Report to the Board of Directors

Community Support Services Base Funding Increase

Meeting Date: **July 17, 2018**

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

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

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

Recommended Motion

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

Background

The 2018/19 Community Investment Funding Increase provided to the South West LHIN by the Ministry of Health and Long Term Care includes $1,490,100 (i.e. 2%) in base funding designated to "*support the sustainability of community services, including community support services, acquired brain injuries services and assisted living services in supportive housing*". This funding could be applied by the LHIN in a variety of ways to sustain community support services (CSS), including the recommended option of providing a general base funding increase. The Community Support Services sector represents approx. 3% of total funding allocated by the South West LHIN.

For 2018/19, all Health Service Provider sectors have received some form of a base increase to their opening base allocation, except CSS. It should be noted that some sectors received an increase as a general base increase while other sectors (i.e. CHC) received as a targeted base increase.

Over the past number of years, the LHIN elected to allocate new base funding into targeted initiatives. Although community support services would have been a part of many of those targeted initiatives, the funding would not have gone towards sustaining operations. The CSS sector has not received a general base increase since 2015/16. The history is as follows:

- 2007/08 - 1.5%
- 2008/09 and 2009/10 - 2.25%
- 2010/11 - 2.0%
- 2011/12 - 1.5%
- 2012/13 to 2014/15 - 0%
- 2015/16 - 1%
- 2016/17 and 2017/18 - 0%

During the development and negotiation of the 2018/19 Multi-Sector Service Accountability Agreements (M-SAA) focused on service, financial and performance commitments, many CSS providers signaled risks associated with receiving no general base adjustment. A main contributor to this risk is the projected impact of Bill 148 - Fair Workplaces and Better Jobs Act.

The LHIN Board recently received a great presentation from the CSS Council (on behalf of the sector) sharing important information on the sector's programs and services and the opportunities and challenges moving forward. The presentation was filled with stories from clients and about some of the ways the partners continue to support people in their homes and communities. Strong community support services are essential in a health care system that helps people stay healthy, active and happy. The human resources challenges and fiscal pressures outlined in the presentation help round out the situation faced by our provider partners in operating stable programs for the benefit of clients. A general base adjustment will help support our provider partners in delivering quality services and programs to clients and their families.

Next Steps

Subject to the Board's consideration of the motion, LHIN staff are prepared to issue funding letter, amend agreements and trigger funding allocations.

Agenda item 5.2

Report to the Board of Directors

Governance Policy Harmonization

Meeting Date: **July 17, 2018**

Submitted By: **Governance & Nominations Committee Co-Chairs**

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

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

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

Background:
Refer to the draft minutes of the Governance & Nominations Committee meeting held on June 28, 2018 included in the consent agenda section of this meeting package. Attached to the draft minutes are marked-up versions of the policies under consideration.

South West LHIN

Agenda Item 5.3

Report to the Board of Directors

Terms of Reference – Indigenous Work Group

Meeting Date:	**July 17, 2018**
Submitted By:	**Governance & Nominations Committee Co-Chairs**
Submitted To:	☒ **Board of Directors** ☐ **Board Committee**
Purpose:	☐ **Information Only** ☒ **Decision**

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

See attached.

Background:
Refer to the draft minutes of the Governance & Nominations Committee meeting held on June 28, 2018 included in the consent agenda section of this meeting package.

Ontario
Local Health Integration Network

DRAFT – Terms of Reference
The South West LHIN Board of Directors
Indigenous Work Group

Purpose: To review, from a Governance perspective, current status of South West LHIN Indigenous Health Services and Relations

Membership: Three or more members of the Board of Directors (Chair of the Board ex-officio).

Issues identified to date:
- Who's doing what (LHIN staff: Lead, Senior Team, Aboriginal Health Committee)
- Follow up on proposed meeting with Chiefs
- What's funded (programs, services, gaps)
- Sub-Region representation
- SOAHAC role/representation

Reporting to Board through the Governance Committee
- Link to other Board Committees as appropriate

Existing documents/resources:
- Roadmap
- Action plan

Agenda item 5.4

Report to the Board of Directors

Board Committee Appointment

Meeting Date: **July 17, 2018**

Submitted By: **Governance & Nominations Committee Co-Chairs**

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

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

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

Background:
Refer to the draft minutes of the Governance & Nominations Committee meeting held on June 28, 2018 included in the consent agenda section of this meeting package.

