Sub-region Integration Table Terms of Reference

Guiding Principles

The work and decisions of the Sub-region Integration Tables will be grounded by the following guiding principles:

- Patient and caregiver centred
- Equitable and aligned to what specific populations need
- Integrated across sectors and systems
- Borderless access to care
- Trust, respect, and shared responsibility among partners
- Transparency
- Sustainability

The **overall aim** of the Sub-region Integration Tables is to improve

- Health, wellness,
- Patient experience and outcomes,
- Value for money, as well as
- Provider experience

Function and Roles

- Enable, enhance and champion collaboration between patients, providers and other system stakeholders
- Establish sub-region priorities for improvement in line with *Patients First* and the Integrated Health Service Plan
- Ensure a Health Equity lens is in place when identifying local priorities
- Ensure local alignment with LHIN-wide and provincial programs
- Work together to reduce duplication and find opportunities to integrate services
- Foster an environment of shared responsibility
- Leverage current communication and reporting structures to share information

Actions and Deliverables

- Build trust among providers and the community
- Maintain a profile of the health and wellness status of the community
- Identify sub-region improvement opportunities, such as
    - Creating shared capacity
    - Integrating programs and services
    - Coordinating care
    - Standardizing approaches to care
- Develop sub-region priorities and strategies for implementation
- Ensure sub-region priorities include those of Francophone and Indigenous people, and any additional populations identified by a Health Equity Impact Assessment

- Ensure coordinated care planning is strengthened and maintained
- Develop local targets to measure and achieve sub-region goals
- Conduct and report on assessments of the sub-region along the maturity journey as described in the Sub-Region Maturity Model (Appendix 1)
- Provide recommendations and updates to the Health System Renewal Advisory Committee on
    - Priorities that cross geographies
    - Opportunities to leverage electronic and other enablers
    - Progress toward sub-region maturity
- Responsible to report on progress toward overall aim and improvement plan to the sub-region residents and the Health System Renewal Advisory Committee

Communication

- Highlights will be drafted and available to members in a timely way. Sub-region Integration Table members, who represent sectors, are responsible to circulate key messages in a timely manner to their respective sectors.
- Sub-region Integration Table members are responsible for communicating and engaging with their local sectors to bring forward the perspectives, concerns, and questions from their respective sectors.
- Leverage local effective communication strategies
- Be innovative in the development of new communication strategies

Reporting Relationship

- The Sub-region Integration Tables are accountable to the LHIN CEO or delegate.

Membership

Sub-region Integration Tables will be supported by the LHIN Sub-region Director of Planning and Integration, Clinical Lead, and Health System Planner. Time-limited work groups may also be formed to support the work of the Sub-region Integration Tables. The tables will each consist of approximately 10 to 15 members, excluding Sub-region Director, Planner and Executive Assistant. Tables with large populations and/or specific priority populations may increase to 18 members. The Director and Clinical Lead will initially be the Co-Chairs for the table. As the Sub-region Integration Tables move along the maturity model, the position will be elected by the members.

Members will reflect the following perspectives:

- Addictions and Mental Health
- Community Support Services (from the CSS Lead Agency in the sub-region, with the potential for nomination from other agencies in the future)
- French Language Service (London/Middlesex)
- Home and Community Care (LHIN Home and Community Care Director)
- Hospital
- Long-Term Care
- Patients/Family/Caregivers (3 per sub-region)
- Primary Care Clinical: (Co-chairs of sub-region Primary Care Alliance)
- Primary Care Executive Administrator/Director
- Public Health

The SRIT will leverage the Indigenous Health Committee to imbed an Indigenous voice in the work of the table. The SRIT will seek their input, guidance and advice regarding the planning and implementation of improvements

Other perspectives to consider including based on Sub-region Integration Table priorities are:

- Non-health representative(s) with a regional view and/or social determinants of health perspective
- Specialists

Recruitment

When a Sub-region Integration Table member's tenure is completed or a member resigns, the member's delegate will act as interim member while work is underway to secure a new member.

In the case where a formal mechanism to engage a sector is not available, or for those in non-health sectors, Sub-region Integration Table members will bring forward names of potential candidates. The nomination(s) will be circulated to the Sub-region Integration Tables for endorsement.

There may be times when additional individuals will be invited to participate in meeting discussions. Permission should be sought from the co-Chairs in advance of the meeting if additional guests are to be included.

The LHIN CEO may appoint members if deemed necessary.

Recruitment of Patient, Family, and Caregiver members of the Sub-region Integration Table will follow the South West LHIN's Patient, Family or Caregiver Partner recruitment process.

