Fairview/Parkwood Mennonite Homes
Board Agenda
March 28, 2019 5:30 pm Fairview Boardroom

Call to Order, Opening Remarks	Marion Good
Approval of Agenda	Marion Good
Devotions (next meeting Ruth Konrad)	Marion Good

Fairview Mennonite Homes

Minutes (February 28/19) — Marion Good

- Resolution to Approve

Business Arising — Marion Good

Report from Leadership — Elaine Shantz

- CEO Report
  - Resolution – CEO Report (2/19)

- Executive Director Key Performance Indicators — Christine Normandeau
  - Resolution – Executive Director Report (2/19)

- Quality Improvement Plans (to be submitted to the LHIN) — Elaine Shantz
  - Resolution

Resolution to adjourn Fairview Business — Marion Good

Parkwood Mennonite Home

Minutes (February 28/19) — Marion Good

- Resolution to approve

Business Arising — Marion Good

Report from Leadership — Elaine Shantz

- CEO Report
  - Resolution – CEO Report (2/19)

- Executive Director Key Performance Indicators — Elaine Shantz
  - Resolution – Executive Director Report (2/19)

- Quality Improvement Plans (to be submitted to the LHIN) — Elaine Shantz
    - Resolution

Resolution to adjourn Parkwood Business — Marion Good

Joint Agenda

1. Policy & Ethics Committee Report — Jennifer Krotz

2. Tri-County Shared Services Proposal — Elaine Shantz

3. 2019 Dates to Remember:

Thursday, April 25th	Board Meeting, Parkwood
Thursday, May 23rd	Board Meeting, Fairview
Wednesday, June 19th	Annual General Meeting, Parkwood
Monday, June 24th	Board Summer Event, Cambridge Mill

Resolution to adjourn meeting — Marion Good

In camera session with CEO

In camera session with Board

FAIRVIEW MENNONITE HOMES

BOARD of DIRECTORS MEETING MINUTES # 2019 – 561

February 28, 2019

Present:	Marion Good	Fred Schiedel
	Bob Shantz	Jennifer Krotz
	Ed Nowak	John Shantz
	Ken Frey	Ruth Konrad
Absent:	Nancy Mann	
Staff:	Elaine Shantz, Brent Martin, Barb Montague	

A. NEAR TERM ISSUES AND REPORTING

1. Minutes of Meeting #2019-560

Motion to approve the minutes of #2019-560 dated January 24, 2018 was made by Ken Frey;
Seconded by Ed Nowak Carried

2. Report from Leadership

CEO Report:
The CEO report was presented by Elaine Shantz;
Highlights included:

A corrective action plan is currently being developed for the RQI, which proves to be a challenging process.

Negotiated with peopleCare to purchase their nursing policies; will be consistent across the organization.

The Francophone model to integrate minority groups in LTC will be finalized the end of March.

Elaine discussed a possible spiritual care partnership with Preston Mennonite Church and Wanner Mennonite Church.

The law suit between Angeline Ball and Cambridge Landscaping/Fairview has been resolved, with no liability.

Motion to authorize Marion Good to sign the LSAA on behalf of the Board was made by John Shantz;
Seconded by Fred Schiedel Carried

Motion to authorize Marion Good to sign the MSAA on behalf of the Board was made by Ken Frey;
Seconded by Ruth Konrad Carried

Motion to adopt the WWLHIN Patient Declaration of Values was made by Fred Schiedel;
Seconded by Ed Nowak Carried

Motion to accept the CEO report as presented was made by John Shantz;
Seconded by Bob Shantz Carried

Executive Director Key Performance Indicator Report:
Elaine Shantz presented Fairview's Key Performance Indicator Report.

Motion to accept the Executive Director report for January was made by Jennifer Krotz;
Seconded by Fred Schiedel Carried

Executive Director's Operational Plan:
Elaine Shantz advised the top 3 objectives of the plan;

1. Compliance
2. Building
3. Growth Opportunities

Budget Presentation:
Bob Shantz advised that the Finance Committee met to review budgets. Budgets were circulated to the Board for consideration.

Brent Martin reviewed the General Assumptions from the Budget which was provided to the Board; Brent advised the budget has a net income of approximately $300,000.

Motion to approve the Budget as presented was made by Bob Shantz;
Seconded by John Shantz Carried

Motion to adjourn Fairview's meeting was made by Ruth Konrad;
Seconded by Jennifer Krotz Carried

B. JOINT AGENDA

1. Spiritual Care Working Group Elaine Shantz

As part of the Strategic Plan, Elaine Shantz advised there will be a working session on April 2nd to develop a faith-based platform which will move us forward into the future. Participants will include leadership from both homes, Marion Good, key external community partners as well as a facilitator.
Elaine extended the invitation to the Board members for their participation.

2. **Annual Meeting/Annual Report** Elaine Shantz

   The AGM will be held on June 19th; possibly at Parkwood in the Fellowship Hall; however, if we open the invitation up to include community and our residents, we may need to hold at a larger venue.
   The theatre group, 'No Longer Relevant' will be performing.

3. **Policy Review** Jennifer Krotz

   The Board policies will be reviewed annually going forward.
   Jennifer asked the Board take the next month to look at the policies and send any comments or proposed changes to Barb Montague; a committee meeting will be scheduled sometime after the next Board meeting to review.

4. **Procurement Standing List Approvals** Brent Martin

   Brent presented a Payment Exemptions document stating that, in recognition of the Procurement Policy, certain vendors would be exempted and payments over $25,000 (up to $100,000) will require authorization from any two signatories.

   Motion to approve the Payment Exemptions made by Bob Shantz;
   Seconded by Fred Schiedel Carried

Motion to adjourn the meeting at 9:30 PM made by Ken Frey;
Seconded by Fred Schiedel Carried

In camera session with CEO

In camera session with Board

Chief Executive Officer Report
Fairview Mennonite Homes
February 2019

1. Community meetings

Internal/External

Strategic Plan: CEO attended resident coffee break to roll out the strategic plan at Fairview. Over 100 residents attended from Independent Living, Villas and Retirement Living. It was a positive experience to interact with residents. They were keenly interested in future plans for Fairview. Meeting dates have been set for Parkwood in April.

Two employee coffee breaks were well attended by front line team members to roll out the strategic plan. Employees were also introduced to the Kindness initiative. It was good to spend time with the front-line team allowing them to ask questions. Meeting dates have been set for Parkwood in April.

Anniversary Lunch: CEO celebrated one-year anniversary with a leadership team lunch. It has been a privilege to be the CEO of Fairview and Parkwood. The year has been filled with both opportunity and challenge. It was good to celebrate with the leadership team – they have come a long way in 12 months. The team was able to set 5 stretch goals for the next year!

Ontario Health Care teams: Things continue to move forward at a rapid pace with health care modernization. CEO has been involved in discussion with Cambridge North Dumphries group as potentially an early adopter Ontario Health team. Several working sessions have taken place, as well as, a dinner which involved CEOs and Governors. Marion Good, Bob Shantz and John Shantz attended. Included in as attachments to the Board report are 1) CND Leadership Conversation from the CEO working group; 2) Governors Session Meeting Notes; 3) Cambridge, North Dumphries Governors Session and; 4) Meeting Evaluation the summary of questions from the session.

Shared Services: Preparation of the proposal outlining Shared Services to be presented to Tri-County homes in April included numerous meetings for the purpose of discussion and information. CFO and CEO met with Director Administration from Tri-County. CEO met with previous CEOs of Tri-County and Fairview – Bob Veitch and Tim Kennel. Ken Frey from Board of Directors supported CEO with organizational structure and edit of draft. This is presented to the Board for discussion (See attached).

RFP Meetings: Pharmacy presentations, tours and individual meetings have been conducted. The selection process has resulted in deferring the decision for one year. Remedy's will continue to support Parkwood and iPharm Fairview. Both pharmacies agreed to the value-added offers in their proposals. It was a good process and team decision; a growth experience for our team. In one year, we will be better equipped to consider a 5-year, one pharmacy agreement for the organization.

Upcoming Meeting: The LHIN has approved the Integrated Assisted Living proposal for Fairview; submitted in November 2018. Meeting is scheduled for next week to review the Memorandum. A status update will be provided at the Board meeting.

2. Projects

Shared Services Proposal: CEO will present at the March Board meeting.

Information Technology: Continued challenges with our service provider underscores the need to move forward with the hiring of an IT employee.

Cyber Attack: CEO met with claims department regarding recovery of documents. Financial compensation to recreate, purchase and customize documents is under review.

Accounting System Upgrade: This has been deferred until after year end.

Francophone guide: The guide will be completed by March 31 and reviewed in April by the working group. CEO and Francophone team held a conference call with Assistant Deputy Minister LTC who noted this would be a favourable submission if/when Fairview applies for additional LTC beds.

3. Committees

Kindness Committee: The Kindness Committee held its inaugural meeting to determine next steps to roll-out the initiative with consultant Olivia McIvor. This initiative will involve residents, employees, volunteers and families. Twenty kindness mentors will be licenced, (10 at each campus). Persons to be licenced will be selected through an application process. The first year we will focus on friendship, inclusion and trust. There are 12-character traits which allows for the organization to roll this out over the next 4 years. Our goal will be to enrich our culture of kindness through a four-year journey.

Definition of Kindness: Being a positive influencer, resilient, excellent, compassionate, trustworthy, courageous, friendly, service oriented, responsible, integral and inclusive.

Building Committee: Met in early March to review recommendations for enhancement in the Retirement Home and Centre. There was consensus regarding the enhancements recommended. Additional work was requested by the Building Committee to look at the office space in the event accounting offices are moved off-site. A further meeting was held with architect Bob Dyck to move the project forward. Director Building Services is taking the lead on the refurbishing.

Policy and Ethics Committee: Met to prepare a draft Medical Assistance in Dying (MAID) policy for Board consideration. See attached.

Synergy Committee: Preston, Wanner's and Fairview completed a review to determine spiritual care partnership. Wanner's and Preston have determined they will pursue combined pastoral leadership. The next step is to determine how Fairview will participate. While Fairview will continue to move forward with a Director Spiritual Care and Culture; it is the intention to strengthen partnerships through programing integration.

4. Human Resources

Steve Pawelko Executive Director is off work since March 1st due to health-related issues. He is being reassessed the end of May with regards to return to work. Christine Normandeau has taken on the role of Acting Executive Director. While this is a difficult time for all – Christine is providing excellent leadership and stability to the campus and the team.

5. Other

Bill 74 The People's Health Care Act

The second reading of Bill 74 is almost complete, and it is expected it will go to standing committee shortly. While there are many conflicting rumors about what this means for us and how quickly change will take place, new information appears to be forthcoming each day. The greatest uncertainty is the Ontario Health teams, how we in LTC fit into these teams, and what the governance for LTC will look like in the future.

As noted above, Fairview has been approached to be part of the Cambridge North Dumphries proposal to become an early adopter Ontario Health Care team. This is one option for us to consider; however, it leaves Parkwood on its own. There is a possibility to form or join a frail elderly team. CEO has been approached to consider becoming a lead. This is a stretch for an organization the size of Fairview/Parkwood; larger organizations such as St. Joe's in Guelph might be better suited.

CEO will continue to seek as much information as possible to support the Board in future decisions. After the governor's meeting, a discussion with Lisa Levin CEO of Advantage regarding the model proposed was helpful. Lisa advised the Cambridge North Dumphries model appears to be taking on the form of a merger. It is now understood there will be different models of governance allowed. The Accountable Care Partnership model should also be considered. Expressions of interest will be forthcoming from the Ministry for early adopters, soon, which should provide more detail.

In summary, health care reform has been ongoing for over 30 years and to-date reforms have not produced the improvements in access and quality of care the provincial governments expected. Because of this, and based on current trends, further reform to integrate service delivery is likely. It is still unclear the requirements for LTC. LHIN CEO Bruce Lackner advises LTC providers take their time; to stay close to what is happening but not to make hasty decisions. CEO will forward information as it is forthcoming.

Centralized Procurement

On March 18, the province issued a news release highlighting the government's new and expanded system of centralized procurement. It is important to note LTC is not required to follow the procurement directive.

6. Risk

As reported at the February Board meeting the AB claim has been resolved without liability to Fairview.

There are no outstanding claims currently to report.

Cambridge North Dumfries

Leadership Conversation:

Preparing for Health System Change
Meeting #4

MARCH 18, 2019

1. Welcome, Introductions, and Objectives

- Patrick Gaskin, CMH
- Bill Davidson, Langs

- 12:15pm to 12:20pm

Meeting Objectives

1. Define key characteristics of a CND Ontario Health Team model
2. Prepare for March 19 Governor's Session
3. Confirm workplan for completing the Expression of Interest

Agenda

Item	Time
Arrival and lunch to be served	*12:00 – 12:15 PM*
1. Welcome, Introductions and Objectives	12:15 – 12:20 PM
2. Updates	12:20 – 12:30 PM
3. CND Ontario Health Team Scope	12:30 – 1:15 PM
4. Development of service delivery integration model	1:15 – 2:15 PM
5. Development of governance model	2:15 – 3:00 PM
6. Review of key messages and supporting information	3:00 – 3:15 PM
7. Preparation for Governor's Meeting	3:15 – 3:40 PM
8. Commitment and decision-making	3:40 – 3:50 PM
9. Next steps	3:50 – 4:00 PM

2. Updates

- All participants

12:20pm to 12:30pm

1. Information updates
2. Review of EOI criteria (if available)

Health Systems Transformation Updates

Ontario Health

12 Board of Directors announced

3 with background in healthcare

Andrea Barrack – Global Head, Sustainability and Corporate Citizenship at TD Bank Group
CEO for Unison CHC before she became the CEO of the Ontario Trillium Foundation

Adelsteinn Brown – Dean of the Dalla Lana School of Public Health at UofT

Shelly Jamieson – former Secretary of Cabinet and former CEO of the Canadian Partnership Against Cancer

Expression of Interest

- Delayed a couple of weeks
- *Any other updates?*

Premiers Council – Hallway Medicine

- 9 regional engagement sessions sent by invitation only

Alliance for Healthier Communities
Alliance pour des communautés en santé

3. CND Ontario Health Team Scope

- All participants

12:30pm to 1:15pm

1. Review of strategic opportunities and focus identified at March 4 meeting
2. Initial patient population
3. Initial participating sectors
4. Approach to scale/expansion

Strategic Opportunities

From March 4th

- Opportunity to reduce demand on hospital
- Opportunity to shift acute-care spending to primary and community care
  - Strengthen prevention and health promotion
  - Bend cost curve
- Alignment with government priorities
  - “Ending Hallway Medicine”
  - System navigation
  - Focus on primary care, home and community care, and mental health and addictions

Initial Patient Population

From March 4th

- Palliative and end-of-life because significant cost to health system and expected volume increase in CND
- Youth to adult transition – medical and mental health
- Street-engaged people because cuts across sectors
- Mental health and addictions due to CND's experience and current collaborations

What population:

- Involves three or more service providers?
- Aligns with the government priorities?
- Demonstrates our ability to collaborate and work together?
- Is manageable?
- Is a foundation to scale to other populations?

Initial Participating Sectors

From February 20th

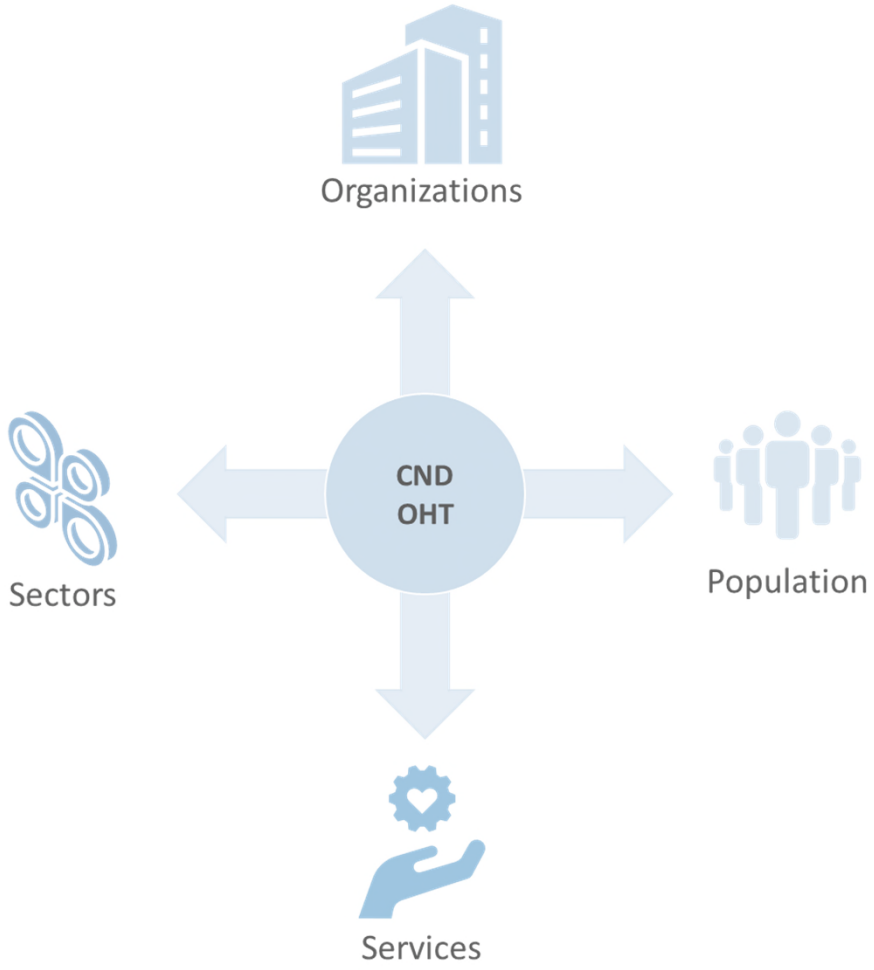
- Coalition of the willing
- Range of types of service providers (e.g., mental health, primary care, community, acute)
- Derived from “those around the table”
- Role for community services (e.g., housing)?

What sectors:

- Are represented at the planning table?
- Have limited barriers to participating in the new model?
- Have flexibility to evolve if the model evolves?
- Have existing collaborations that can be leveraged?
- Would present a compelling story due to stronger collaboration?