Report to the Board of Directors

Agenda item 6.1

May 2018 Financial Update

Meeting Date: **July 17, 2018**

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

Submitted To: **Board of Directors**

Purpose: **For Discussion**

Purpose

The purpose of this report is to provide a high level summary of significant changes to the 2018/19 projections as at LE02 (May 31, 2018).

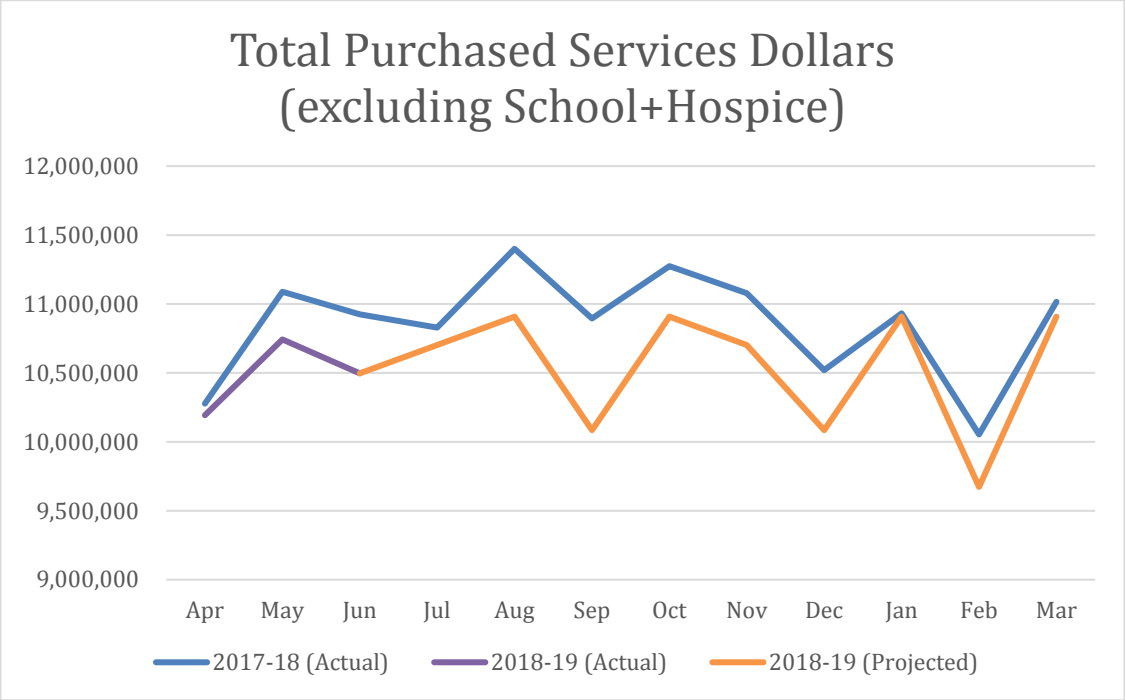
LE02 Year End Projection

Overall the projected surplus has increased $12.1M from the opening balanced budget. A number of items contributed to this change, the most significant of which were:

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

- There has been a delay in the transition of the Geriatric Resource Nurses to Parkwood. This is expected to occur in the coming months.

- On June 18, 2018 we received direction from the ministry that the LHIN is to implement a freeze of discretionary spending and a freeze on hiring (with the exception of care coordination and positions serving the public). These freezes have been implemented as a cost savings measure pending the implementation of an expenditure management strategy by the new government. We are seeking an exemption for certain critical positions currently vacant.