Occasionally, members will be unable to attend meetings. For members representing sectors, a delegate will attend the meeting in place of the member. The LHIN Sub-region Director will work with sector representatives to identify a sector delegate. It is the responsibility of the Sub-region Integration Table member to ensure their delegate is up-to-date on Sub-region Integration Table activities.

Ongoing recruitment and maintenance of Sub-region Integration Table membership is the responsibility of the Sub-region Integration Table as a whole. Recruitment of working group members will be the responsibility of Sub-region Integration Table members and will depend on focus and needs of the working group.

Meeting Observers

The Sub-region Integration Tables success depends on open and honest conversations between members. To ensure that this trust can be maintained, the meetings are normally not open for observation to the public, media, politicians and other health service providers that may not be privy to the full context of conversations. Should a patient/caregiver wish to observe the meeting, they would meet with the LHIN's Patient Engagement Lead to understand purpose of the meeting and determine if it would be appropriate for the individual to come to a meeting.

Health service provider sectors that are represented at the Sub-region Integration Table will be able to provide their input into Sub-region Integration Table work via their sector representative and will receive regular updates from their sector representative.

Member Responsibility

- All members are responsible to actively contribute to achieving the overall aim
- Each member is responsible to work with their peers (patients, families, physicians, local and/or LHIN-wide providers) to collectively improve the system
- Each sector member is the link between the Sub-region Integration Table and the sector they represent. Members will consult with their sector on issues/questions/ideas arising from the Sub-region Integration Table and bring the sector's views to the Sub-region Integration Table meetings
- Local representatives on the Health System Renewal Advisory Committee and Patient and Family Advisory Committee are responsible for information flow between committees
- The Sub-region Director and Clinical Lead are responsible for
    - information flow to and from the LHIN, and
    - ensuring availability of local and LHIN-wide tools and resources to support work of the group
- All members are expected to attend meetings unless exceptional circumstances occur. Recognizing that these circumstances do occur, alternate sector-based delegates will be jointly identified by LHIN staff and individual members. When needed, every effort will be made to apprise delegates of relevant information prior to the meeting occurring.
- Individual members are also accountable to their own respective Boards, and Health Service Providers funded by the LHIN would be accountable to the LHIN, for both their own performance (sector specific) and their contributions to the shared improvement plan

Sector Representation

- Sub-region Integration Table sector members are expected to provide two-way communication between the Sub-region Integration Table and their respective sectors
- Should concerns be raised by the sector around this communication, the LHIN Sub-region Director will facilitate discussions between the representative and the sector to ensure regular, transparent communication between the member and the sector

Appointment Term

- Inaugural members will receive 3 or 4 year terms to accommodate the time required to develop relationships, processes, tools, and plans*
- Terms will be staggered to ensure succession planning
- Terms may be shortened for members who are unable to meet their responsibilities to the table
- Members may be re-appointed if this is the wish of their sector and if they agree
- Longer term – Terms will be 3 years
  **some exceptions may apply – e.g., in a sub-region where there is only one hospital corporation*

Conflict of Interest

Committee members are required to fulfill the duties of their appointment in a professional, ethical and competent manner and avoid any real or perceived conflict of interest. Committee members have an obligation to declare a personal or pecuniary interest that could raise a conflict of interest concern at the earliest opportunity to the Chair(s). Each member has an ongoing obligation to disclose any actual, potential or perceived conflict of interest arising at any point during a member's term of appointment in regard to any matter under discussion by the Committee or related to the Committee's mandate.

Decision Making
Where possible, decisions/advice should be made by group consensus, leveraging the Consensus Model for Decision-Making (see Appendix 3). Consensus is defined as group-decision making where members develop and agree to support a decision in the best interests of the whole based on the information available, viewpoints presented, and discussions related to that decision.
Should members be unable to come to consensus, decisions can be made by a vote of greater than 50%. Quorum of greater than 50% is required in these cases.

Meetings
Meetings will be held in person a minimum of 8 times a year and will leverage technology where needed to optimize participation.

Monitoring

Monitoring the Work of the Sub-region Integration Table
There is an expectation that the Sub-region Integration Tables will be monitoring local data to inform their work and measure progress. Work is still underway at each Sub-region Integration Table to determine the best measures for the sub-region.

The Sub-region Integration Tables will use the Health Equity Impact Assessment as a tool to apply an equity lens as improvements are planned implemented and measured.

Measures should:

- Align to sub-region priorities and system-level outcomes
- Reflect initiatives where multiple sectors must contribute to realize improvement
- Evolve to include measures that reflect the overall objective of 'living well in the community'.

Sub-region dashboards will be created to support sub-region monitoring and improvement in the South West LHIN. It is anticipated that this dashboard will have a level of provincial standardization, local customization, and will evolve over time.

