South East Local Health Integration Network

Board of Directors Meeting No. 114 A

Wednesday February 05, 2014

Family and Children's Services
of Frontenac Lennox and Addington
817 Division Street
Kingston, Ontario

M I N U T E S

Present: Donna Segal (Chair)**; Andreas von Cramon (Vice Chair) **; Lois Burrow**; Janet Cosier**; Len Kennedy**; Arthur Ronald**; Dave Sansom** (quorum); and Paul Huras**
Recorder: Jacqui Prospero **
Regrets:
Guests: Sherry Kennedy (COO); Pat Reynolds (Board Coordinator)**; Caitlin denBoer (Communications Lead)**; Darryl Tooley (Sr. Consultant, Performance Optimization); Rick Giajnorio (Sr. Consultant); Cynthia Martineau (Director, Health System Design)**; and Jennifer Payton (Planning & Integration Consultant); Amanda ??? – KPMG;

** via phone

D. Segal provided comments – please insert here

Paul's remarks were captured via written notes he provided:

- My job is to get you the best advise possible based on the best evidence available
- Strong, detailed, well laid out process which is focused
- 1st – Improving the patient journey – the vision, principles, strategies
- 2nd – functional / operational structural changes which will achieve the tactics, which will improve the patient journey
- 3rd – the form – what will get us there
- 2 weeks ago two separate comments on the same day
    - Large place – liked where we are with AMH, but understood we are doing the right way and we don't need anyone from Kingston telling us what to do
    - 4 hours later… large place from Kingston said we are doing it the right way – just let us
- The factors are not rocket science and have been documented before in every part of the province, but with no action.
- We need system lenders to step out and say no one organization can do this in isolation, we need to work together to affect change
- Whatever form is deemed best we must hold it accountable to the functions we have identified as essential and the timelines to get it done.
- On behalf, I made a guarantee to the clients, their families and AMH HSP that recommendations would be implemented this time.
- Health Links is not the answer.
- Some of the strongest expertise in the province in health links reside in the SE LHIN – Health links are not designed to run hospitals, CCAC or AMH
- We need standard protocols for each sector to enable Health Links to link` with them.

1. **Call to Order, Chair's Remarks and welcome of guests.**
   The Chair welcomed guests and members to the meeting at 1:15 pm.

2. **Selection of Timer and Observer:**
   a. Timer = Chair deemed not required due to conference call.
   b. Observer = L. Kennedy

3. **Conflict of Interest Declaration**
   All members confirmed no conflicts.

4. **Approval of the Agenda**
   That the Agenda be approved as circulated.

Moved by: A. von Cramon
Seconded by: D. Sansom
Carried – 2014-114A-01

5. **Business Arising:**

a. Addictions and Mental Health Redesign Update on Option Development – 1:18 pm

- S. Kennedy asked the members to share with the team their thoughts on the AMH redesign in order to better understand the nature of other deliberations that occurred and what was said; it was noted that leadership; structure; and governance have not been discussed in the majority of the process, but expected to be part of a more advanced process. Articulating and understanding the problem was key; the optimal client journey was created to try and better address how we would prefer clients to move through the system; the AMH redesign grew from the Clinical Services Roadmap (CSR) i.e.: tweaking or adding foundational pieces across the region were not going to solve the problem; some organizational interests have gotten in the way of this process; there were more than seven options originally, but they were narrowed down to three – including risks and benefits for each option as many were similar in design and scope.
- Board members expressed their concern about how the task force got to the three options presented to the board; the need for a better understanding of the implications to the organizations that are going to be involved; stakeholder buy-in to the solution; the need for high level plan and implications of implantation in order to drive towards a decision would be helpful, but understand not likely due to resource constraints; political ramifications and financial challenges to the rural communities; what are the specific problems that really manifest themselves – how we think they can be solved, without considering governance options? What are the problems? Form before function? Needing buy in from all those that are involved in the process now (doing the job now), but believe they need to tell us they need change and want to be involved in that change; regional strategies are something that the LHIN board has not done a good job of; a need to focus more on community based supports for all healthcare services the LHIN overseas; persuading the current governance of what needs to change – the behavioural, standards, expectations, contractual agreements, etc.; the need for change is understood, but not always how and why. Access, referral, EMR – are all elements required for all of the community – not just AMH clients – how do we manage this for other patients – issues that are common to all clients in the system – Chronic Diseases, etc.; Not clear on Option 1 – behaviours, standards and accountability – we haven't been successful with option 1 – but not sure why – perhaps organizational interests get in the way; what would it take to close the gap on the two or three biggest hurdles with the first option. There is a need to bring the stakeholders along with the board understanding of what is happening as this has not been as fulfilled and leaves the LHIN and this project with operational and communication risks; when a new "board" is created within the options who