Approach to Scale / Expansion

What are the priorities for scaling across CND?



4. Development of Service Delivery Integration Model

- All participants

1:15pm to 2:15pm

1. Initial basket of services
2. Potential models of integration
3. Identification of integration mechanisms
4. Shared services and Enabling Technology

Initial Basket of Services

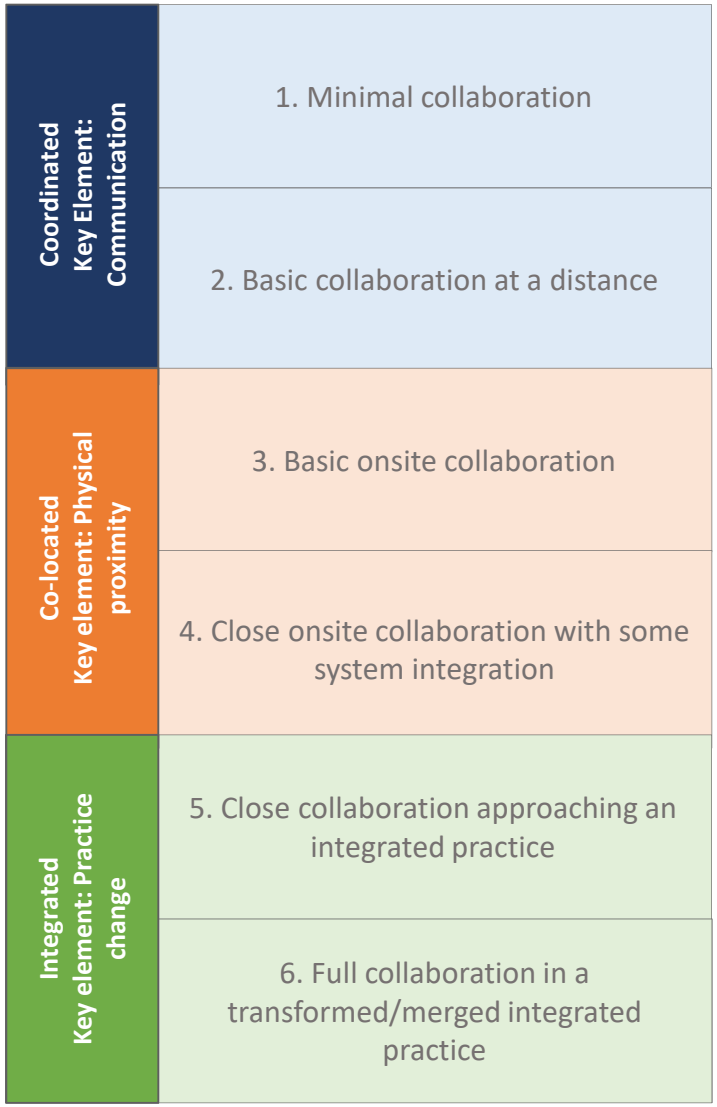
Examples

What services:

- Will demonstrate early wins?
- Are necessary from the start to support the target population?
- Are easily incorporated into a collaborative model?
- Can be added later?

Potential Modes of Integration*

- *What is achievable within the initial year?*
- *Does the model change over time?*
- *Does the model vary depending on service or organization?*
- *What steps have to be in place to achieve the model?*



SAMHSA-HRSA Standard Framework for Levels of Integrated Care

Identification of integration mechanisms

Common protocols

- Referral pathways
- Intake and assessment
- Screening and service

Team collaborations

- Shared care or service plans
- Case conferencing
- Shared professional development
- Educational opportunities

Planning tools

- Collaborative quality improvement plans
- Shared care visions

Infrastructure

- Digital health tools
- Co-location (client spaces)
- Shared staff spaces

- What are the priority mechanisms to support the model?
- Are there other integration mechanisms to consider?
- Which integration mechanisms can be added as the model evolves or expands?

Shared Services and Enabling Technologies

Examples of Services to Share

- Reception
- Building Maintenance
- IM-IT Support & Planning
- Back-office services

Examples of Technologies to Share

- EMRs/HIS
- Back office systems
- Provincial/ Regional Systems
- Client information systems

What shared services and technology:

- Are readily available?
- Can support integration and collaboration?
- Should be added later?

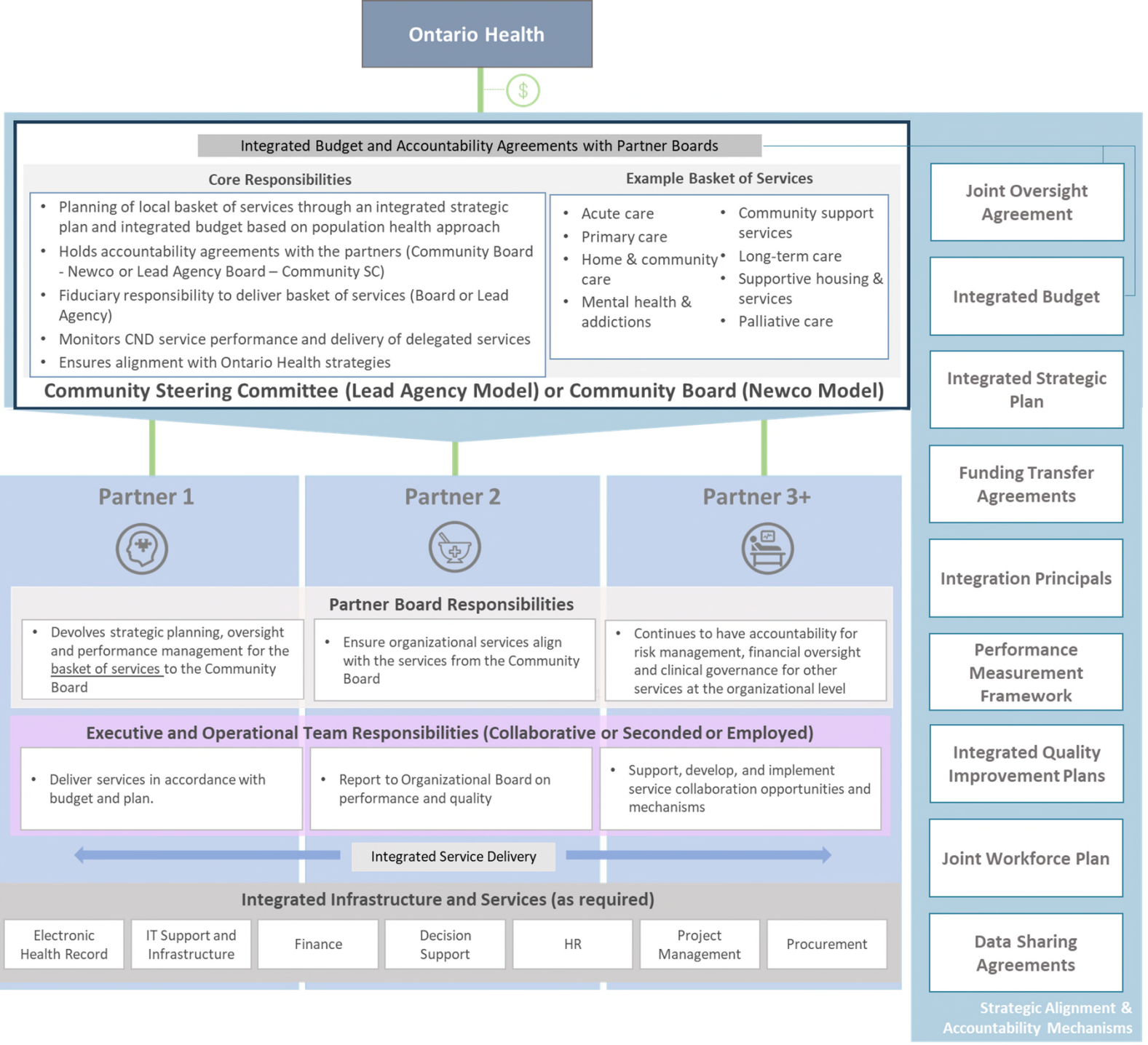
5. Development of Governance Model

- All participants

2:15pm to 3:00pm

1. Funding model (if known)
2. Legal structure
3. Decision-making
4. Accountability mechanisms
5. Strategic alignment mechanisms

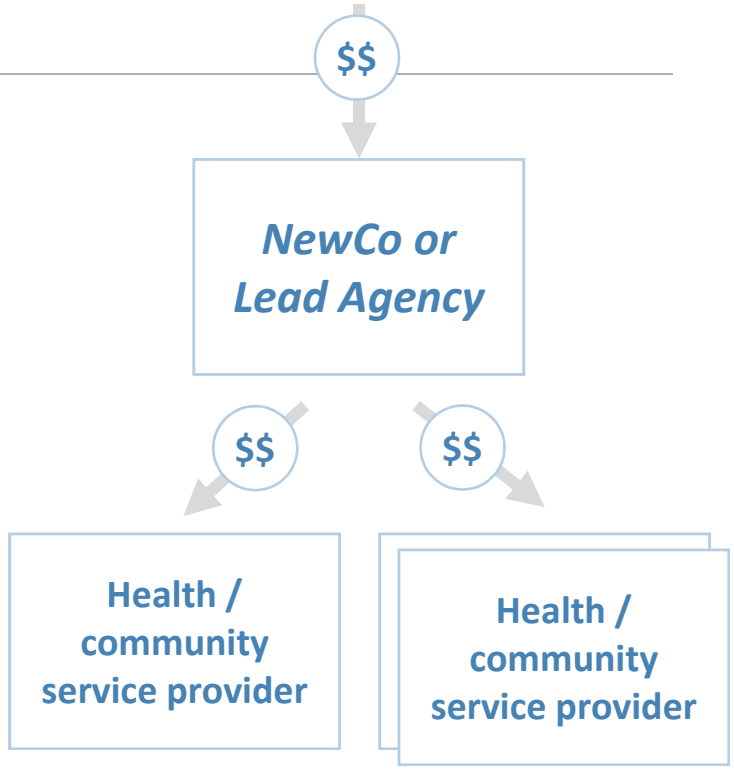
Future-state Vision



Funding Model

Known

- Single pot of funding
- Single organization receives the funding to be dispersed to other organizations
- Remaining funds can be retained and reallocated as desired
- Lots of unknowns

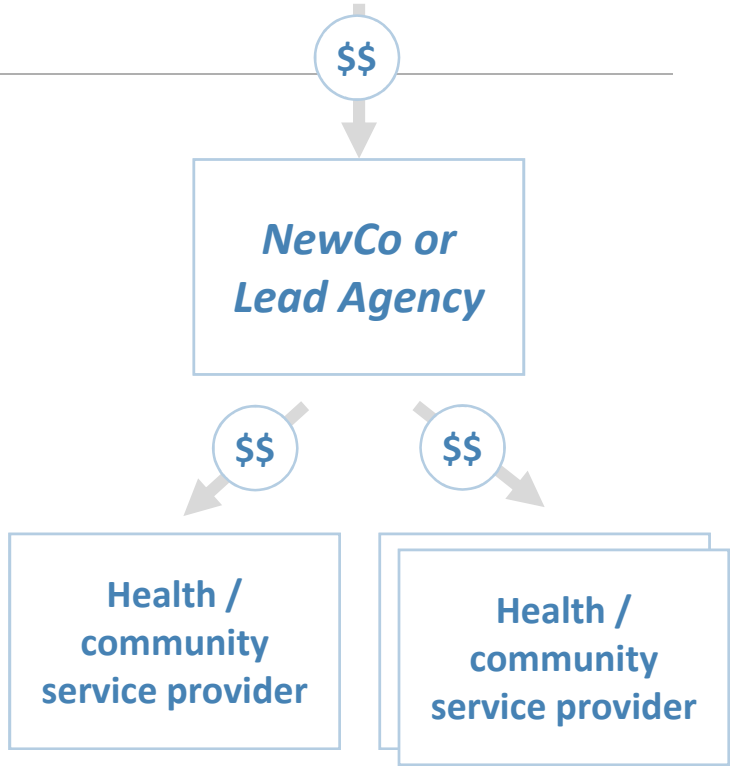


- Should an existing partner receive and disperse the funds (Lead Agency Model)?
  - Which has the back-office capability?
- Should a NewCo be established to receive and disperse the funds?

Legal Structure

Characteristics

- NewCo established or Lead Agency appointed as single point of accountability
- Partners retain existing legal and governance structures
- Lead Agency or NewCo under Community Board receives and direct funds according to accountability agreements among the partners
- Staff remain with existing employers with possibility of secondment or new hire for an integrated executive team

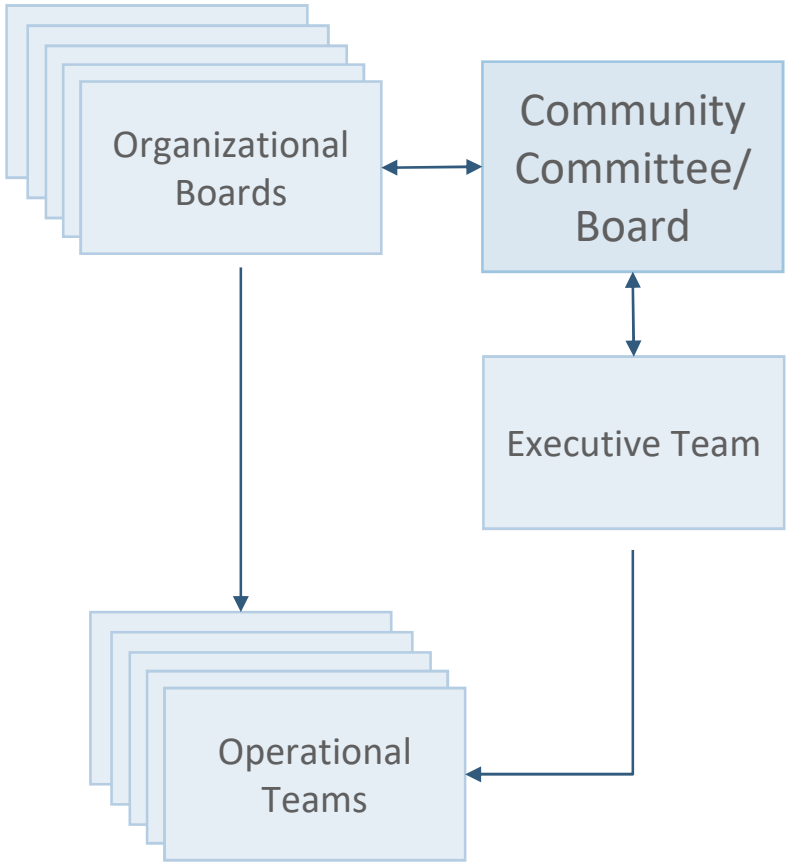


- What are the perceived benefits and risks associated with each option?
- Other models for consideration?
- Consideration: Unknown if OHT EOI will required a specific model

Decision-making Structure

Characteristics

- Community community/board comprising representation from partners and CND community
- Board could be a “steering committee” structure under a Lead Agency model
- Or a “board” structure of a NewCo
- In either model partners maintain own organizational boards and executive and operational teams