Evaluating the Evolution of the Sub-region Integration Tables
The Sub-region Integration Tables will use the maturity model (Appendix 1) as a basis to measure the evolution of the tables as a planning entity. The South West LHIN will work with the Sub-region Integration Tables to develop tools to evaluate progress. One key component of this evaluation will be a survey of the sectors to determine if the table to sector communication is successful.

Appendix 1: Sub-region Maturity model

Domains	Maturity Level		
	Developing	**Functional**	**Excelling**
Culture *Evolution of trust and respect initially between table members and ultimately shared responsibility across sub-region health service providers, patients and the broader community*	**Communication & Cooperation** • Leaders with transformation characteristics are in place • Communication processes are developing between sub-region integration tables and sub-region stakeholders • Members are cross appointed to Health System Renewal Advisory Committee and Patient and Family Advisory Committee • Shared understanding of how table will evolve • Endorsement, adoption and application of the Provincial Patient Engagement Framework • Prepare patients/family caregivers to partner with organizations with an appreciation that multiple engagement methods need to be used • Embrace the belief that patients and caregivers have the capacity to be full partners in this journey and have a meaningful role in planning, implementing and measuring healthcare improvements	**Coordination & Collaboration** • Culture is cross-sectoral • Strong relationships are built between members • Communication, engagement and negotiation is robust (e.g. sub-region integration table sector membership to full sector) • Patient engagement activities are planned in a purposeful, integrated way that is informed by best practices • Work on breaking down silos in patient engagement and share positive impact of engagement activities on achieving higher quality of care (leverage the *Principles for Partnering in Patient Engagement*, QAG, February 2016)	**Coalition & Integration** • System co-design between patients, providers and community stakeholders is formalized and strong • Proactive, people focused intrinsic motivation for change and shared improvement is being demonstrated • Transparent public communication is valued and ongoing • Providers are able to challenge each other in healthy and respectful ways • Support is evident to spread and scale successful improvement and engagement work that is happening • Proactive and effective patient engagement is built into professional and organizational development • Continually looking for opportunities that require partnership where organizations become the platform that activates the generosity, capacity, intelligence and resources of patient, families and caregivers
Improvement & Innovation *Evolution of quality, performance, patient engagement and strategic improvement activities to move from individual improvement pilots to a sub-regional and regional shared focus and system capacity*	• Commit to align 'shared focus' within strategic plans and develop a shared improvement plan for the sub-region • Shared understanding of the greatest opportunities, regionally and locally • Work is aligned to LHIN-wide and provincial priorities • Key areas where patient engagement is likely to make a difference have been identified • Commitment, characteristics and skills of local clinical leaders to endorse the plan have been secured • Quality improvement is embedded in organizations • Capacity building for patient engagement is underway • Identify barriers to improvement activities	• Continuous learning from reporting and monitoring on progress re: shared improvement plan • Celebrate and communicate 'short term wins' to keep teams energized • Implementation of shared improvement plans for the sub-region – and remove barriers to improvement initiatives • Improvements are co-designed with patients and caregivers • Implement experienced-based design approaches	• Innovation is evident in all system level improvement • High impact, sustainable and shared results are being realized • Shared system of quality is in place that demonstrates continuous capability to implement best practice as well as eliminate practices no longer supported by evidence • Outcomes and experience data drive improvement • Outcomes link patient/family caregiver engagement to improved outcomes (for instance system efficiency)

Domains	Maturity Level		
	Developing	**Functional**	**Excelling**
Integration *Evolution from individual organizational focus to reduction of duplication and service delivery/back office integration within sub-region*	• Information sharing around current integration activities at a variety of levels (e.g. back office, service delivery, patient point of contact, etc.) is occurring • Identification of further integration opportunities has begun • Planning for resources to support implementation is underway • Integration activity improves or maintains a positive patient experience, access, equity, safety and health outcomes among different populations with specific needs	• Integration activity maintains or improves service levels, functional alignment, and efficient service delivery or administrative operations • Jointly integrating services for coordination and transitions of care • Coordinate sharing of resources to support implementation of improvement plan	• Proactive back-office integration among providers in the sub-region • 'On the ground' shared resources are optimized to support improvement across sectors • Integration activity improves or maintains service levels and costs, system navigation and coordination structures, availability of health human resources, strategic alignment with LHIN priorities, or broader health system consistency, standardization, or efficiencies
Accountability *Evolution to shared responsibility and clear accountability including owning shared performance outcomes*	• Organizational and system data is shared transparently across sub-region • Agree on improvement indicators and a small set of relevant system metrics for regular monitoring • Signed shared commitment statement to indicate agreement to work towards the overall aim and work plan priorities	• Local performance measures that are meaningful to the sub-region are identified and routinely monitored • Reflect the shared commitment statement in individual Service Accountability Agreements as a local condition • Work with patients/family caregivers to identify and report data that is valuable to them	• Shared responsibility for performance, outcomes, and results • Shared responsibility for monitoring and acting on high impact sustainable system outcomes at scale, including both LHIN funded and non-LHIN funded partners • Providers share responsibility for monitoring impact of key initiatives to improve population health, their experience of care and the value for resources expended • Structure is established for governance to manage a dual role in supporting their own organization as well as identifying and supporting sub-region integration activities • Targets and benchmarks are identified and sub-region outcomes are publicly reported • Formal shared accountability agreement in place • Patients and family caregivers have access to clear and useable information