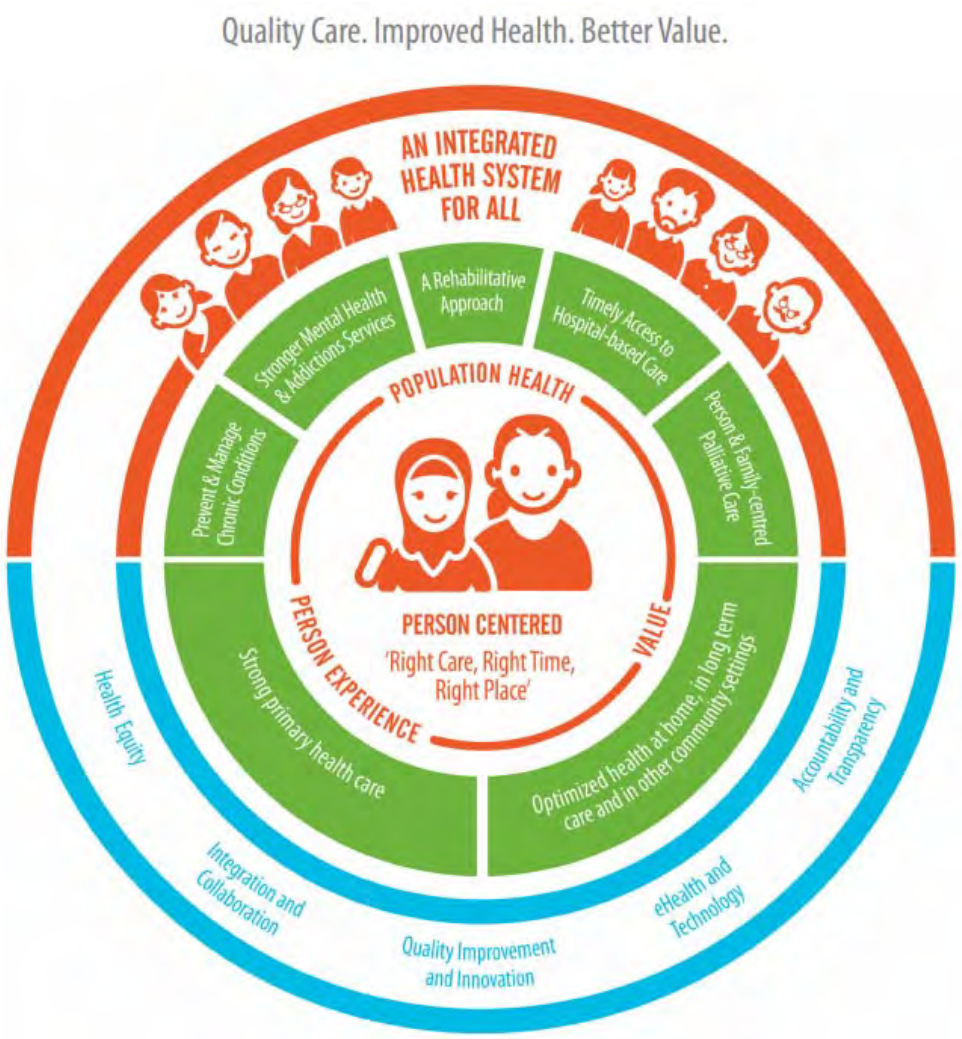
South West LHIN

Integrated Health Services Plan and Strategic Plan

July 17, 2018

Ontario
Local Health Integration Network

Our 2016-2019 IHSP

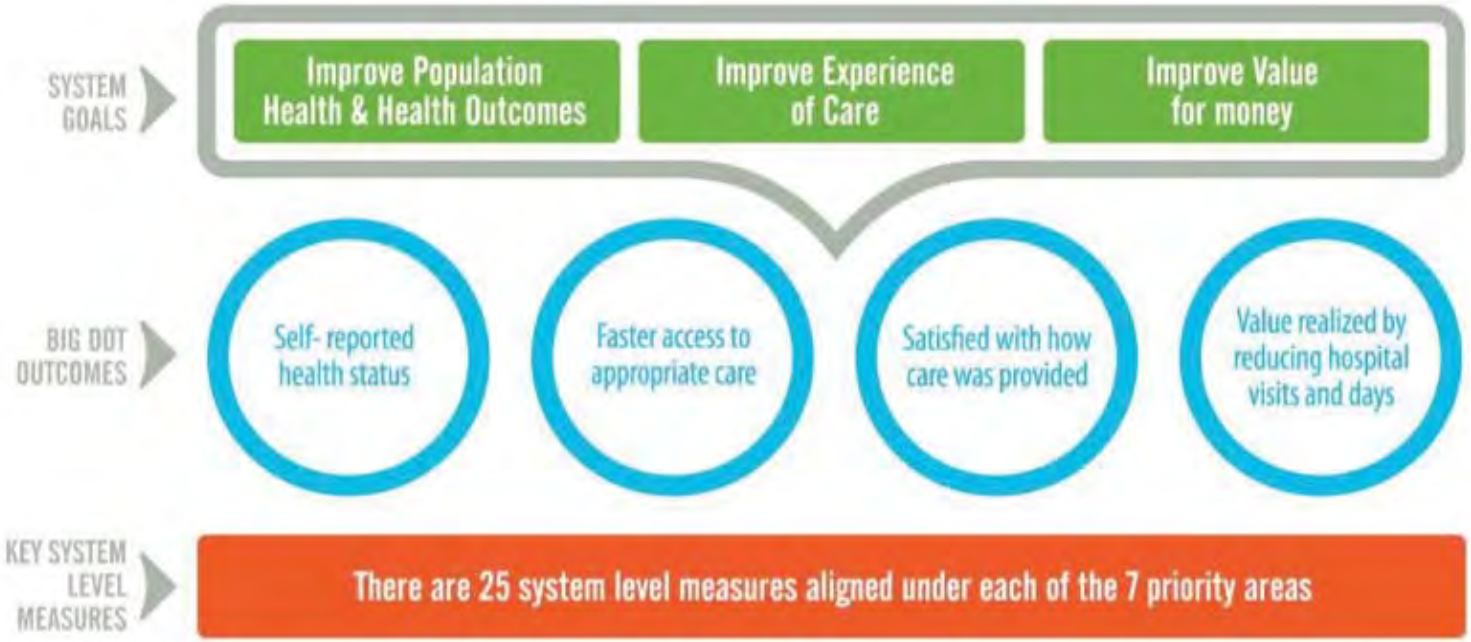


Seven Priorities

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

How are we doing?

- We have held gains in some areas and continue to need to improve in others (see 17/18 Q3 Report on Performance Board Package) http://www.southwestlhin.on.ca/accountability/Performance.aspx



Planning for the Future in the South West

The Integrated Health Services Plan sets the direction for the health system and outlines a collective plan for improvement for 2019 - 2022

The organizational strategic plan is being created to support the South West LHIN's development as a new organization.