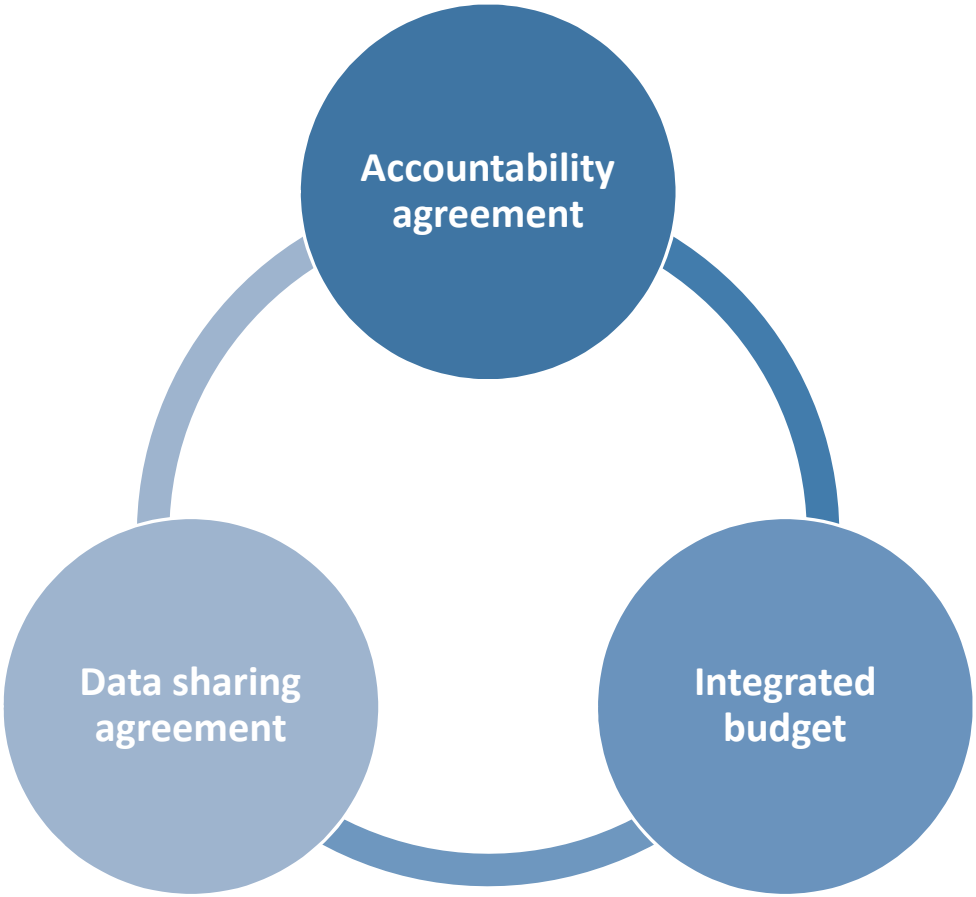


Decision Making Structure

Decision Making Roles and Responsibilities

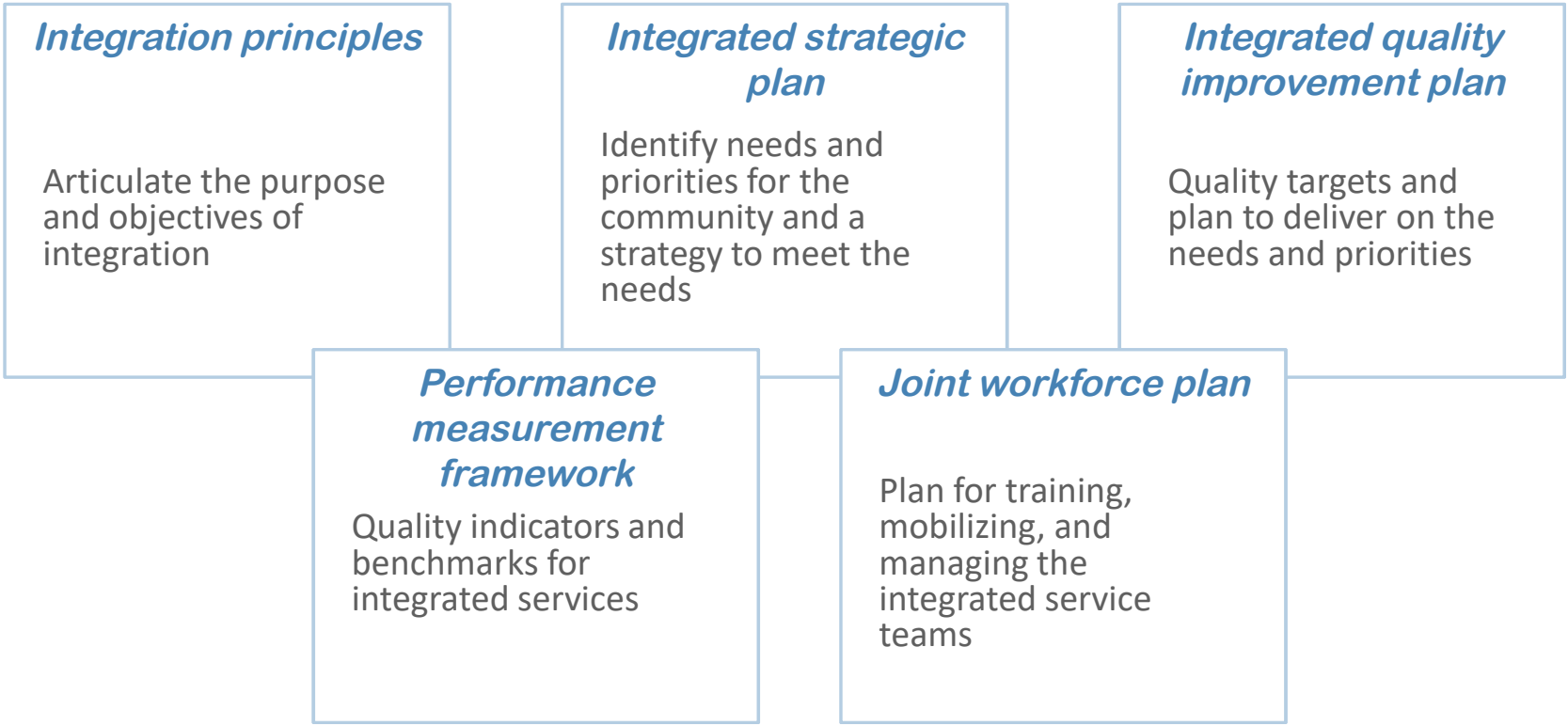
Community Board	• Develops and maintains the strategic plan and budget • Holds accountability agreements with the partners • Fiduciary responsibility to deliver basket of services • Establishes service collaboration structures • Monitors CND service performance and delivery
Organizational Board	• Devolve strategic planning, oversight, and performance management for the basket of services to the Community Board • Ensure organizational services align with delegated services from Community Board • Continues to have accountability for risk management, financial oversight, and clinical governance at the organizational level
Executive and operational teams	• Deliver services in accordance with budget and plan • Report to Organizational Board on performance and quality • Support, develop, and implement service collaboration opportunities and mechanisms

Accountability Mechanisms



- Are there other accountability mechanisms that should be in place?

Strategic Alignment Mechanisms



- Are there other strategic alignment mechanisms that need to be in place?
- Which mechanisms are higher priority?
- Are there mechanisms that can be deferred until a later phase?

6. Review of Key Messages and Supporting Information

- All participants

3:00pm to 3:15pm

1. CND profile
2. Partner profiles
3. Readiness characteristics

CND Profile

From March 4th

- Community needs and trends
- Mortality and morbidity
- Examples of patient trust and testimonials
- Supporting documentation includes HealthLink Expression of Interest, Collaborative Quality Improvement Plans, Mortality and Morbidty stats from public health, Sub-regional profiles from WWLHIN

- Is there other information to include in the CND profile?
- Who will provide the planning group with the documentation?

Partner Profiles

Saint Lukes Place			
Established	[year]	Sector	Long Term Care
Description	please provide a short description of your organization – up to 250 words		
Funding Sources	please provide a list of all your funding sources *e.g., LHINS, MOHLTC, fundraising*		
Target Population	If applicable - please describe the target population your organization serves *e.g., specific catchment area, demographics*		
Partnerships and Collaborations	Please list any partnerships or collaboration initiatives with other organizations *e.g., partnership with home and community care, public health unit, region, etc.*		
Services Provided	This section was completed by referencing your accountability agreements with the LHIN. Please verify the information below.		
Digital Health Technologies	Please list any digital hea collaboration *e.g., ConnectingOntario, e*		

Service Categories	Service Examples
Residential Services	• LTC beds • Dietary services
Case Management/Support	• Nursing Support

- Is there other information to include about the organizations?
- Who at your organization will complete the profile?

Readiness characteristics

Governance readiness examples from March 4th

- Lead Agency model for Children's Mental Health (Lutherwood)
- Sub-regional planning table
- Primary care working group
- CMH – Department of Family Medicine demonstrates relationship between primary and acute services

- Are there other examples of readiness?
- Which ones tell the most compelling story?

Readiness characteristics

Service integration readiness examples from March 4th

- Coordinated Care Plans
- Collaborative Quality Improvement Plans
- CSS integrations (from a few years ago)
- Here 24/7 – MH&A services, intake and referral
- SOS Team
- In-home Team
- Neighbourhood Approach (CSS?)
- Situation Tables
- The Hub(s)
- Regional Care Coordination (Diabetes, Orthopedics, Back pain coming soon)
- CareDove (system navigation and referral)
- System Coordinated Access (status?)

- Are there other examples of readiness?
- Which ones tell the most compelling story?

Readiness characteristics

Technical readiness examples from March 4th

- CareDove
- System Coordinated Access
- Here 24/7 Portal
- Virtual visits and evisits
- CMH – Co-health and MyChart
- eHealth Centre for Excellence
- Tech start-ups in the region
- Consolidation on Caseworks
- Community withdrawal support app
- EMHWare – Used by all lead agencies and 130 agencies provincially
- Digital, clinical communities of practice

- Are there other examples of readiness?
- Which ones tell the most compelling story?

7. Preparation for Governors' Meeting

- All participants

3:15pm to 3:40pm

1. Review draft agenda
2. Additional key messages or content

Draft Agenda

5:15pm	5:30pm	5:45pm	6:00pm	6:20 pm	7:00 pm	8:00pm
Registration	**Dinner**	**Welcome**	**Update**	**Discussion**	**Q&A**	**Adjourn**

Health System Transformation (20 min during dinner)

- Premier's Council Report on Ending Hallway Medicine
- People's Health Care Act, 2019
- Ontario Health Teams
- CND Health System Transformation Work to date (Chris, Patrick)

A potential model for a Cambridge North Dumfries Ontario Health Team (20 min)

- Strategic benefits and risks of being an early adopter
- Expression of Interest process and criteria (if known)
- Overview of potential model for a CND OHT

Q&A Session (30 min table discussion; 20 min plenary discussion)

- Where do you see opportunities for collaboration and integration?
- What questions and feedback on potential CND OHT model
- As governors how would you like to be informed and engaged?

Key Messages

- Existing examples of collaboration
- Gentle reminder to not develop competing proposals
- Benefits of participating as an early adopter and risks of not doing so
- Potential for the need of rapid decision-making

- What other key messages do the Governors need to hear?

8. Commitment and decision-making

- All participants

3:40pm to 3:50pm

1. What commitment are we asking from the boards and the organizations?
2. How can we facilitate rapid decision-making among partners?

Review

- Review Draft Governor's Presentation

9. Next Steps

- Daniel Doane

3:50pm to 4:00pm

1. Summary of action items

Joint Board Governors' Session
Provincial Transformation of the Health Care System
March 19, 2019 Galt Country Club
MEETING NOTES

Attendees

Daniel Doane, Facilitator	**MD+A Health Solutions**		
Anil Maheshwari	Grandview Medical Centre	**Anne Tinker**	Saint Luke's Place
Barbara Carter	Langs	**Bill Davidson**	Langs
Bob Shantz	Fairview Mennonite Home	**Brenda Hallman**	Hospice of Waterloo Region
Bruce Lauckner	WWLHIN	**Cheryl Vandervalk**	Cambridge Memorial Hospital
Chris Cassolato	Two Rivers FHT	**Chris Dissanayake**	Grandview Medical Centre
Dave Bechtel	Langs	**David Pyper**	Cambridge Memorial Hospital
Denise Carter	Langs	**Denise Smith**	Cambridge Memorial Hospital
Devon Krainer	House of Friendship	**Dianne DalBello**	Waterloo Region NPLC
Doug Morris	Stonehenge Therapeutic Community	**Elaine Habicher**	Cambridge Memorial Hospital
Elaine Shantz	Fairview Mennonite Home	**Gary Leduc**	Hospice of Waterloo Region
Harpreet Arora	Grandview Medical Centre	**Heather Kerr**	Stonehenge Therapeutic Community
Heather McLeod	Cambridge Memorial Hospital	**Helen Fishburn**	CMHA WW
Ian Miles	Cambridge Memorial Hospital	**Jeff Hunter**	Langs
Jeff Poll	Grandview Medical Centre	**Joe Kane**	Cambridge Memorial Hospital
John Colangeli	Lutherwood	**John Shantz**	Fairview Mennonite Home
Judy Nairn	Hospice of Waterloo Region	**Julie Nicholls**	CMHA WW
Kathy Markowiak	CMHA WW	**Katie Hamilton**	Cambridge Memorial Hospital
Keith Cressman	House of Friendship	**Leanne Terry**	Waterloo Region NPLC
Marion Good	Fairview Mennonite Home	**Mary Friesen**	House of Friendship
Mekalai Kumanan	Two Rivers FHT	**Michael Plauntz**	Hospice of Waterloo Region
Michelle Godin	Waterloo Region NPLC	**Nicola Melchers**	Cambridge Memorial Hospital
Pam McIntosh	House of Friendship	**Patrick Gaskin**	Cambridge Memorial Hospital
Rebecca Stuart	Community Support Connections	**Russ Ashton**	Two Rivers FHT
Salim Muzaffar	Community Support Connections	**Sandra Hett**	Cambridge Memorial Hospital
Sarah Boudreau	Langs	**Sharon Bal**	Delta Coronation FHO
Shazia Alavi	Grandview Medical Centre	**Staci Bartlett**	Saint Luke's Place
Sunny Field	Lutherwood	**Saren Rao**	Cambridge Memorial Hospital
Tim Edworthy	Cambridge Memorial Hospital	**Will Pace**	Community Support Connections
Winnie Lee	Cambridge Memorial Hospital		

Welcome

- Bill Davidson welcomed governors from a wide variety of community agencies to the joint board governors session to begin the important dialogue about what health care looks like as a result of a significant provincial transformation and where to go as a community
- This meeting follows four planning sessions by CND leadership facilitated by MD+A
- Tonight will be a combination of education and the opportunity to participate in dialogue
- Bill acknowledged committee members Patrick Gaskin, Chris Cassolato and Jeff Poll who have organized this meeting
- Bill introduced the facilitator, Daniel Doane, MD+A

Outline

- Will share hard work already done in planning sessions – asking for suggestions to begin the dialogue and encourage everyone's participation
- Participants to capture discussion on Discussion Notes page and leave this at the end of the meeting

Objectives

1. Share updates/information regarding health system changes
2. Discuss opportunities, risks and potential actions of being an early adopter of OHT
3. Overview of potential model for a CND OHT
4. Gather feedback from board members on potential CND OHT model

What questions do you hope to have answered tonight? (Comments from participants)

1. What's next?
2. What choices do we have?
3. What is the timeline?
4. What is the methodology?

Health System Transformation (see presentation page 5)

- Daniel referred to Premier's Council Report on Ending Hallway Medicine, identified areas of concern and opportunities for improvement
- New legislation is Bill 74: The People's Health Care Act, 2019
- This legislation establishes a new agency "Ontario Health" and Integrated Care Delivery Systems as Health Service Providers
- The act has broad integration powers for the Minister; statutory obligation to look for integrations
- Ontario Health is single agency responsible to implement the government's health strategy through five regional offices; single point of fiscal accountability
- 30 – 50 Ontario Health Teams with a minimum of three health service providers per team, each serving an average of 300,000 residents

- **Chris Cassolato** shared there is a great base to work with in this process; build communication, start to build trust
- Primary Care Collaboration Group represents most of the family practices in CND and focus is on sharing resources, identifying gaps and talking about access
- Highlighted participation in discussions about collaborative QIPs

- **Patrick Gaskin** highlighted Specialized Outreach Services program, partnership of Stonehenge and CMHA, integrated team that offer outreach services for vulnerable populations
- Also talked about service of peer support worker through Stonehenge who works in CMH Emergency to support individuals and families in recovery journeys
- Highlighted work of CMHA with Here 24/7

- **Bruce Lauckner** acknowledged work of leaders leading up to this meeting
- Do what's right for your community's residents
- This decision moves to an agency with greater structure, clarity and direction with a single voice
- Home Care still a big question – how and when this will be transferred
- Needs: address opioid crisis, waiting list for mental health services, digital health
- Readiness Assessment expected week of March 25; this is an ongoing process with no set deadlines for setting up Ontario Health Teams
- Focus remains on patients, not on organizations
- This community is well set up for this change, good at collaborating

- **Daniel** thanked Bruce and his team who have been very engaged in work to date, his guidance and insight has been very important
- Daniel invited questions for Bruce:
  - Concern re time given for transition

    - Be mindful of the personal toll on those involved in this process
    - Government wants this to succeed so will be supporting the OHTs
  - HSP's not continuing to exist?
    - Ernst & Young report talks about too many agencies, too many transfer payment recipients
    - Focus on the patient – this community already does this very well
  - Perspective of early adoption?
    - Academics may be first, it's okay to be close second; doesn't have to be perfect; don't worry about structure at this point
  - Where did this come from in a government of nine months?
    - Goal is to change structure; there are serious issues with access to care in parts of the province

Model Discussion (see presentation page 13)

- Remember this is a transformation process
- Strategic benefits of being an early adopter: can set own course, protect community priorities; "Made in Cambridge/North Dumfries" model; opportunity to shape the model; get early adopter support – government wants this to be successful; build on work already done
- Risks include: undefined model, costs/benefits; time and effort required; impact of rapid change
- Mental health and addictions is potential first step for CND OHT; have collaborative QIP, need is high, potential for impact is high; patient centered, team based, wraparound services
- Model 1: Lead Agency
  - Community Steering Committee providing oversight and coordination
  - local and regional service delivery partners
  - executive team
  - shared infrastructure for efficiencies
- Model 2: Community Newco
  - broader basket of services
  - independent board of directors
  - single point of accountability
  - can deliver services or coordinate to contract out through purchased services

Table Discussion and Plenary Session

Summary of key themes from table notes and plenary discussion

1. What is important to you as governors as we advance planning for an OHT?

Theme: Need information to support planning and decision-making

- Need to clearly define the objectives and outcomes (what are the "pain points we are trying to fix?) We need to clearly define what are trying to achieve to understand whether the proposed model will be effective and appropriate.
- Need more information and direction from government. Difficult to create the model when we don't yet know the end-product.
- Need enough time to figure things out.
- Need the right information to understand and manage the risks of health system transformation (financial, patient, foundation fund raising, human resources)
- Lessons learned from other jurisdictions
- Need to assess whether CND is a viable size or whether we need to consider partnering with other sub-regions. Does CND have the critical mass to be its own OHT?
- Need more information on how the entire transformation process will be planned and coordinated.
- What does Phase 2 look like beyond MH&A? Will help answer the "where" and "when" for agencies that don't provide MH&A services.
- Need to be aware and aligned with other government mandates for change (e.g. municipal realignment)

Theme: Importance of communication and collaboration

- Ensure ongoing engagement with and among boards
- Need collaboration among all the agencies – avoid "turf wars"
- How will the different culture of local agencies be managed when they come together?
- How will agencies not involved in phase 1 will have their voices heard?
- Maintaining trust among organizations

Theme: Supporting and engaging patients and staff

- Ensure that our local needs and priorities are preserved
- Improving the patient experience
- Address wait-time issues, particularly for mental health and addiction services
- Minimizing impact on patients during health system transformation, and ensuring that quality and stability of services to patients is maintained.
- Minimizing impact on staff during health system transformation, and ensuring staff input and engagement
- How will services be coordinated with other OHT (e.g. specialist services)

- Being able to retain and attract human resource talent, and maintain knowledge and expertise in our organizations
- Securing input from staff during the planning process and before a submission

Theme: Impact to funding

- Need to understand the potential impact on third-party funding and donations
- A needs assessment to inform funding distribution under a new model
- Information on funding model
- A funding model for planning and integration

2. Where do you see opportunities for collaboration and integration?

Theme: Patient experience and service delivery

- Single point of entry for patients. Improved access – any door is the right door.
- Leverage what we already to well in the local health system.
- Develop a model of care that fully leverage primary care – create a "one-stop-shop"
- Better integrate home care into service delivery
- Ensure that "orphaned" patients have access to a primary care provider
- Include patient perspective and priorities in the new model.
- Collaboration across sub-regions
- Resource sharing for memory clinics, CHF clinics, etc.
- Clear pathways for palliative patients
- Collaboration with communities
- Merging of complimentary services (e.g. LTC and hospice)

Theme: Human resources

- Retain staff in the local health system

Theme: System efficiencies and transparency

- Free up financial resources for front-line care and services
- Lead agency model could be a good transition step toward the Newco model to build trust and transparency across organizations and boards.
- System transparency
- Reduce duplication of services
- Leverage fundraising focused on specific needs

Theme: Information and information systems

- Opportunity for government to mandate a single shared-EMR – but need more information on who would fund the required investment.
- Better knowledge transfer across the local and regional health system
- Standardization of data

3. What do you consider to be the key benefits and challenges with the potential models?

Benefits

- Lead Agency Model
  - Achievable in the short-term
- Newco Model
  - Seems to get at the benefits of the new OHT model that the government is looking for
- Both models
  - Models provide partnering opportunities, especially if done well
  - Potential to reduce barriers for sharing information – privacy barriers less likely under one umbrella structure
  - Savings and synergies that can be achieved in terms of consistent system
  - Opportunity to develop and delivery a clear roadmap for patients for their treatment and care
  - Efficiencies through back-off integration
  - Could improve timely access by removing layers
  - Could improve accountability

Challenges

- Lead Agency Model
  - Might not go far enough, quickly enough
  - How would the lead agency be determined?
- Newco model
  - Do we have the leadership to get to model?
  - How do we get here while still delivering health care?
  - How do we integrate private agencies?
  - How do we ensure fair representation from stakeholders with a strong patient voice and focus?
  - How will wage harmonization be addressed?
- Both models
  - Could these new models actually create silos for regional agencies?
  - How do agencies fit in who don't work in areas of focus? How will their opinions and priories be shared and reflected?
  - How will agencies that work across sub-regions or regions be included?
  - Risk that model lacks personal touch with patients
  - Risk that model advances without sufficient community involvement
  - Lack of a common IT platform; barrier for the movement of information
  - Loss of agency identity
  - Impact on fundraising
  - Complex change/multiple steps required to change
  - Role of independent primary care physician in these models

- Some organizations may not want or be able to participate in these models
- Model might contribute to health system complexity
- If we begin with a focus on one area only (e.g MH&A) what is he incentive for new idea and innovation that are not part of that focus area?
- Impact on union representation?
- Impact on staff morale
- Greater demand and expectations put on staff
- How do we maintain and grow those services during transition if all the attention is on creating new structure?