Domains	Maturity Level		
	Developing	**Functional**	**Excelling**
Population Health *Evolution to a clear understanding and collective actions to reduce health inequities across the sub-region*	• Develop shared understanding of sub-region's health and human profile, services, etc. • New relationships needed for success are being forged (e.g. primary care, Indigenous communities) • Each sector understands the population they are currently serving, inclusive of the full patient journey	• Patients and their families are maximizing self-care options • Highest risk health users are identified and patients with high care needs have coordinated care plans, inclusive of social determinants of health interventions • Mechanisms are available to continually describe the health of local populations including the existence, causes and impact of health inequities • Integrated cross-sector pathways are being implemented including funding that follows the patient	• Population health goals/strategies are identified and stratified for full population (including prevention and wellness) • Strong linkages and structures are in place between health care treatment system, rehabilitation and health promotion systems • Healthy public policies are developed, refined and evolve to optimize system wide improvements in wellness and reduction of health inequities • Culturally competent care providers along with patients and families are having impact on overall health of the population • Coordinated care plans are inclusive of social determinants of health • Incentives for prevention/wellness in place • Citizens are engaged and health equity optimized • Full appreciation of population including underserved populations and strategies in place to address inequities

Appendix 2: Consensus Model for Decision Making

The simplest and most basic definition of consensus is, '**general agreement about something**'. (Soanes, C. and Hawker, S., ed., The Compact Oxford English Dictionary of Current English. 3rd ed. Oxford University Press, 2005.)

In this approach, people are not simply for or against a decision, but have the option to situate themselves on a scale that lets them express their individual opinion more clearly. This model is usually used with a round, so that everyone in the meeting is given the opportunity to state where they are according to the following six levels:

1) Full support
2) Acceptable
3) Support with reservations
4) I am not thrilled with it, but I can live with it and will not block it
5) Need more information or more discussion
6) Cannot support it and cannot accept it

If everyone is at level #4 or above (3, 2, or 1), then by definition, consensus has been reached.

If someone is at level 2, 3 or 4, they have the option of explaining their reservations. These can be addressed by the meeting, if the group wishes to. This is not absolutely necessary for achieving consensus if everyone is already at 4 or higher, but it usually improves the recommendation or suggestions being discussed.

If someone is at level 5, they have the obligation to explain what information or discussion they require from the group. If someone is at level 6, it is important for them to try and offer a solution that can accommodate their needs and the needs of the rest of the group.

In addressing someone's reservation, it is important to:

a) ask everyone for possible solutions (the person expressing the concern and the rest of the group have the responsibility to find solutions)
b) ask people to suggest improvements as alternatives that meet the objectives of the entire group

IDENTIFYING CONSENSUS

Consensus is a relative term. There are varying levels of agreement with decisions, as indicated in the table below. Levels 1 through 5 all constitute consensus. Only Level 6 lacks consensus.

Level	Position	Feelings and Behaviour		
1	Agree strongly	"I really like it!"	"I'll advocate for it publicly whether or not it's adopted"	"I'll actively support its implementation"
2	Agree	"I like it"	"I'll advocate for it publicly"	"I'll support its implementation"
3	Agree with some reservations	"I can live with it"	"I'll support it publicly and privately even with my reservations"	"I'll participate in its implementation"
4	Disagree, but willing to go along with majority	"I don't like it. I'm willing to go along with it, but I want my disagreement acknowledged"	"I'll support it publicly and privately when asked"	"I won't work against its implementation"
5	Disagree, and won't be involved in implementation	"I really don't like it, but I'm willing to go along with it because I don't want to stop others"	"I'll not oppose it publicly or privately"	"I will not be involved in its implementation, but won't sabotage it"
6	Opposed, and will work to block	"I hate it and will work to block it!"	"I'll advocate against it publicly if adopted"	"I'll work to sabotage it"