Draft 2019-22 Pan-LHIN Priorities and Imperatives

All LHINs will be drafting their 2019-22 IHSPs based on a common set of LHIN Priorities and Imperatives.

Pan-LHIN Priorities

- **Patient Experience & Community Engagement**
- **Health Equity**
- **Population & Public Health**
- **Sub-Regional Planning & Integration**
- **Innovation**
- **Value for Money**

Draft 2019-22 Pan-LHIN Imperatives

Improve the patient experience

Address health inequities by focusing on population health

Reduce the burden of disease and chronic illness

Build and foster healthy communities through integrated care closer to home

Drive innovation through sustainable new models of care and digital solutions

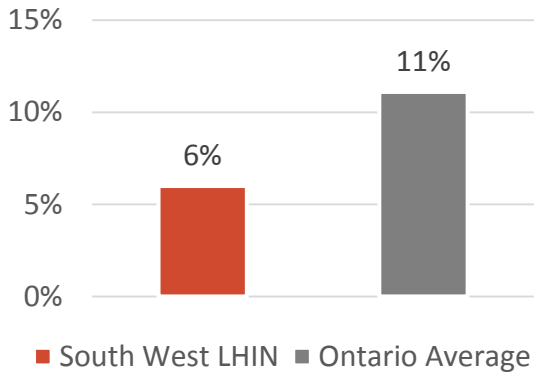
Drive efficiency and effectiveness

Determining population needs in the South West?