4. **As governors, how would you like to be informed and engaged?**
   - Additional Governor session meetings
   - Round table discussions – more frequent as Ontario Health is evolving
   - Routine board briefing materials that are consistent and aligned across for all organizations
   - Video or audio recordings of planning meetings and Governors meetings

Wrap up Question

Based on conversations today, is it worthwhile to have executive leads continue to work on this process?

- Strong consensus by show of hands.

Next Steps

- Share information with your boards – presentation from today and outcomes from notes will be shared electronically
- Have conversations with your boards and provide what else your boards need to support Expression of Interest
- Think about your role, where does your organization feel comfortable joining the process

Thanks

- Reminder to leave Discussion Notes and evaluations
- Thanks to Daniel for facilitating and getting through lots of information
- Thanks to governors for being so engaged in conversation; feedback is very meaningful and valuable

Cambridge North Dumfries

Governors' Session:

Preparing for Health System Change

MARCH 19, 2019

Agenda

Item	Time
1. Registration	5:15 – 5:30 PM
Dinner service (presentations during dinner)	*5:30 PM*
2. Welcome and review of topics and discussion	5:40 – 5:50 PM
3. Update: Health System Transformation	5:50 – 6:10 PM
4. A potential model for a Cambridge North Dumfries OHT	6:10 – 6:30 PM
Coffee/desert service	*6:30 PM*
5. Group and Plenary Discussions	6:30 – 7:50 PM
6. Wrap-Up	7:50 – 8:00 PM
7. Adjourn	8:00 PM

Meeting Objectives

1. Share updates/information regarding health system changes
2. Discuss opportunities, risks and potential actions of being an early adopter of OHT
3. Overview of potential model for a CND OHT
4. Gather feedback from board members on potential CND OHT model

2. Welcome and review of topics and discussion

- Bill Davidson, Langs

5:40pm to 5:50pm

3. Update: Health System Transformation

- Daniel Doane, MD+A
- Chris Cassolato, Two Rivers FHT
- Patrick Gaskin, CMH
- Bruce Lauckner, WWLHIN

5:50pm to 6:15 pm

1. Premier's Council Report on Ending Hallway Medicine
2. People's Health Care Act, 2019
3. Ontario Health Teams
4. CND Health System Transformation Work to date
5. Perspective on Health System Transformation

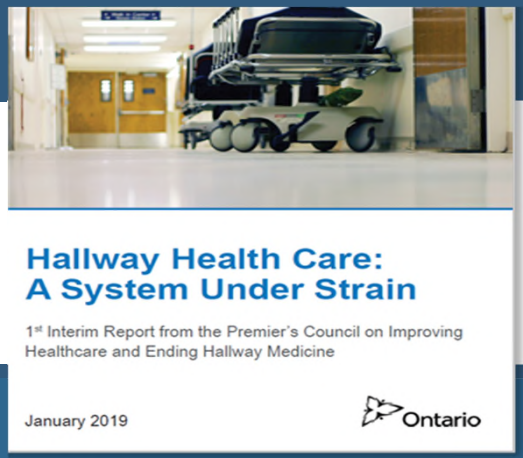
Premier's Council Report on Ending Hallway Medicine

Areas of Concern

- Immediate and long term care capacity pressures
- Difficulty navigating system
- Lack of coordination and efficiency
- Aging population
- Lack of accountability in system (too many players)

Opportunities for Improvement

- Digitally-enabled care
- Integrated health care delivery
  - One seamless partnership
  - Coordinated, wrap around services
- Efficient and modern service delivery



People's Health Care Act, 2019

Bill 74: The People's Health Care Act

Released on February 26, 2019 by MOHLTC

The legislation would establishes:

- 'The Agency' – Ontario Health
- 'Integrated Care Delivery Systems - ICDS' - Ontario Health Teams (ICDS designated as Health Service Provider)
- Broad integration powers for the Minister
- Does not explicitly exclude physicians as HSPs

Establishes statutory obligation for HSPs, ICDSs and the Agency to, separately and in conjunction with each other, seek opportunities to integrate the services of the health system to provide co-ordinated, effective and efficient services.

People's Health Care Act, 2019 – Ontario Health

- **Single** agency responsible for implementing MOHLTC strategy
- **Transfers** functions/powers of six provincial agencies + LHINS to Ontario Health agency and ICDSs

People's Health Care Act, 2019 – Ontario Health Teams

Ontario Health Teams

*a specific **geographic region**, or*
specialized patient population

***single** point of fiscal accountability*

*at least **three** health service providers*

Governance and legal structures have not been prescribed in legislation.

Health Service Providers

- Hospital
- Primary care
- Mental Health or Addictions
- Home care or community
- Long-term care home
- Palliative care
- *Any other service provider supporting or delivering health services*

Ontario Health Teams

By the numbers

30 to 50 Ontario Health Teams

300,000 average number of individuals cared for in a region *(geography or patient population)*

100% eventually will serve Ontario's whole population

Expression of Interest (EOI)

- Rolling intake of proposals
- OHTs to be phased in gradually
- EOI delayed, may be released end of March
- Ministry will assess "readiness" of OHT

Features

Continuum of care by multiple HSP

Defined performance model

Communication and Information Sharing

Virtual Care and digital access

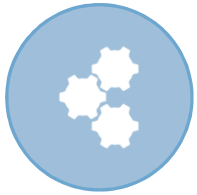
Integration Examples in CND

Planning and Governance

- Sub-Regional Planning Table (Health Link)
- Primary Care Collaboration Working Group
- Collaborative Quality Improvement Plans/Working Groups
  - Mental Health & Addictions
  - Discharge Planning
- CND Mental Health and Addictions Action Plan
- CMH Department of Family Medicine
- Leadership Group on Health System Change

Services

- Coordinated Care Plans (Health Link)
- In-home Team
- SOS Team
- Connectivity Tables
- CMH Regional Care Coordination (Diabetes, Orthopedics)
- MH&A counselling and support shared across primary care
- Community psychiatrist (CMH)
- The Hub



Technology

- Here 24/7 and provider portal (MH&A)
- e-Referral Platforms (CareDove System Coordinated Access)
- Virtual visits and eVisits
- CHRIS (Home and Community Care/In-Home Team)

Perspective on Health System Transformation

Bruce Lauckner

Chief Executive Officer

Waterloo Wellington **LHIN**

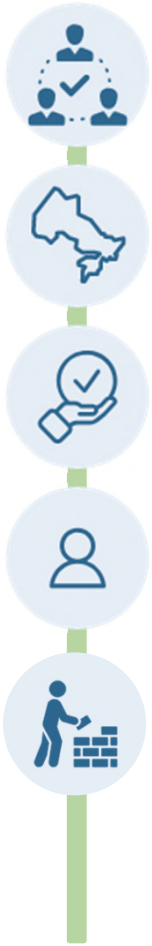
4. A potential model for a Cambridge North Dumfries Ontario Health Team

- All participants

6:15pm to 6:35pm

1. Strategic benefits and risks of being an early adopter
2. Overview of potential model for a CND OHT

Strategic benefits of being an early adopter



Setting our own course and protecting our community priorities

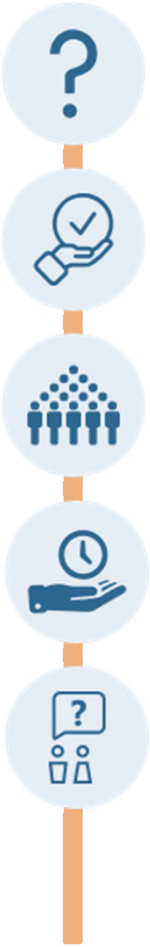
Leadership opportunity to develop innovative model for the province and shapes sub-regional and regional alignment

Potential for early adopter support resources

Deliver improved model of care for patients sooner

Building and accelerating on work that has begun

Risks associated with being an early adopters



Undefined OHT model and process

Undefined cost/benefit proposition

Unknown broader political environment

Time and effort required

Impact of rapid change

Mental Health and Addictions as a potential first step for CND's Ontario Health Team

- *Patient-centred*
- *Team-based collaboration*
- *Wrap-around services*
- *Digitally-enabled*
- *Basis for expansion to other populations and services*

Potential OHT Governance Model

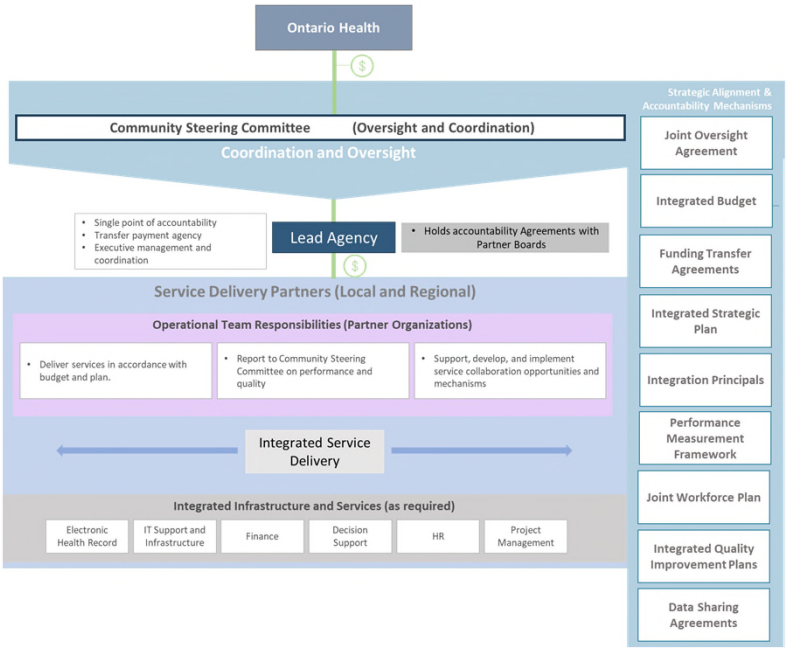
Models are illustrative ONLY!

Starting point for exploring governance and legal structures.

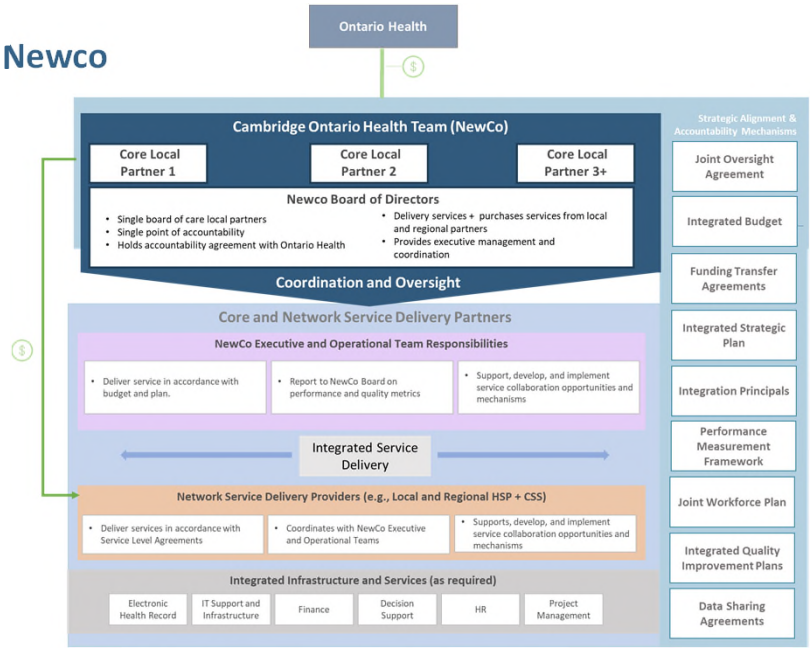
May evolve between models overtime (e.g Model → Model 2)

Seeking Governors' perspectives on these models or suggestions for other potential models.