the highest tier of board will hold the accountability with the LHIN, but would have the powers to delegate down to the geographic boards;

- The three options include the ability to maintain the current governance structure as one of them; the question is which governance will enable the changes to the system that are required.
- Health Links, CSR, assisted living strategies, etc. are not ignoring the AMH clients, but there is still a need for common approaches for how these clients will be addressed across the system – what type of governance do we need in the region to make this happen?
- There are three options on the table for consideration. Change will have to happen, even if the governance of the region for these providers does not change; implementation planning would help to drive out the required changes in specific deliverables – i.e.: common basket of services, co-location, change of charter documents; change of job descriptions – common nomenclature – i.e.: case managers; moving to similar technologies in order to provide consistent services across the system,
- Change management is to create diverting platforms that will allow organizations to move forward with improvements for both the clients and organizations; there currently are no changes to current accountability agreements that would enhance our ability to be more robust; there does not appear to be any "network" approach to provide other options that the LHIN may not have considered,
- The Ministry of Health and Long-Term Care (MOHLTC) is looking at an AMH strategy for the province, but they are not at the advanced level the SE LHIN is at. They are eagerly watching what we are doing to determine the best approach. There are four overarching priorities, the first of which is improved planning, integration ???? (Paul has list).
- It is important to note that option one has not been successful in the past, but is still on the table for consideration; implementation planning would help to flush out some of the constructs for governance would be addressed in options 2 and three;
- No decisions that will be made will be arbitrary in nature.
- Any in-depth fleshing of the options would require more expertise and resources than the LHIN can provide.
- There is a need to ensure that the decision is strategic and that the financials don't drive it.

LEAVE OPEN SESSION – 2:35 pm

That the board consider matters of public interest regarding Approval Addictions and Mental Health Redesign – High Level Implementation Risks pursuant to ss 9(5) of the Local Health Systems Integration Act 2006 s.9 (5).

Moved by: J. Cosier
Seconded by: D. Sansom
Carried – 2014-114A–02

6. In Camera Session: - 2:40 pm

That the Chair rise and provide a verbal report from an in-camera discussion on Addictions and Mental Health Redesign – High Level Implementation Risks.

Moved by: D. Sansom
Seconded by: J. Cosier
Carried – 2014-114A–03

7. *Timer – not required.*

Observer – good discussion, although quite lengthy the use of phone during these challenging weather conditions were helpful. The in-camera session was helpful in allowing the members to better understand some of the more intricate details involved.

8. Date, time and location of next meeting:
Monday February 24, 2014 – SE LHIN Offices

Future meetings:
Monday March 31, 2014 – SE LHIN Offices
Monday April 28, 2014 – SE LHIN Offices
Monday May 26, 2014 – SE LHIN Offices
Monday June 23, 2014 – SE LHIN Offices

9. Adjournment
That the meeting be adjourned at 4:35 pm

Motioned: D. Sansom

Noted departures:

Meeting Chair: _____
Donna Segal

Secretary: _____
Paul Huras