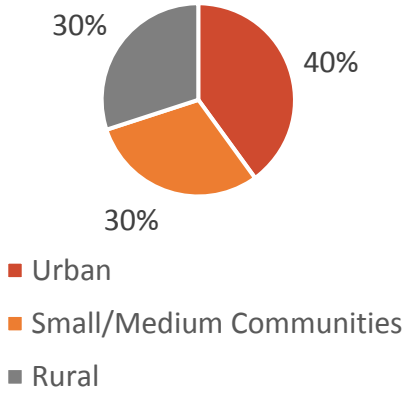
South West LHIN Demographic and Health Trends: A Sampling

Forecasted Population Growth, 2016-2025

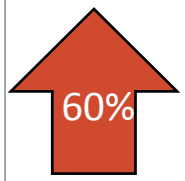
The South West LHIN is growing at a slower pace than the rest of the province



Population Distribution



General Health Highlights

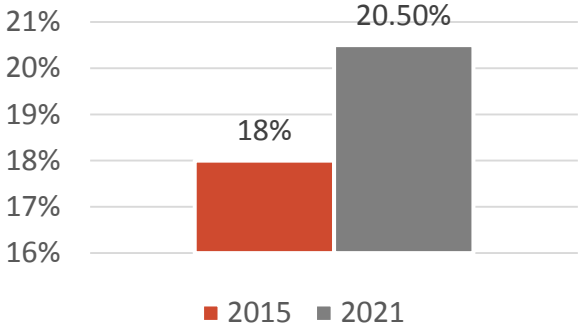


60% of residents, and climbing, are overweight or obese

Cancer rates are favorable compared to the province, however, overall mortality rates associated with illness are above the Ontario rate

Percentage of Population 65+

The percentage of residents 65 years or over will continue to grow at a faster pace than the rest of the province



Prevalence of Chronic Conditions in the South West LHIN

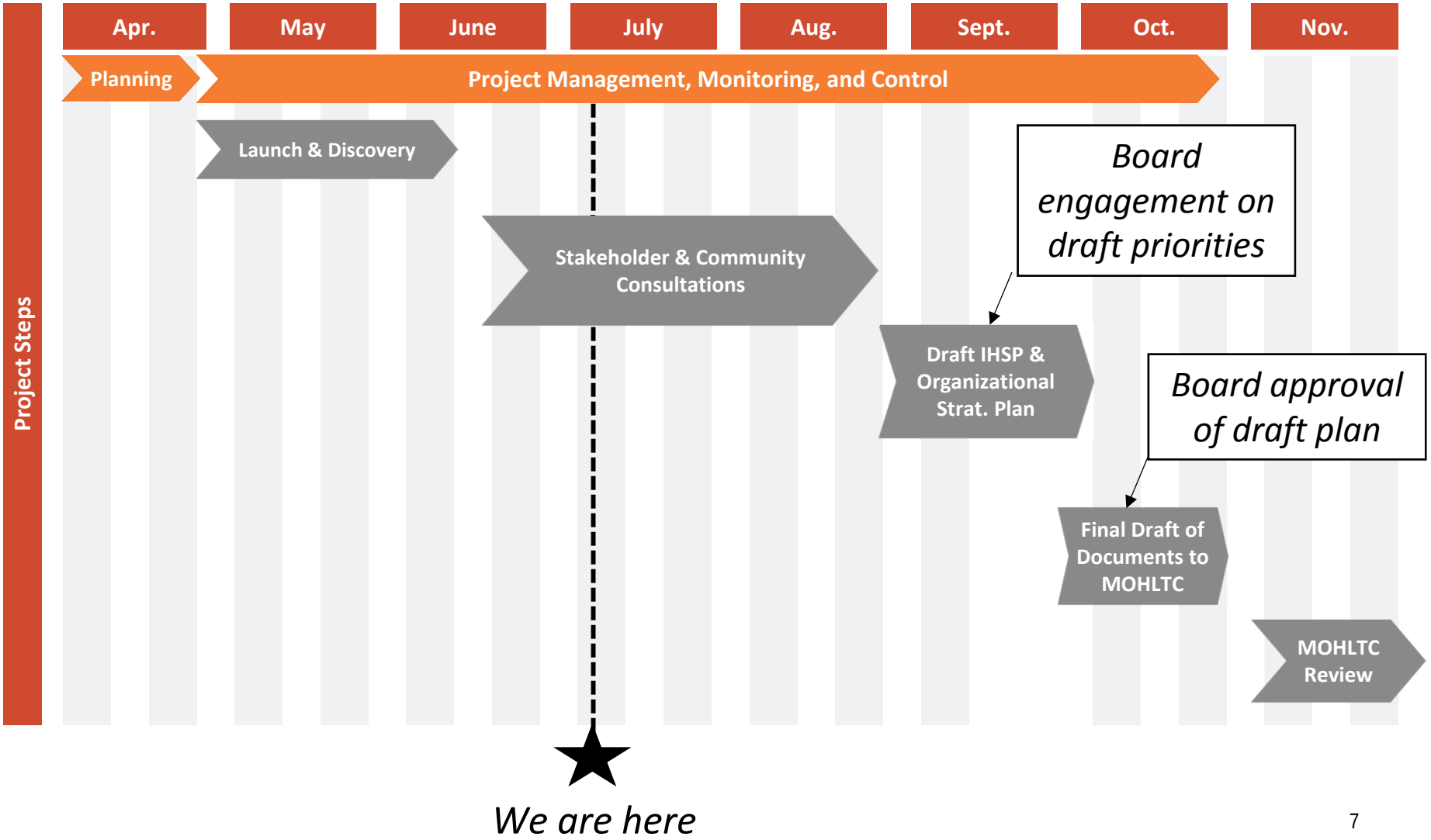
Rate per 100 people, 2013 (age 12+)