Model 1: Lead Agency

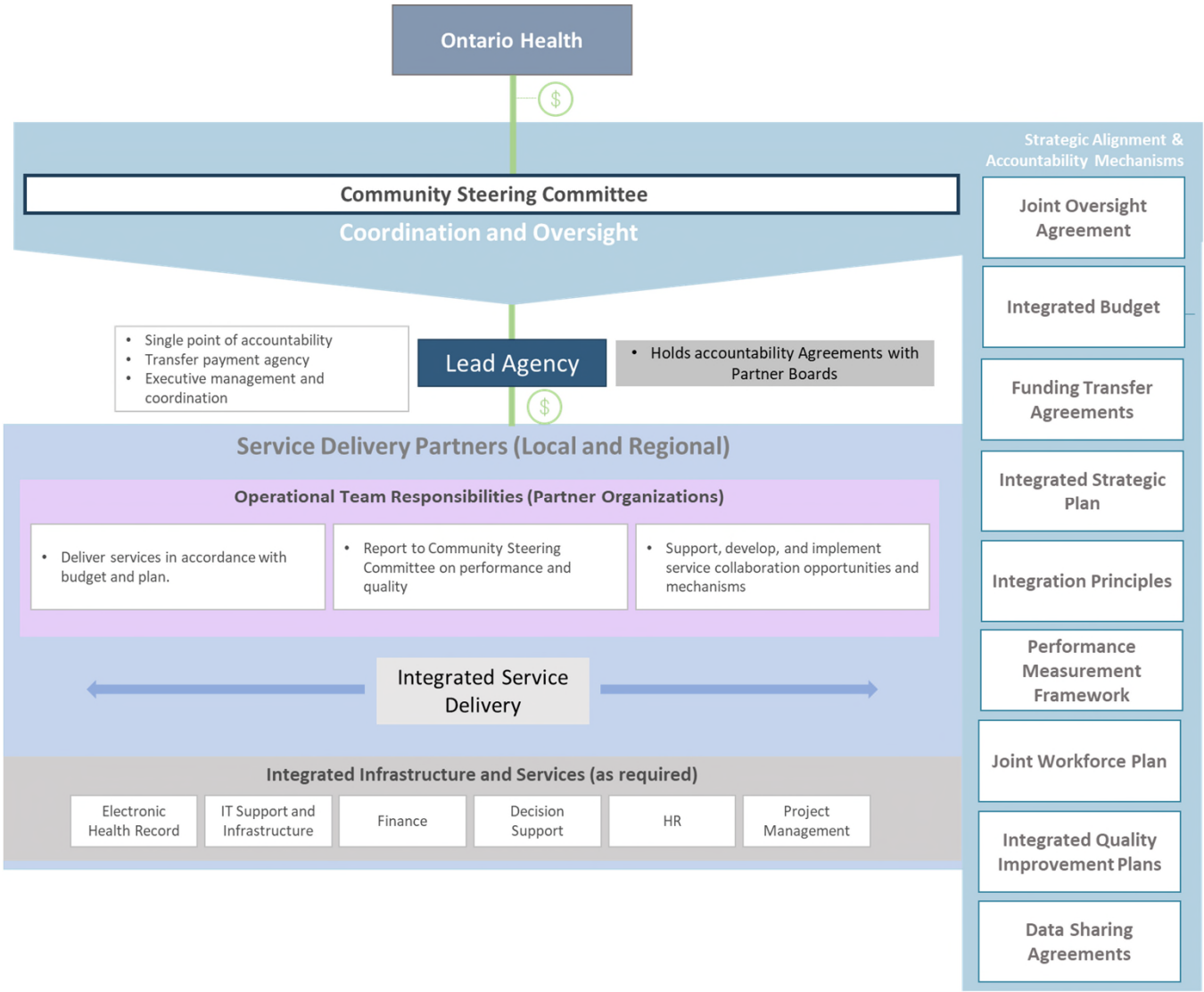


Model 2: Community Newco



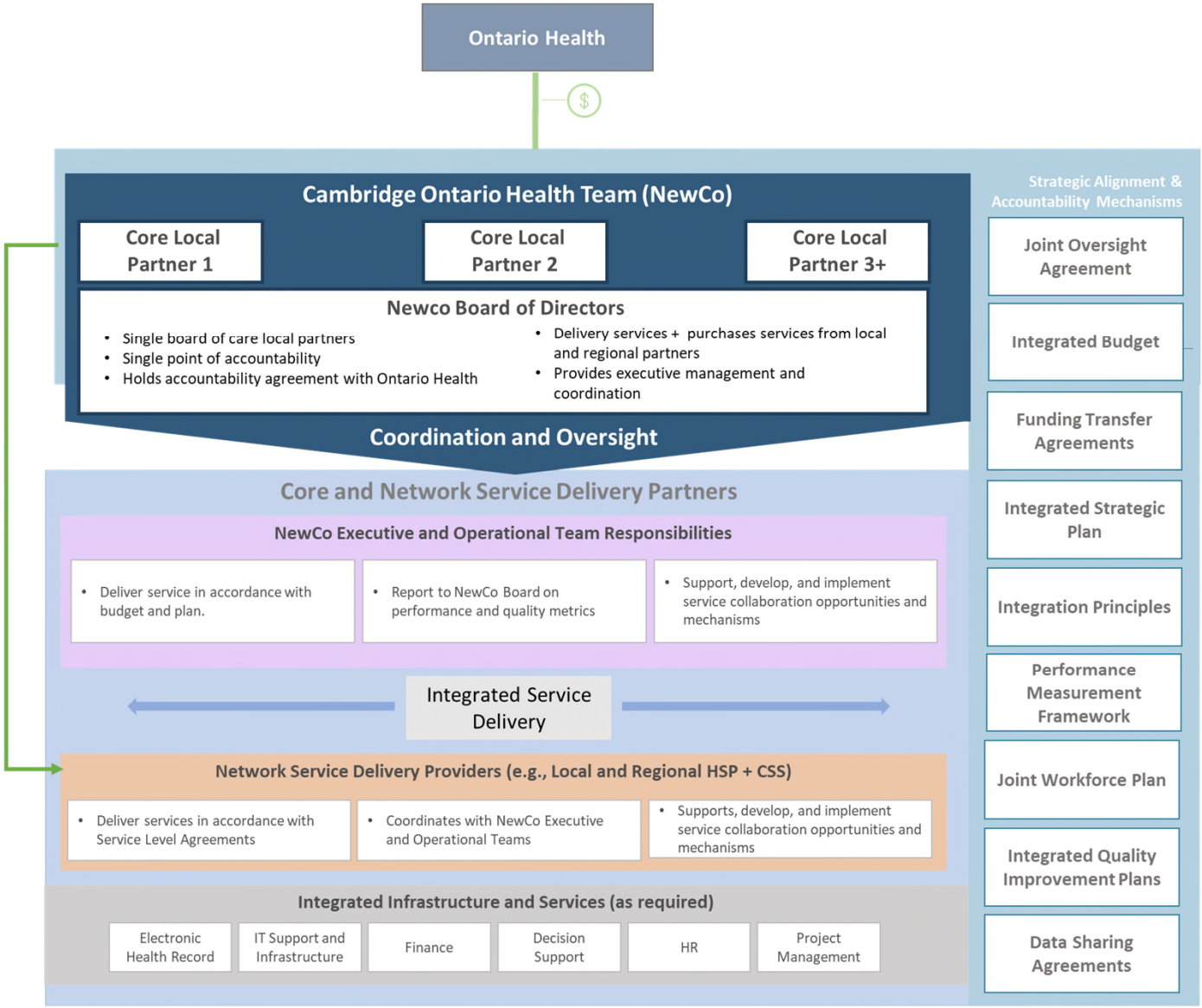
Lead Agency OHT Model

- Designated Lead Agency receives funding from Ontario Health
- Community Steering Committee with delivery partner representatives sets priorities, funding allocations, performance measures for a designated basket of services (e.g. initially MH&A – then expanded)
- Lead Agency acts as transfer payment agency for designated basket of services identified in a Community Health Plan.



NewCo OHT Model

- New integrated community board with "core" local health care providers.
- NewCo OHT received funding from Ontario Health for a designated basket of services (e.g. MH&A).
- NewCo "core" partners deliver integrated, seamless services in collaboration with network service delivery partners.
- NewCo OHT purchase services from a network of partners.



5. Table and Plenary Session

- Choose a “Rapporteur”
- Record key points on paper provided
- Each table will be asked to share one point from one question (2 minute each)
- We will collect notes to inform planning. Please leave on table, along with evaluation forms.

6:35 pm to 7:50pm

1. What is important to you as governors as we advance planning for an OHT?
2. Where do you see opportunities for collaboration and integration?
3. What do you consider to be the key benefits and challenges with the potential models?
4. As governors how would you like to be informed and engaged?

6. Next Steps

- All participants

7:50pm to 8:00pm

Based on what you have heard, do you feel it is worth further investment in executive and board time to develop an expression of interest for an Ontario Health Team?

1. Share information with your Boards.
2. Confirm what information you board be required to move forward with participating in a EOI.
3. Determine whether you want to participate as a core or network partner.
4. Determine at what stage (early, middle, late) your organization would consider participating in an OHT.

Preparing for Health System Change – Governor Education Session
March 19, 2019 Meeting Evaluation

Meeting Score out of 5

4	5	5	3	4	5	5	4	4	5	5	5	4	5	5	5	5	4	4	5	5	5	4	5	5	4	5	5	5	5	Average	4.6

What questions do you hope to have answered tonight?

- What will OHT look like in our area?
- Planning before plans
- Wage parity
- Role of for profits
- Risk mitigation of resource investment for integration if things change again.
- How will it really role out?
- What changes are expected or timing
- How can CMH position staff in terms of expected changes to better serve our community
- What is timeline for the proposal
- What could this look like locally?
- What choices do we have?
- How concrete is this plan?
- How do we ensure patient privacy?
- Clarity re: readiness of OHT
- Consideration of Financial (1pt for $)
- What are the biggest impacts for Lang's with the recent /ongoing changes?
- What will the new transformation look like?
- Still a lot of confusion and not fully knowing how we are going to achieve OHT
- Many challenges we are just starting the journey
- How far along are organizations in the work towards OHT?
- What's next? How will we do it?
- What are the opportunities?
- To get more information about upcoming changes to FHTs
- What changes are coming? Real change

- What is my role
- Opportunities to increase integration (key longstanding)
- Approach and timeline
- Do we have choices?
- Timeline
- Expected outcomes and timing
- What will be the impact on current support programs and agencies resulting from funding changes
- What next from Province
- What choices do we have
- How can the new model protect the integrity of regional needs and defined challenges?
- What does the future of LTC look like
- Will senior care be included in the OHT
- Timelines around transformation
- Integration or centralization of funding? Merger?
- What is the timeline for change?

Please rate what you thought of the meeting overall

- this was good overall
- I wish there was more opportunity for us to ask questions near the end of the session
- The diverse perspectives of governors/agencies was very helpful
- Great mix of people around the tables
- Not enough answers
- Effective use of time considering the vast amount of information
- Very useful to have different “partners” views
- Also useful/helpful to know no one knows the answers at this time.
- Alleviated many of my concerns
- Good to meet with leaders throughout Cambridge
- Helpful presentations
- Appreciated MD&A – model suggestions
- Enhanced my comfort level at the prospect of dealing with OHT
- Engaging all participants mad us all aware of challenges ahead and the need for a cohesive approach.

- Excellent opportunity to engage with different stakeholder agencies
- Good high level discussions could easily start with the topics mentioned
- Very important to discuss with other agencies. Help understand each other's viewpoints
- Good presentation of known information
- Very much appreciated the facilitated group discussion
- Needed to hear about local work to incorporate provincial directions
- Good overview of work to date and potential go forward actions
- Appreciated Bruce's comment and overview of changes
- Gave some insight about what is coming and how to prepare for it.
- Good start at collaboration at the governance level
- Very informative and engaging
- Good discussion and outline
- Preliminary planning – perspectives and concerns
- Great overview of key topics and models including risks and opportunities from different sectors
- Appreciated the outline of potential frameworks/models
- Expected outcomes
- Very helpful
- A lot of information to absorb. Facilitators did a good job guiding us through the evening
- Very helpful evening in understanding current state and upcoming changes
- An opportunity for learning about the OHT implementation
- Good conversation
- Good questions – some answered some not
- It is extremely helpful to have other organizations to talk to or bounce ideas off of.
- Good information – lots more questions

What questions do you still have after the session?

- How much of a time commitment will this be for all the Governors as well as for our Executive Director?
- Scope of Health team

- Lessons learned from other jurisdictions
- Wage parity (esp. if for profit changes also drive up wages)
- Funding for actual integration work
- Health human resource integration plan – what if people leave the sector
- Timelines? Summer is coming – how can we expect Board input during summer months
- Is there access to other provincial experiences eg. risks. Management, legal, union
- My question entirely relates to the organizational structure of the new organizations
- How do we get full participation of independent contractors (physicians) funded by an alternate source?
- What will our OHT look like locally?
- How do we continue to stay involved?
- How do we engage disengaged physicians?
- Can we ensure care remains central to our Health System?
- Do we have all key leaders from our community on the team?
- Still somewhat bewildered
- Sessions such as this one tonight very valuable
- Lead agency vs. NewCo
- Specific ways how this change can help mental health waitlist?
- Is this related to Canada as being an aging population?
- Is this anyway related to privatization of healthcare?
- Budget? Asked to do more? Government asking too much?
- A lot more detail required – more information
- It is good to see this community willing and planning to develop the models and move forward to the OHT goal.
- How do we ensure patients stay front and centre in the design of this structure, especially for vulnerable populations like indigenous and those who are homeless or have been incarcerated.
- Is our OHT large enough or too small?
- Do we grow service integration in layers?
- How does this impact integrated services which currently exist between hospitals?
- How do regional providers engage in a variety of OHTs

- Does this effect patient access to services across OHTs?
- How to fund hospital capital equipment?
- What happens to the family health teams?
- Many areas not addressed – realize early days
- How about foundations – how do they move with this?
- Many
- Many – however excellent start
- Models/timeline/approach
- Desire to have deeper discussion by specialized area
- Ultimately understanding how the model chosen will work and the inclusion of all agencies in OHT and integrating private agencies
- How will regional providers fit into the OHT?
- There is potential for a great deal of change at the individual. Organization, patient, and community level.
- Will there be support to help people with transition?
- Need more direction regarding models
- More details around the changes and more direction
- What control will the OHT have over each organization
- Who owns the assets – buildings etc (purchased by OHT)
- How does Municipal reform impact plans and waterloo region vs Cambridge and north Dumfries
- What happens if you are not chosen as one of the lead agencies and all 50 have been chosen? Are you forced to adopt a specific model?

What other information do you need in order to bring to your board to make a decision regarding participation in the CND OHT Expression of interest?

- need notes from today
- need more information on the scope/terms of reference/risks
- helpful to have digested and contextualized information. Present as models/options rather than blue sky – we all have such different roles and perspectives that a blank page can be overwhelming and inefficient.
- Impact – more details

- Notes/presentation
- Consideration of collective strategic plan – some place to begin
- Notes from the meeting
- More general information as things progress along.
- More information from Health Ontario – requirements
- No EOI until explicit information available
- Require more information
- Specific example of execution
- Very high level/general information to public
- “Government wiping hands does not implement well…”
- Summary of the EOI working group and objectives
- Who is paying MD&A to do this work?
- Impact on staff and budgets for different models
- Structure of EOI steering committee in relation to provider boards & roles vice versa
- Are we an early adopter or waiting
- Patient services will be maintained throughout transition
- Do not like term NewCo.
- Draft model
- Briefings on key decisions as they come
- Summary of this evening
- More details

Fairview SENIORS COMMUNITY

Proposal:

Shared Services

For:

Tri-County Mennonite Homes

Submitted by:

Board of Directors and Leadership

of Fairview Community

Abstract:

A strategic Shared Services group, comprised of preferred partners who share a commitment to a faith-based mission, will strengthen our collective sustainability, enhance our expertise, continue to build our reputations as the preferred places to live, and preserve the values and history we all hold dear.

Initiative:

The Fairview Seniors Community Board, along with Parkwood, is seeking partners to join a Shared Services Collaborative (Inc.).

While we are currently financially stable and profitable, our recent strategic planning convinced us that dramatic challenges facing the sector require a new and innovative response. We believe an ideal 'enterprise' scale of $40-80 million in annual operations will be essential to properly resource our communities of care.

Through creative partnership we can provide strengthened resources for:

1. executive leadership,
2. financial management,
3. care planning,
4. community engagement,
5. legislative compliance,
6. deeper access to expertise,
7. property development and maintenance,
8. innovation, and
9. reputation growth

At the same time, we can maintain the unique faith-based culture and characteristics of each partnering entity.

We are approaching Tri-County Mennonite Homes first due to our common values, similarity in organizational sponsorship, and convenient geographic location. Additional potential partners have been identified.

Need:

Our organizations serve the most vulnerable populations – and these populations are changing and more diverse. Residents/clients are living longer, with co-morbidities, mental health challenges, and dementia; many are entering the campuses of care with increased acuity. The demand for care and services is rapidly increasing, along with the need to help hospitals find more appropriate beds for the Alternate Level of Care (ALC) patient population.

AdvantAge, our not-for-profit Ontario organization, lists numerous challenges facing the sector, including: human resources, the shifting needs of the demographics, housing limits for seniors, community supports, LTC capacity and media attention for this vulnerable sector.

At the same time, funding pressures demand ongoing efficiencies and a greater critical mass to operate fiscally sustainable Campuses of Care for those who require assistance with daily living.

Additional challenges, ranging from staffing and facilities management, to legislative compliance and day-to-day events, frequently shift the management team's focus from strategic opportunities that ensure the organization's sustainability.

In short, small, not-for-profit Campus of Care organizations do not have the same efficiencies and immediate access to expertise as larger organizations.

The number of LTC and Campus of Care operators continues to shrink, as smaller organizations merge, for survival.

Of the 625 homes in Ontario, 58% of homes are privately owned – with 44% owned by only nine operators who continue to grow; 24% are non-profit/charitable; 16% are municipal and 2% are other.

Since 2013-14, Ontario has added 381 'classified beds' (total of 76,891 beds today). The government plans to add 15,000 beds over the next five years: a clear opportunity for growth for those who are prepared.

With the new 'Ontario Health' announcement, the landscape and funding mechanism of healthcare is once again transforming. Partnerships and/or joint ventures with other health care providers now appear to be inevitable.

Our experience with Shared Services:

Fairview and Parkwood Mennonite Communities share a decades-long history, built upon foundational Mennonite values.

While we are two, separate, not-for-profit organizations, we have found a model of sharing resources that has benefited both, guided by the beliefs that shape how we approach our work and our care of residents.

Together, we have evolved toward our current structure, led by one CEO, separate Boards (with the same members), and shared policies, processes and service contracts. We have built on our strengths to respond to multiple changes in government, with the concurrent shifts in legislation, structure, policy, funding models, and more, while providing exemplary care and services.

In 2018, we committed to a new strategy that will strengthen our organizations' sustainability, consistency, efficiency and access to deeper expertise across the organization, by building a community for all.

To preserve our values and history, while continuing to grow, we know we must continue to be financially strong, resilient, and nimble enough to pursue opportunities to expand, continuously improve care, and broaden the quality and range of services and supports we offer current and future clients, and the surrounding community.

Today, Fairview and Parkwood have experienced the benefits of Shared Services. We are fiscally sound, have strong leadership and an experienced team.

We wish to share and build upon the Fairview and Parkwood strategy with our faith-based partners to ensure our collective continued sustainability through membership in a Shared Services group.

Proposal:

Fairview and Parkwood Mennonite Homes propose the creation of a not-for-profit Support Services corporation, governed by its own Board.

Each of the partners would continue to be owned independently. No changes are proposed to the governance structures of the participants. The existing Boards of Directors would remain responsible for governance and oversight of their operating divisions.

As a starting point, we envision the following possibilities for these shared services:

Administration	Finance	Care and Services	Building Management
• Human Resources, Organizational Health • Policy and Legislation • Professional Development and Succession • Benefits • Labour Management • Occupational health and safety	• Finance / accounting • Payroll, purchasing • Supply Chain Management • Information Technology • Risk Management e.g., security	• Clinical expertise • Decision Support, including key performance indicators, education, infection control	• Capital planning / projects • Maintenance • Conservation and energy management

Benefits:

These are the benefits we envision, suggested by our shared experiences and research:

1. Sustainability as faith-based organizations.
2. Enhance care, services expertise, and processes, supporting continuous improvement in day to day front line activities.
3. Extensively enhance HR / Professional Development / Succession planning to attract, retain and develop staff at all levels, and create robust succession plans
4. Meet legislation, regulations and reporting requirements, with consistent policies and procedures
5. Realize greater efficiencies, capitalising on economies of scale, shared experience, and expert knowledge
6. Share and use best practices and expertise to provide leading edge care
7. Value for technology expenditures; facilitate / leverage introduction of new technologies and software (e.g., implement accounting system)
8. Improve strategic planning, accountability and risk management with access to extensive expertise, benchmarking and statistical analysis
9. Significantly increase ability to quickly respond to opportunities, manage challenges, and respond to changes

(See Appendix B)

Rollout: 2019

April

Proposal Presentation

June

Commitment / Memorandum of Agreement

July

Infrastructure and Communications

July / August

Operational Review

Future State Action Plan

September

Drafts and approvals of Strategic Plan

October – December

Implementation begins

(See Appendix C)

Funding Model:

We propose:

1. Funding based on 3% of annual revenue
2. Payments every quarter, in advance
3. Fee for extra unique, specific needs and personnel, e.g., Strategic Planning, Union contract negotiations, project management for major capital projects such as opening a new home
4. A five-year commitment, with a review at the end of three years
5. Any surplus will go back to organizations or be used to build the group further

(See Appendix D)

Organizational Structure

The Fairview and Parkwood boards have proposed a separate, not-for-profit Shared Services corporation, with the key leadership roles identified.

The Shared Services group would have its own Board of Directors, comprised of two members from Fairview Mennonite Homes, one each from Parkwood Mennonite Home, and two potential partners. If we go beyond two partners, the Board structure will be evaluated at the end of three years.

Further discussion is welcome on how we integrate additional team members from partner organizations.

(See Appendix E)

Summary:

As we collectively face numerous pressures to our faith-based, not-for-profit organizations, we remain committed to continuing to provide the very best care. With this common ground, and by working together, we can ensure the sustainability of our organizations and continue to provide the very best in senior living.

We look forward to your Board of Directors' feedback, and hopefully, receiving their approval to move forward with the proposed Shared Services model. Thank you.

References

AdvantAge Ontario. (2018). Igniting Change. 2019-2024 Strategic Plan

Corporate Leadership Council Report. (2006). HR shared services: determining the scope, scale and structure. Corporate Executive Board: (catalogue no. CLC15GXNSI)1-9.

Deloitte MCS Limited. (2013). Shared Services Handbook – Hit the Road. A practical guide to implementing shared services. https://www2.deloitte.com/content/dam/Deloitte/dk/Documents/finance/SSC-Handbook-%20Hit-the-Road.pdf (Accessed: February 14, 2019)

Marciniak, R. (2013). Measuring service satisfaction in shared service organizations. Procedia - Social and Behavioral Sciences 81: 217 – 223

McDowell, Jim. (2011). "Shared services centers can drive significant savings: a study of U.S. integrated delivery systems that used shared services centers found significant reductions in labor costs in key administrative areas." *Healthcare Financial Management,* June 2011, p. 118+. *Academic OneFile,* Accessed 27 Feb. 2019.

Ramphal, R (2013). A literature review on shared services. African Journal of Business Management. V7(1):1-7.

Redman T, Snap E, Wass J, Hamilton P (2007). Evaluating the human resources shared services model. Int. J. HR. Manage.18(8):1486- 1506.

Rutledge, C. and Duncan, G. (2002). Shared Services: Better services at lower costs. Accenture. CFO1_wp_rutledge.pdf www.CFOProject.com

Ulrich, B. (2006). The Cosmopolitan Vision, trans. by Ciaran Cronin, Cambridge: Polity Press

Appendix A

Why are we strong?

As Anabaptists, we share core values of faith, community and reconciliation, as articulated by Palmer Becker in 'Anabaptist Essentials'. These faith-based values are the foundation and springboard that have supported us to build Campuses of Care for those who require assistance with daily living.

By strengthening our organizations in the face of many external pressures, we ensure that, together, we can continue to sustain our unique faith and values. This is what truly differentiates us.

At Fairview and Parkwood, the strength of, and commitment to, our faith-based values is embedded in everything we do. It shines through our logo, whose circle represents community, and three elements represent mind, body and spirit. Our values are also expressed through our operating principles, human resources policies, kindness initiative, new strategic plan, and internal and community relationships.

While we share similar organizations' goals to create a surplus, what differentiates us is how we build upon our faith-based values to determine where we reinvest these funds to fulfill our mission. For example, we have built supportive housing and independent living at fair market value. Our villas were built and sold at cost with a continued philosophy to resell at a reasonable cost. We have invested in a vibrant Seniors Active Living Centre, a warm and welcoming congregate dining area, and have a Director of Spiritual Care on staff.

Tri-County has many similar examples of reinvesting to ensure they provide an exceptional place to live and work. Our shared values have supported our past collaborations as new avenues of service unfolded. Similarly, our committed congregations support our meaningful work. Every day, we live our values to enhance our services and spaces to continuously build and support our community, in congruence with our beliefs.

This is who we are, as Mennonites, and how we have built our organizations. We share the same purpose and commitment to living our values. With gratitude and humility, we see that many people, of Mennonite and other faiths, respect us and our reputations, to the extent that people from 19 different church denominations and/or faiths have chosen to make Fairview or Parkwood their home.

Today, we can reach deeply into our faith and values and build upon our willingness to work together to meet the challenges and changes we now face; at the same time, we will prepare our organizations to meet the future from an even greater position of strength.

Together, we can demonstrate what it means to be a faith-based organization in the 21st century, as we continue to provide affordable, not-for-profit services to build a community for all.

Appendix B

Benefits

Shared services models have been explored throughout the world. A white paper published by Accenture quantifies the benefits their clients have experienced, stating that companies may reduce back office costs by 25 to 50 percent.

Fairview and Parkwood have experienced good results in sharing administrative services, costs and expertise, policies, procedures, and processes. We hope to share similar benefits with potential partners, making our existing funds go farther, so we may reinvest in programs that reflect our faith-based values and extend our outreach into the community.

Specific outcomes include:

1. Sustainability as faith-based organizations with deep Mennonite roots and a reputation we have built over decades; able to strategically work together as preferred partners to strengthen our organizations
    a. Leverage our common purpose, mission, vision and values in a consistent message, emphasizing the trust and reputation we have built in our unique geographic area
    b. Bonding together to prevent mergers with partners who may not share the values of our standalone organizations
    c. Continue to attract and build strong community partnerships
    d. Build upon our reputations to continue to attract strong volunteer support and charitable donations
2. Enhance care, services expertise, and processes, supporting continuous improvement in day to day front line activities and creating time for the senior team to focus on strategic issues and opportunities and growth, through:
    a. Director of Administration
    b. Policy development
    c. Education
    d. Service providers
    e. Increased access to specialized expertise: Clinical and nursing, financial, technology, legal support, communications
    f. Meet regulations
    g. Shared learning, re inspection
    h. Increased access to expertise to leverage redevelopment, expansion, and infrastructure improvement
    i. Increased time for strategic and financial planning
3. Extensively enhance HR / Professional Development / Succession planning to attract, retain and develop staff at all levels, and create robust succession plans
    a. Address shortage of leadership in sector: grow internal capacity
    b. Opportunity to grow professionally: developing inhouse opportunities
    c. Leverage our expertise and help each other

    d. Develop relationships with colleges further to create a talent pipeline
4. Meet legislation, regulations and reporting requirements, with consistent policies and procedures
5. Realize greater efficiencies, capitalising on economies of scale, shared experience, and expert knowledge
    a. Overhead savings
    b. Reduction of labour costs
    c. Enhanced buying power through shared purchasing decisions
    d. By capitalising on economies of scale, standardisation, consolidation, and automation processes, while improving service quality
    e. Shared knowledge and accountability
    f. Shared meeting structure e.g., ED meeting
    g. Maximize funding
    h. Leverage experience
    i. Solve problems once
6. Share and use best practices and expertise to provide leading edge care
    a. Transfer knowledge and more deeply align to business requirements
    b. Provide leading edge care and workplace
    c. Ability to conduct one home pilots and share
    d. Enhance Health and safety environment
    e. Leverage opportunities and expertise to innovate
7. Value for technology expenditures; facilitate / leverage introduction of new technologies and software (e.g., implement Nurse Call)
    a. We have an advantage in that we share the same systems: Nav, PCC, BCI (phone), Execulink, service provider
    b. Hire a technology focused person who can lead us into the future with cutting edge systems and innovation
8. Improve strategic planning, accountability and risk management with access to extensive expertise, benchmarking and statistical analysis
    a. Additional security protocols
    b. Improved decision support, dashboards, benchmarks and indicators; staff and boards able to compare results across divisions / organizations, as desired
9. Significantly increase ability to quickly respond to opportunities, manage challenges, and respond to changes
    a. Team available
    b. New builds: assist each other
    c. Opportunity for growth
    d. Fine tune processes in building plans
    e. Reporting to legislative bodies
    f. Become a ‘elder cluster’ in region

Appendix C

Roll-out

April: Proposal Presentation

- Fairview and Parkwood Boards, and Elaine Shantz, President and CEO

June: Commitment and Signing, Memorandum of Agreement

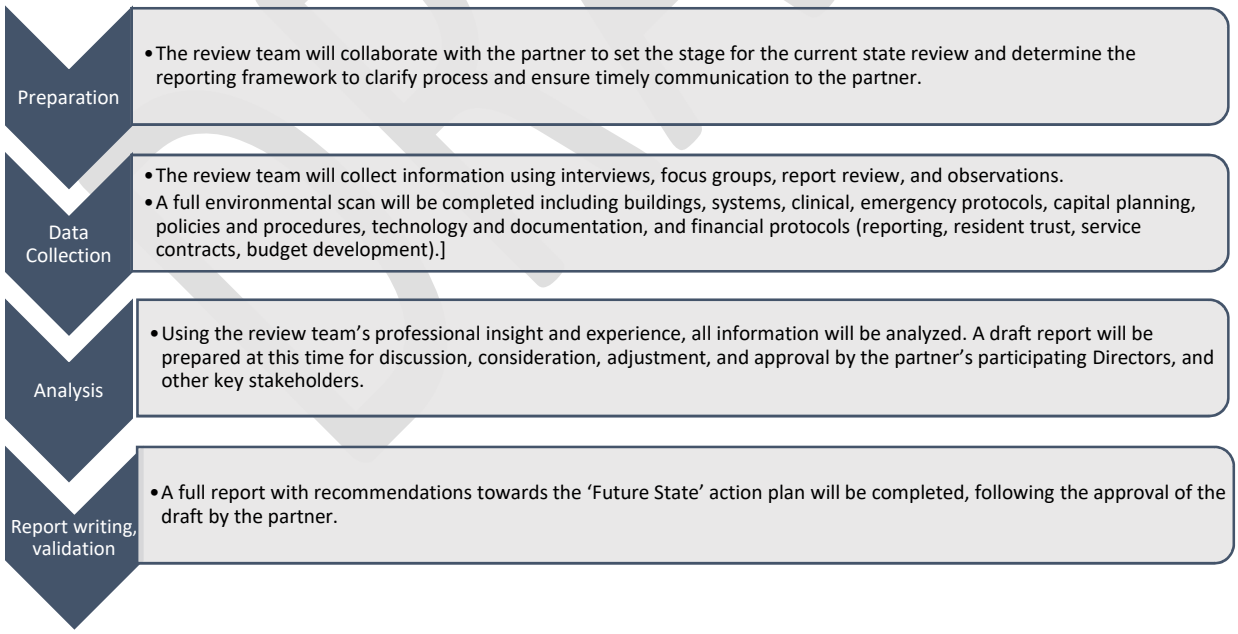
- Partner Boards of Directors

July: Infrastructure and Communications

- Board Selection
- Change Management and Communications Plan
- Identify / Lease Office Space

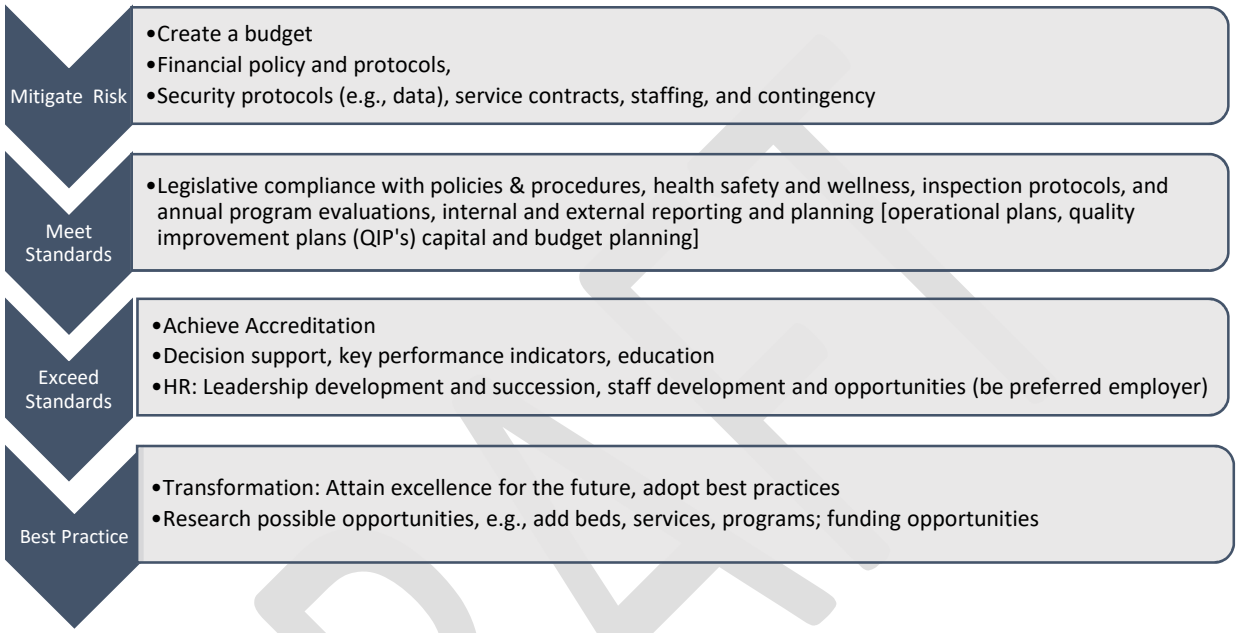
July: Operational Review

A review team from FMH and PWH will collaborate with the partner's selected Directors (e.g., Long-Term Care, Assisted Living, etc.) to conduct a current state review through a four-step planned discovery process, to: understand the operations in terms of leadership capacity, quality of care, financial management; understand the strengths and weaknesses, as well as the efficiencies and growth opportunities of the partner, and identify crisis pieces to establish which areas would most benefit from shared services.



August: Future State Action Plan

The Action Plan, with timeline, will form the direction and the basis of a proposed Shared Services Agreement that will support all partners to achieve the identified benefits in the proposal and help guide all partners through the transition period and support the strategic goals of the participating organizations. It will also Forecast future business needs (3, 5 years) and potential impact on staffing and services needed. It will also include an integration plan for the shared services, as well as a start-up plan, including the move.



September: Drafts and approvals

- Strategic Plan
  a. Will the business be expanding and how?
  b. Will expansion lead to increased transactions?
  c. What improvements/efficiencies will enable us to be nimbler and respond to opportunities, quickly?
  d. Are acquisitions / mergers anticipated; will this require an ability to quickly scale up processes and services? Will the current structure meet those needs? Will outside expertise need to be acquired?
- Service Level Agreements

October – December: Implementation

- Write policies
- Integrate back office
- Develop processes

Appendix D

Funding Model

We propose funding based on 3% of annual revenue, with payments every quarter, in advance. Unique and specific needs (such as those for a major capital project, union negotiations, legal issues, etc.) would be an additional fee. We would conduct an annual financial evaluation.

A five-year commitment, with a review at the end of three years, would allow us to fully develop, implement and realize the benefits of the model. Any annual surplus would go back to the organizations or be used to build the group further.

The fees would not only cover the day-to-day operations of the partner organizations, but also provide significant benefits in terms of 'extras'. For example, with access to more expertise, we can solve problems once, together. We can trial pilots and share the learnings. We can address common HR and union questions, together. We can realize greater benefits from our funding by pooling resources to offer professional development across our organizations, at a reduced cost per person.

Example:

We've made certain assumptions, based on Fairview Mennonite Homes and Parkwood Mennonite Home. For ease of calculation, we've selected a revenue of $20M:

- 3% of $20M = $600,000
- Based on our own costs (number of people, salaries, benefits), this represents a savings of $475,000
- With offices located within 1-hour drive of initial partners (looking at Waterloo Region at this time), we've also assumed each partner could realize additional revenues through the administration space repurposed on each site
- Further savings would be realized through increased buying / negotiating power; shared software licensing; additional expertise gained through existing staff, contracts saved (e.g., Sienna); reduce costs based on consistent / strong processes and practices

Anticipated additional direct costs to homes / fee for service:

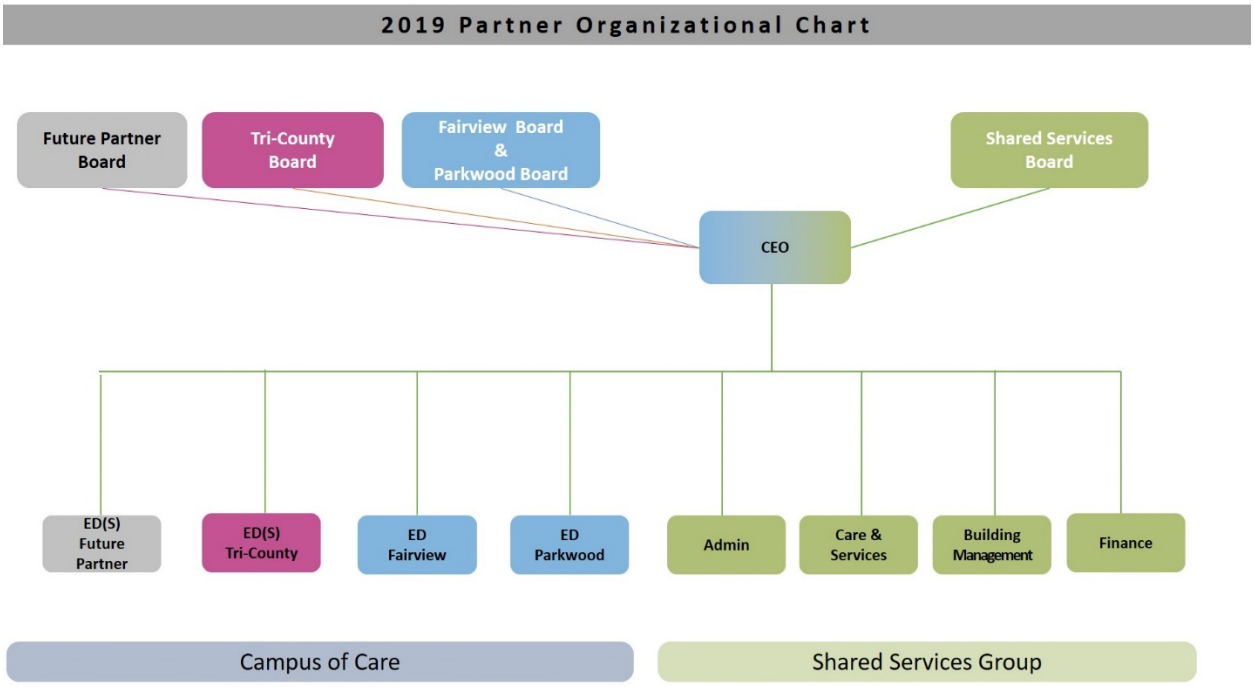
- Additional consultants attributable to projects that are site-specific
- Building related
- Union negotiation

Potential start-up costs:

a. Time set aside for Project team
b. Acquiring and furnishing space, contingency
c. Technology implementation
d. Recruitment
    i. Potential retraining costs of staff who do not transition
    ii. Potential packages for outgoing staff
e. Training, change navigation

Appendix E

Proposed Organization Chart



Fairview Parkwood	Manual:	Governance	Reference No.:	
	Section:	Board of Directors		
	Subject:	Medical Assistance in Dying		

POLICY

At Fairview and Parkwood Seniors Communities, we believe in the sacredness of life. Our goal is to add meaning and value to life through excellent care, including palliative and end-of-life care.