	SOUTH WEST	ONTARIO
Arthritis (age 14+)	20.6	17.3
Asthma	9	7.5
Cancer	1	1.9
Chronic obstructive pulmonary disease (age 35+)	4.8	4.3
Diabetes	7	6.6
High blood pressure	17.5	18.3
Heart disease	4.7	4.8
Have a chronic condition	39	37.3
Have multiple chronic conditions	15.6	15

Demographics, health status indicators, and population growth all pose challenges that will influence how and where healthcare services need to be delivered in the South West LHIN.

Full LHIN-wide and sub-region analysis of population statistics will be available for planning purposes.

IHSP and Strategic Plan Development Timelines



Engagement Strategy – Summer/Fall 2018

Leverage internal and external expertise to inform key strategic priorities for the organization as well as LHIN-wide and sub-region health system priorities.

1. Leadership Retreat (Administrative and Clinical) on June 25th to set the stage and provide key themes.

2. Internal
   - Build awareness
     - All - Staff meetings
     - Newsletter
   - Conversations at staff meetings
   - Conversation with the Cultural Transformation Committee
   - On-line survey

3. External
   - Conversations with Sub-region Integration Tables, Patient and Family Advisory Council, and Health System renewal Advisory Committee and other South West LHIN-wide committees
   - Conversations with key groups of health system providers
   - Conversations with municipal and provincial leaders

4. Board
   - Focused discussion on draft priorities
   - Approve draft Integrated Health Service Plan for submission to the Ministry
   - Approve internal strategic plan for implementation

Core Questions being used to Assist in IHSP and Strategic Plan Development

1. What is working well in South West LHIN and should continue?
2. What are the things that are getting in the way of the South West LHIN successfully achieving its vision?
3. What are the new things that the South West LHIN should explore to be successful in achieving its vision?
4. What are the most important health care related issues that need to be addressed in the next three years?
5. Are there other considerations that we should know from the community?

Discussion

1. What does Board engagement on the draft Integrated Health Services Plan and Strategic Plan priorities look like in September?

2. The Board to Board reference group is meeting in September. How would you like to engage with this group on the draft priorities?

3. Provincial MPPs from the South West LHIN are included in the overall external engagement strategy. What strategies for this engagement would you recommend?