In accordance with our beliefs, faith and values, it is the policy of the Board that we (employees, volunteers, Board members) will not recommend or participate in the implementation of medical assistance in dying (MAID).

We recognize and respect it is every individual's right to make choices and that this is the resident's home. We also recognize our legal responsibility. As such, we will advise the Local Health Integration Network's intake team when a resident inquires about MAID, and we will allow the procedure to take place in the resident's home.

In addition, we will not express any personal moral judgments about the beliefs, lifestyle, identity or characteristics of a resident who wishes to access MAID. We will ensure, as is consistent with our values, that the duty of care is continuous and non-discriminatory. We will also endeavor to ensure that potential and current residents understand our policy.

This policy covers:

1. The legal obligations and professional expectations of our Homes with respect to medical assistance in dying (MAID).
2. The process to manage requests for medical assistance in dying, including offering alternatives that will help the resident to realize meaning and value to living, until natural death occurs.
3. Reporting requirements.

DEFINITIONS

1. *MAID – Medical Assistance in Dying*
   in accordance with federal legislation, includes circumstances where a medical practitioner (i.e., physician) or nurse practitioner, at an individual's request: (a) administers a substance that causes an individual's death; or (b) prescribes or provides a substance for an individual to self-administer to cause their own death.
2. *Effective and Timely Referral:*
   A referral made in good faith, to a non-objecting, available, and accessible Physician (in our case,

the LHIN intake). The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral. The timeliness of the referral should be in proportion to the patient's prognosis.

3. *Physician:*
   A person who is entitled to practice medicine in Ontario.
4. *Nurse Practitioner:*
   A registered nurse who, under the laws of Ontario, is entitled to practice as a nurse practitioner, and autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances, and treat patients.

BACKGROUND

Following a decision by the Supreme Court of Canada, which determined that an absolute prohibition on medical assistance in dying violates the Charter rights of individuals, and is unconstitutional, the federal government passed legislation in 2016, through amendments of the Criminal Code of Canada (Bill C-14), detailing the circumstances under which an individual may request or self-administer a substance to cause their death.

In 2017, Ontario passed the Medical Assistance in Dying Statute Law Amendment Act, 2017, which made the procedure available in Ontario.

The public and care providers may access a MAID care co-ordination service information line, that is available 24 hours a day, seven days a week at: Toll free 1-866-286-4023. Referral services are available Monday to Friday, 9 a.m. – 5 p.m. EST, in English and French. Translations for other languages can also be requested. TTY services are also available at 1-844-953-3350.

REFERRAL PROTOCOL:

1. In Canada and in Ontario, it is a resident's right to request medical assistance in dying; it is also their right to have their request treated with the utmost privacy, per privacy legislation, and, in accordance with our values, with kindness, respect and compassion.
2. If a resident requests information about medical assistance in dying, staff will immediately (during their shift) advise the Director of Care, as part of our duty to make an effective and timely referral.

3. The Director of Care will meet with the resident and remind the resident of the Homes' policy with respect to medical assistance in dying.
    a. At Fairview and Parkwood, we do not recommend medical assistance in dying.
    b. We will not participate in the MAID process (e.g., assessment, consent).
    c. We will not participate in the procedure.
    d. We will allow the procedure to take place in the resident's home.
4. The Director will also offer the resident other supports for consideration, including spiritual care, social work supports, pain management, palliative care and end-of-life care.
5. The Homes' role in supporting the resident is:
    a. The Director will refer the resident's request to the Local Health Integration Network intake team within 24 hours, in writing, and document the referral in the resident's medical record, as part of an effective and timely referral.
    b. The Director will advise the resident that contact with the LHIN (or possibly, their physician) has been made.
    c. The LHIN is now the lead in following through with a referral to the MAID team.
    d. The Home will request that the MAID team keep the Home (via the Director) apprised of the status of the resident's request and provide advance notice of important dates.
6. The Director will advise the CEO of the resident's request within 24 hours of receiving the request, in writing (e.g., in an email).
7. The CEO will ensure the Board is informed of such requests Board through the Key Performance Indicators.
8. Should the resident wish to proceed with medical assistance in dying, upon meeting the criteria, including assessments and consents, as determined by the MAID team and the legislation, the resident may proceed with the procedure in their home.
    a. It is the MAID team's responsibility to be in contact with the resident's family members' contact
    b. MAID will be administered by the MAID team in accordance with a patient's requests, which may include the presence of family and friends.
    c. The Coroner's office will contact the resident's family member's contact to confirm/determine if there were any concerns related to MAID that could lead to a Coroner's inquest.
9. When the resident has passed, they will be treated in the same way as any resident who has passed.

10. The Director will capture the event in the Key Performance Indicators.

REFERENCES

1. Bill C-14. An act to amend the Criminal Code and to make related amendments to other Acts (Medical Assistance in Dying). 2016. http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384 014

2. Canadian Medical Association. Principles-based Recommendations to a Canadian Approach to Assisted Dying. 2015. https://www.cma.ca/Assets/assets-library/document/en/advocacy/cmaframework_assisted-dying_final-dec-2015.pdf

3. Carter v. Canada (Attorney General), 2015 SCC 5, [2015] 1 S.C.R. 331.

4. Ministry of Health and Long-Term Care, Medical Assistance in Dying. Dec. 2018. http://health.gov.on.ca/en/pro/programs/maid/#objection

5. College of Nurses of Ontario. Guidance on Nurses' Roles in Medical Assistance in Dying. 2016. http://www.cno.org/globalassets/4-learnaboutstandardsandguidelines/maid/maid-june-23- final.pdf

6. CPSO. Policy Statement #4-16. Medical Assistance in Dying. 2016. http://www.cpso.on.ca/Policies-Publications/Policy/Medical-Assistance-in-Dying

7. CPSO. Policy Statement #6-16. Planning for and providing quality end-of-care life. https://www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/End-of-Life.pdf?ext=.pdf

8. Final Report: Provincial-Territorial Expert Advisory Group on Physician-Assisted Death. 2015. http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf

9. Parliament of Canada. Report of the Special Joint Committee on Physician-Assisted Dying. Medical Assistance in Dying: A Patient-Centred Approach. 2016. http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=42&Ses=1&DocId=8120006 R http://www.parl.ca/DocumentViewer/en/42-1/PDAM/report-1/page-78#19 (section on Conscientious Objection)

10. Ottawa Hospital. Policy: Medical Assistance in Dying. https://www.ottawahospital.on.ca/en/documents/2017/02/admviii850-medassistanceindying2017-lm-2.pdf/

11. St. Joseph's Healthcare, London. 2018. Medical Assistance in Dying. https://www.sjhc.london.on.ca/your-st-josephs/clinical-ethics/resources-patients-families-and-community/medical-assistance-dying

2018 - 2019 Monthly - Fairview Executive Director Board Report

LONG TERM CARE

Indicators	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD Avg.	YTD Total
% Monthly Occupancy	98.5	98.8	98.7	98.2	99.7	98.0	98.5	100.0	100.0	98.8	99.7		99.0	
# Admissions	5	3	3	4	2	0	2	0	0	2	1		2.0	22.0
# Code Training	1	0	0	1	0	0	0	0	13	0	0		1.4	15.0
# Complaints *(Resident)*	0	0	0	0	0	0	2	3	0	3	2		0.9	10.0
# Critical Incidents	2	2	0	3	0	3	7	3	0	4	1		2.3	25.0
# Discharges / Deaths	3	3	4	4	0	1	3	0	0	2	1		1.9	21.0
# Employee Complaints	0	0	0	0	0	0	2	0	0	0	0		0.2	2.0
# Expenditures over $25,000	1	0	0	0	0	0	0	0	0	0	0		0.1	1.0
# Fire Drills	3	0	1	3	3	1	3	3	3	3	0		2.1	23.0
# Legislative Inspections	0	0	0	0	0	0	1	1	0	0	0		0.2	2.0
# New Hires	6	4	2	2	3	2	4	4	4	4	5		3.6	40.0
# Non-Compliance	0	0	0	0	0	0	0	1	0	27	0		2.5	28.0
# Terminations	3	0	2	2	0	3	0	4	6	5	0		2.3	25.0

MONTH - February 2019	
% Monthly Occupancy	6 lost time days -transition time from one resident death to new admission of the same room #205.
Admissions	1 - February 28, 2019- Spousal Reunification
Code Training (*name codes*)	None
Complaints *(Resident)*	1. Nurse did not respect the residents resfusal of bath- Performance management for employee and another nurse provides bath. 2. Family dissastified with moms placement on the secure wing and with the staffing compliment- provided education to family to improve awareness and understanding of needs.
Critical Incidents	1- critical incident involving a resident refusing a bath and an employee saying "this needs to get done" residetn responed with aggression. Performance management and education of policy provided for employee with the expectation that it will not occur again.
Discharges / Deaths	1 Death
Employee Complaints	None
Expenditures over $25,000	No
Fire Drills	No fire drills completed for the month
Legislative Inspections	None
New Hires	1 new hire in dietary 3 new hires in nursing
Non-Compliance	No fire drills completed for the month
Terminations	
Successes/Challenges/Events	
Success	Nurse consultants offered knowledge and assistance to nursing department to meet RQI order requirements.
Challenge	Implementing RQI orders
Events	Couples dinner for Valentine's day- residents made spagetti for the dinner. A good time was enjoyed by all.

2018 - 2019 Monthly - Fairview Executive Director Board Report												APARTMENTS and RETIREMENT SUITES		
Indicators	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD Avg.**	**YTD Total**
# Monthly Occupancy - Suites	2	2	2	0	1	1	2	4	2	1	1		2	18.0
# Monthly Occupancy - Apt.	0	2	1	2	0	1	1	2	0	2	2		1	13.0
# Monthly Occupancy - Court	0	0	0	1	1	1	1	0	0	0	0		0	4.0
# Monthly Occupancy - School	1	1	1	1	0	0	2	1	3	4	3		1.5	17.0
# Monthly Occupancy - Villas	0	0	0	0	0	0	0	0	0	1	2		0	3.0
# Admissions	2	2	2	3	4	1	3	0	0	4	3		2.2	24.0
# Code Training	2	1	0	1	0	0	0	0	13	0	0		1.5	17.0
# Complaints (*Resident)*	0	0	0	0	0	0	1	0	1	5	2		0.8	9.0
# Discharges / Deaths	1	1	1	1	2	2	3	5	1	5	2		2.2	24.0
# Employee Complaints	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# Expenditures over $25,000	0	0	0	0	0	0	0	0	0	1	0		0.1	1.0
# Fire Drills	2	1	1	1	2	0	2	3	3	3	0		1.6	18.0
# Legislative Inspections	0	0	0	0	1	0	0	0	0	0	0		0.1	1.0
# Mandatory Reporting	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# New Hires	0	2	0	0	0	0	0	0	1	0	0		0.3	3.0
# Non-Compliance	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# Terminations	0	0	0	0	0	0	0	1	0	0	0		0.1	1.0

MONTH Narrative - February 2019	
# Monthly Occupancy - Suites	1 Empty 108
# Monthly Occupancy - Apt.	2 Empty 209, 613
# Monthly Occupancy - Court	Full
# Monthly Occupancy - School	3 Empty 112, 314, 306
# Monthly Occupancy - Villas	2 Empty 843B, Villa K
Admissions	6
Code Training (*name codes*)	0
# Complaints (*Resident)*	Ongoing complaints about marjauna smoking in apartments, family complaint about first complaitant slandering resident
Discharges / Deaths	One resident passed away at Fairview Apartments (palliative) another died at PSA after a fall in unit.
Employee Complaints	0
Expenditures over $25,000	No expenditures over $25 000
Fire Drills	0
Legislative Inspections	0
Mandatory Reporting	0
New Hires	0
Non-Compliance	0
Terminations	0
Successes/Challenges/Events	
Success	Fairview annual tenant meeting was well attended.
Challenge	The weather was a challenge in February causing snowy, icy conditions in our parking lots and walkways. February 13th our Auxilliary Valentine's tea was cancelled due to stormy weather conditions. The bus also was cancelled or rescheduled due to weather in February.
Events	Valentine Craft Sale, Out to Lunch Bunch went to Creekside Kitchen, Memorial Service remembered Fairview Tenants and Residents

2018 Monthly - Key Performance Indicators Definitions - Fairview Mennonite Home

Fairview Index			
Long Term Care Residents	84	Employees	77
Retirement Suites	47	Employees	19
Shared		Employees	69
Apartments	141	Employees	0
PSA	56	Employees	0
Court	35	Employees	0
Villas	26	Employees	0

Note: There are 31 subsidized Fairview appartments and 16 Preston School apartments.

Occupancy / Vacant - Long Term Care

% of vacant Long Term Care from Point Click Care report

Occupancy / Vacant - Retirement Suites

# of vacant suites at month end

Occupancy / Vacant - Retirement Apartments

# of vacant apartmens at month end

Occupancy / Vacant - Villas

# of vacant villas at month end

Admissions

# of new admissions for the current month

Code Training

# of emergency training completed each month
Code description to be noted in narrative
All nine (9) Codes to be completed annually

1) **Red** – Fire
2) **Green** - Evacuation
3) White - Violent Person
4) **Yellow** – Missing Person
5) Grey – Air Quality
6) **Orange** – External / Loss of essential services
7) **Purple** – Intruder / Hostage
8) Black – Bomb
9) **Blue** – Medical Emergency

Complaint(s)

Complaint which has been reported to the CEO or Board of Directors
Complaint which has been reported to the Ministry of Health (MoH) or Retirement Home Regulatory Authority (RHRA)

Critical Incident(s) Long Term Care (LTC)

Definitions of the following are detailed in Critical Incident System (CIS)
Narrative to include detailed description of each incident

1) Mandatory Reports to Ministry of Health

a. Misuse/misappropriation of resident's money
b. Unlawful conduct that resulted in harm/risk to resident
c. Abuse/neglect
d. Misuse/misappropriation of funding provided to a licencee

2018 Monthly - Key Performance Indicators Definitions - Fairview Mennonite Home
2) Unexpected Death
3) Disease Outbreak
4) Incident causing injury to resident where resident is transferred to hospital
5) Medication incident/adverse drug reaction
6) Emergency
7) Environmental Hazard
8) Missing Resident
9) Controlled substance missing
10) Contamination of drinking water supply
Discharges / Deaths
# of residents who have died
# of residents discharged from the home. Narrative to include the reason for discharge
Employee Grievances / Complaints
# of employee grievances or written complaints that has not been resolved in 30 days
Grievances / Complaints to be recorded each month until resolution have been reached Narrative to include grievances proceeding to arbitration
Expenditure over $25,000
# of capital expenditures; approved as part of budget or due to unexpected breakdown/emergency over $25,000
Narrative to differentiate between planned and emergency
Fire Drills
Fire Drills: Number of fire drills completed per month. Legislative requirements include:
1) Three (3) monthly in Long Term Care
2) Two (2) monthly in Retirement Home
3) One (1) annually in Independent Living
Legislative Inspection
# of inspections completed from a governing body
1) Ministry of Health - a) Resident Quality Inspection (RQI); b) Critical Incident; c) Complaint
2) Ministry of Labour
3) Public Health
4) Fire Department Annual
5) Commission on Accreditation of Rehabilitation Facilities (CARF)
Mandatory Reporting Retirement Home (RH)
Incidents under the Act reportable immediately to RHRA that cause harm, or risk of harm to a resident resulting from:
1) Improper or incompetent treatment or care
2) Abuse by anyone
3) Neglect by the licensee or staff
4) Unlawful conduct
5) Misuse or misappropriations of resident's money
New Hires
# of new hires each month
Non Compliance
# of standards not in compliance. This would include Written Notifications, Voluntary Plans of Corrective Action; Compliance Orders issued from a legislative body. Narrative to describe type of notification.
Terminations
Employees terminated by payroll in the month. This will include resignations and supervisor termination. To be defined in narrative.

The formula for YTD AVG in row 4, column K is:

```
=IF(COUNT(B4:J4)>0, AVERAGE(B4:J4), 0)
```

This statement checks whether there are entries in the row, and, if there are, finds the average and puts it in this spot. If there isn't, it puts in 0.

The formula for YTD Total in row 4, column L is:

```
=SUM(B4:J4)
```

Then, drag down to place the formula in each row and column

The average rounds to the nearest whole number and updates as new entries are added.

Although we don't have to, we might want to consider showing one decimal place in the average column so we can see a bit more detail.

PARKWOOD MENNONITE HOMES

BOARD of DIRECTORS MEETING MINUTES # 2019 – 246

February 28, 2019

Present:	Marion Good	Fred Schiedel
	Bob Shantz	Jennifer Krotz
	Ed Nowak	John Shantz
	Ken Frey	Ruth Konrad
Absent:	Nancy Mann	
Staff:	Elaine Shantz, Brent Martin, Barb Montague	

A. CONTEXT OF THE MEETING

1. Call to Order, Opening Remarks
Marion Good called the meeting to order at 6:20 pm.

2. Agenda was approved by consensus as distributed.

3. Devotions:
Ken Frey read from the book, God is my CEO, in reference to the Board's current interorganizational collaboration discussions.
Ken ended with prayer.

B. NEAR TERM ISSUES AND REPORTING

1. Minutes of Meeting #2019-245

Motion to approve the minutes of #2019-245 dated January 24, 2019 was made by Jennifer Krotz;
Seconded by Fred Schiedel Carried

2. Report from Leadership

CEO Report:
The CEO report was presented by Elaine Shantz;
Highlights included:

Elaine discussed the new centralized Ontario Health Care Agency.

Parkwood is currently working with the architect regarding possible space for potential additional LTC beds.

Elaine Shantz and Marion Good have had meetings with Tri County to discuss Shared Services. They will be presenting to Try County's Board of Directors in April; the presentation will be shared with our Board in March.

Motion to authorize Marion Good to sign the LSAA on behalf of the Board was made by Bob Shantz;
Seconded by Ed Nowak Carried

Motion to adopt the WWLHIN Patient Declaration of Values was made by John Shantz;
Seconded by Fred Schiedel Carried

Motion to accept the CEO report as presented was made by Ed Nowak;
Seconded by Ken Frey Carried

Executive Director Key Performance Indicator Report:
Parkwood's Key Performance Indicator Report was presented by Lis Piccinin.

Motion to accept the Executive Director report for January was made by Jennifer Krotz;
Seconded by John Shantz Carried

Executive Director's Operational Plan:
Lis Piccinin provided highlights from Parkwood's Operational Plan; Lis advised there is development in place for consistent practices across the two campuses.

Budget Presentation:
Bob Shantz advised that the Finance Committee met to review budgets. Budgets were circulated to the Board for consideration.

Brent Martin reviewed the General Assumptions from the Budget which was provided to the Board; Brent advised the budget has a net income of approximately $285,000.

Motion to approve the Budget as presented was made by Ruth Konrad;
Seconded by Fred Schiedel Carried

Motion to adjourn Parkwood business was made by Jennifer Krotz;
Seconded by John Shantz Carried

C. JOINT AGENDA

1. **Spiritual Care Working Group** Elaine Shantz
   As part of the Strategic Plan, Elaine Shantz advised there will be a working session on April 2nd to develop a faith-based platform which will move us forward into the future. Participants will include leadership from both homes, Marion Good, key external community partners as well as a facilitator.
   Elaine extended the invitation to the Board members for their participation.

2. **Annual Meeting/Annual Report** Elaine Shantz

   The AGM will be held on June 19th; possibly at Parkwood in the Fellowship Hall; however, if we open the invitation up to include community and our residents, we may need to hold at a larger venue.
   The theatre group, 'No Longer Relevant' will be performing.

3. **Policy Review** Jennifer Krotz

   The Board policies will be reviewed annually going forward.
   Jennifer asked the Board take the next month to look at the policies and send any comments or proposed changes to Barb Montague; a committee meeting will be scheduled sometime after the next Board meeting to review.

4. **Procurement Standing List Approvals** Brent Martin

   Brent presented a Payment Exemptions document stating that, in recognition of the Procurement Policy, certain vendors would be exempted and payments over $25,000 (up to $100,000) will require authorization from any two signatories.

   Motion to approve the Payment Exemptions made by Bob Shantz;
   Seconded by Fred Schiedel Carried

Chief Executive Officer Report
Parkwood Mennonite Home
February 2019

1. Community meetings

Internal/External

Strategic Plan: A coffee break meeting for the entire resident community has been set for April to roll out the Strategic Plan. A second meeting is planned for the front-line team.

Anniversary Lunch: CEO celebrated one-year anniversary with a leadership team lunch. It has been a privilege to be the CEO of Fairview and Parkwood. The year has been filled with both opportunity and challenge. It was good to celebrate with the leadership team – they have come a long way in 12 months. The team was able to set 5 stretch goals for the next year!

Ontario Health Care teams: Things continue to move forward at a rapid pace with health care modernization. CEO has been involved in discussion with Cambridge North Dumphries group as potentially an early adopter Ontario Health team. Several working sessions have taken place, as well as, a dinner which involved CEOs and Governors. Marion Good, Bob Shantz and John Shantz attended.

A key consideration for Fairview/Parkwood is how we approach OHT with two campuses of care in different cities. Further clarification for LTC will be forthcoming.

Meetings have been set with Jamie Schlegel from Schlegel Villages and Ron Gagnon CEO Grand River Hospital to understand next steps in the Kitchener Waterloo area.

Shared Services: Preparation of the proposal outlining Shared Services to be presented to Tri-County homes in April included numerous meetings for the purpose of discussion and information. CFO and CEO met with Director Administration from Tri-County. CEO met with previous CEOs of Tri-County and Fairview – Bob Veitch and Tim Kennel. Ken Frey from Board of Directors supported CEO with organizational structure and edit of draft. This is presented to the Board for discussion (See attached).

RFP Meetings: Pharmacy presentations, tours and individual meetings have been conducted. The selection process has resulted in deferring the decision for one year. Remedy's will continue to support Parkwood and iPharm Fairview. Both pharmacies agreed to the value-added offers in their proposals. It was a good process and team decision; a growth experience for our team. In one year, we will be better equipped to consider a 5-year, one pharmacy agreement for the organization.

2. Projects

Shared Services Proposal: CEO will present at the March Board meeting.

Information Technology: Continued challenges with our service provider underscores the need to move forward with the hiring of an IT employee.

Accounting System Upgrade: This has been deferred until after year end.

Francophone guide: The guide will be completed by March 31 and reviewed in April by the working group. CEO and Francophone team held a conference call with Assistant Deputy Minister LTC who noted this would be a favourable submission if/when Fairview applies for additional LTC beds.

The above has been a Fairview initiative. Consideration is now given for Parkwood implementation.

3. Committees

Kindness Committee: The Kindness Committee held its inaugural meeting to determine next steps to roll-out the initiative with consultant Olivia McIvor. This initiative will involve residents, employees, volunteers and families. Twenty kindness mentors will be licenced, (10 at each campus). Persons to be licenced will be selected through an application process. The first year we will focus on friendship, inclusion and trust. There are 12-character traits which allows for the organization to roll this out over the next 4 years. Our goal will be to enrich our culture of kindness through a four-year journey.

Definition of Kindness: Being a positive influencer, resilient, excellent, compassionate, trustworthy, courageous, friendly, service oriented, responsible, integral and inclusive.

Building Committee: Met in early March to discuss the potential to add LTC beds at Fairview. The Committee agreed to engage MMMC architect to develop a draft plan that would allow for 60 + beds. This is an attempt to be proactive should a call for additional LTC beds be forthcoming.

Policy and Ethics Committee: Met to prepare a draft Medical Assistance in Dying (MAID) policy for Board consideration. See attached.

4. Human Resources

No report at this time.

5. Other

Bill 74 The People's Health Care Act

The second reading of Bill 74 is almost complete, and it is expected it will go to standing committee shortly. While there are many conflicting rumors about what this means for us and how quickly change will take place, new information appears to be forthcoming each day. The greatest uncertainty is the Ontario Health teams, how we in LTC fit into these teams, and what the governance for LTC will look like in the future.

Fairview has been approached to be part of the Cambridge North Dumphries proposal to become an early adopter Ontario Health Care team. This is one option for us to consider; however, it leaves Parkwood on its own. There is a possibility to form or join a frail elderly team. CEO has been approached to consider becoming a lead. This is a stretch for an organization the size of Fairview/Parkwood; larger organizations such as St. Joe's in Guelph might be better suited.

CEO will continue to seek as much information as possible to support the Board in future decisions. After the governor's meeting, a discussion with Lisa Levin CEO of Advantage regarding the model proposed to Fairview was helpful. Lisa advised the Cambridge North Dumphries model appears to be taking on the form of a merger. It is now understood there will be different models of governance allowed. The Accountable Care partnership model should also be considered. Expressions of interest will be forthcoming from the Ministry for early adopters, soon, which should provide more detail.

In summary, health care reform has been ongoing for over 30 years and to-date reforms have not produced the improvements in access and quality of care the provincial governments expected.

Because of this, and based on current trends, further reform to integrate service delivery is likely. It is still unclear the requirements for LTC. LHIN CEO Bruce Lackner advises LTC providers take their time; to stay close to what is happening but not to make hasty decisions. CEO will forward information as it is forthcoming.

Centralized Procurement

On March 18, the province issued a news release highlighting the government's new and expanded system of centralized procurement. It is important to note LTC is not required to follow the procurement directive.

6. Risk

Statement of claim SB has not been resolved at this time.

2018 Monthly - Parkwood Executive Director Board Report

RETIREMENT SUITES

Indicators	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD Avg.	YTD Total
# Monthly Occupancy Suites (77)	7	4	4	2	2	4	4	4	8	5	4		4.4	48.0
# Monthly Occupancy GH (18)	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# Admissions	1	3	2	2	3	1	2	3	2	6	2		2.5	27.0
# Code Training	1	2	0	0	0	0	0	1	0	1	0		0.5	5.0
# Complaints (*Resident*)	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# Discharges / Deaths	2	1	1	0	3	5	3	2	4	4	0		2.3	25.0
# Employee Complaints	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# Expenditures over $25,000	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# Fire Drills	3	3	3	3	3	3	3	3	3	5	3		3.2	35.0
# Legislative Inspections	0	0	0	0	0	2	0	0	1	0	1		0.4	4.0
# Mandatory Reporting	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# New Hires	4	2	3	3	2	0	0	1	1	1	0		1.5	17.0
# Non-Compliance	0	0	0	0	0	0	0	0	0	0	0		0.0	0.0
# Terminations	1	3	1	1	0	4	0	2	0	1	0		1.2	13.0

MONTH Narrative - Feb. '19	
# Month End Occupancy Suites	1 IL 1 bdrm apt taken March; 1 AL AA unit taken March; 2 A Studios available
# Month End Occupancy GH	
Admissions	Couple took IL Apt 601
Code Training (*name codes*)	
Complaints (*Resident*)	
Discharges / Deaths	
Employee Complaints	
Expenditures over $25,000	
Fire Drills	
Legislative Inspections	Mandatory inspection triggered by family complaint to RHRA
Mandatory Reporting	
New Hires	
Non-Compliance	
Terminations	
Successes/Challenges/Events	
Success	Staff 10 yr anniversary; Dir Ret completed Emergency Plan which includes all emergency code policies (staff education of entire plan to be completed annually as per RHA; this is on top of practising each emergency code annually)
Challenge	RCD continued to assist with recreation programs due to staff issues (another staff family emergency); Influenza Outbreak Feb 21 - March 2; continue to try to hire casual PSW staff for vacation coverage
Events	Retirement tea for 9yr staff Barb Kipfer; Medical Mart incontinence product inservice provided to residents; GH sump pump quarterly checks done

2018 Monthly - Parkwood Executive Director Board Report

LONG TERM CARE

Indicators	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD Avg.	YTD Total
% Monthly Occupancy	99	98	99	98	99	99	99	98	98	97	97		98.3	
# Admissions	2	6	2	4	6	2	2	5	2	4	4		3.5	39.0
# Code Training	2	1	1	1	1	2	0	2	3	3	0		1.5	16.0
# Complaints (*Resident*)	0	0	1	0	1	0	1	0	1	0	2		0.5	6.0
# Critical Incidents	0	0	1	0	0	0	2	1	0	1	0		0.5	5.0
# Discharges / Deaths	3	5	3	4	5	3	5	2	4	6	2		3.8	42.0
# Employee Complaints	0	0	0	1	0	0	0	1	0	1	0		0.3	3.0
# Expenditures over $25,000	1	0	0	0	0	0	0	0	0	0	0		0.1	1.0
# Fire Drills	3	3	0	2	3	3	3	3	3	3	3		2.6	29.0
# Legislative Inspections	0	1	0	0	0	2	0	2	1	1	2		0.8	9.0
# New Hires	4	6	2	1	4	1	4	4	1	2	3		2.9	32.0
# Non-Compliance	0	3	0	0	0	0	0	0	0	0	1		0.4	4.0
# Terminations	2	2	2	3	1	1	4	1	0	4	2		2.0	22.0

MONTH Narrative - Feb. '19

% Monthly Occupancy	Occupancy rate remains high, some troubles filling beds…slow process from LHIN side…large number of beds available in the system, we need to go through 3-4 residents per bed, with associated waits inbetween. Several residents have choosen other Homes.
Admissions	4 Admissions: one from the Hospital which is unusal. 1 Admission due to financial difficulties in the community, resident in arrears for the month of February and 1/2 of January. Paying monthly rate in March. Daughters have intervened and manage finances. Acut remains high with CMI of 1.16
Code Training (*name codes*)	None done this month
Complaints (*Resident*)	Escalating complaints and concerns from 2 families in Snyder's Corner: staff are feeling they are under observation and being harrassed. Both family members are documenting and watching staff. Some serious concerns that one of them is focusing on staff where english is a second language. Assigned to individual managers to assist, Glen- Marian and Lyndsay - Caroline. Worse in the evening hours. We will assign a manager to be around in the evenings to assist when possible. Notice is posted that harrassment will not be tolerated and staff have been offered assistance.
Critical Incidents	None this month
Discharges / Deaths	Average #
Employee Complaints	None
Expenditures over $25,000	None
Fire Drills	X 3 (days, evening and nights)
Legislative Inspections	LTC Compliance - we received 4 Written Notices and 3 Orders on those notices. We requested a review on 2 out of 3 orders and will be notified within 28 days on results of our review request. 1) Care Plans need to be followed: regarding use of hip protectors 24/7 (we will revise to include as tolerated by resident and available 2) PASD's require consent: a few wheelchairs provided by the family or were used post surgery did not have a written consent. (we will revise our practice to include all PASDs require a written consent. 3) We did not follow our own policy on Head Injury Routines on unwitnessed falls (reviewed policy with PMH and FMH. revised, education to staff will be provided, audits will occur). The above 3 were orders. Written Notice: we failed to notify the Director within 1 business day of an incident that resulted in a change of a resident's condition (fall with fracture), we notified them on October 17th instead of the 15th). Reminder to Nursing Managers of the reporting requirements.

New Hires	We have some empty lines that we need to fill…push to hire and onboard enough staff to manage the day to day needs, decrease overtime and manage unexpected sick calls.
Non-Compliance	See Legislative section
Terminations	2 - one new hire, received a full time line elsewhere within the same week of hire.
Successes/Challenges/Events	
Success	Couples Social on February 14th - great attandance, wonderful opportunity for spouse to celebrate. One family complaint that it is inappropriate to leave out single residents with -"Jesus won't approve of this, we need to stop having these couples only socials".
Challenge	Family and Community Education Days on Piecing Together the Long Term Care Puzzle - 4 part series was cancelled d/t a snow storm every Wednesday X 4 in February.
Events	6 Buckets of Estate Planning - provided through a joint venture with WWHospice.

Parkwood Monthly - Key Performance Indicators Definitions

Index			
Long Term Care Residents	96	Employees	146
Retirement Suites Tenants	78	Employees	48
Garden Home	18	Employees	0

Occupancy / Vacant - Long Term Care

% of vacant Long Term Care from Point click Care report

Occupancy / Vacant - Retirement Suites

# of vacant suites at month end

Occupancy / Vacant - Garden Homes

Vacant Garden Homes at month end

Admissions

# of new admissions for the current month

Code Training

# of emergency training completed each month
Code description to be noted in narrative
All nine (9) Codes to be completed annually

1) **Red** – Fire
2) **Green** - Evacuation
3) White - Violent Resident
4) **Yellow** – Missing
5) Grey – Air Quality
6) **Orange** – External
7) **Purple** – Intruder / Hostage
8) Black – Bomb
9) **Blue** – Medical Emergency

Complaint(s)

Complaint which has been reported to the CEO or Board of Directors
Complaint which has been reported to the Ministry of Health (MoH) or Retirement Home Regulatory Authority (RHRA)

Critical Incident(s) Long Term Care (LTC)

Definitions of the following are detailed in Critical Incident System (CIS)
Narrative to include detailed description of each incident

1) Mandatory Reports to Ministry of Health

a. *Misuse/misappropriation of resident's money*
b. *Unlawful conduct that resulted in harm/risk to resident*
c. *Abuse/neglect*
d. *Misuse/misappropriation of funding provided to a licencee*

2) Unexpected Death
3) Disease Outbreak
4) Incident causing injury to resident where resident is transferred to hospital
5) Medication incident/adverse drug reaction
6) Emergency
7) Environmental Hazard
8) Missing Resident
9) Controlled substance missing
10) Contamination of drinking water supply

Parkwood Monthly - Key Performance Indicators Definitions

Discharges / Deaths

# of residents who have died

# of residents discharged from the home

Narrative to include the reason for discharge

Employee Grievances / Complaints

# of employee grievances or written complaints that have not been resolved in 30 days

Grievances / Complaints to be recorded each month until resolution has been reached

Narrative to include grievances proceeding to arbitration

Expenditure over $25,000

# of capital expenditures; approved as part of budget or due to unexpected breakdown/emergency over $25,000

Narrative to differentiate between planned and emergency

Fire Drills

Fire Drills: Number of fire drills completed per month. Legislative requirements include:

1) Three (3) monthly in Long Term Care
2) Two (2) monthly in Retirement Home
3) One (1) annually in Independent Living

Legislative Inspection

# of inspections completed from a governing body

1) Ministry of Health - a) Resident Quality Inspection (RQI); b) Critical Incident; c) Complaint
2) Ministry of Labour
3) Public Health
4) Fire Department Annual
5) Commission on Accreditation of Rehabilitation Facilities (CARF)

Mandatory Reporting Retirement Home (RH)

Incidents under the Act reportable immediately to RHRA that cause harm, or risk of harm to a resident resulting from:

1) Improper or incompetent treatment or care
2) Abuse by anyone
3) Neglect by the licensee or staff
4) Unlawful conduct
5) Misuse or misappropriations of resident's money

New Hires

# of new hires each month

Non Compliance

# of standards not in compliance. This would include Written Notifications, Voluntary Plans of Corrective Action; Compliance Orders issued from a legislative body. Narrative to describe type of notification.

Terminations

Employees terminated by payroll in the month. This will include resignations and supervisor termination.
To be defined in narrative.

The formula for YTD AVG in row 4, column K is:

=IF(COUNT(B4:J4)>0, AVERAGE(B4:J4), 0)

This statement checks whether there are entries in the row, and, if there are, finds the average and puts it in this spot. If there isn't, it puts in 0.

The formula for YTD Total in row 4, column L is:

=SUM(B4:J4)

Then, drag down to place the formula in each row and column

The average rounds to the nearest whole number and updates as new entries are added.

Although we don't have to, we might want to consider showing one decimal place in the average column so we can see a bit more detail.