Sub-region Integration Table Terms of Reference

Guiding Principles – *'Our Moral Compass'*
The work and decisions of the sub-region integration tables will be grounded by the following guiding principles:

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

The **overall aim** of the sub-region integration tables is to improve

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

Function and Roles *(How will they do their work?)*

- 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 local priorities include consideration of Francophone and Indigenous people in the sub-region
- Ensure local alignment with LHIN-wide programs
- Work together to reduce duplication and integrate services
- Foster an environment of shared responsibility
- Leverage current communication and reporting structures to share information

Actions and Deliverables (*What work will they do?)*

- 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 common goals and an improvement plan for implementation of local strategies that align with sub-region priorities and LHIN-wide direction (Huron Perth Quality Improvement Plan is an example)
- Ensure coordinated care planning is strengthened and maintained
- Develop local targets to achieve overall aim

- Provide recommendations to the Health System Renewal Advisory Committee on
    - Priorities that cross geographies
    - Opportunities to leverage electronic and other enablers
    - Ways to achieve shared responsibility
- Responsible to report on progress toward overall aim and improvement plan to the sub-region residents and the Health System Renewal Advisory Committee
- Establish an agreement that will demonstrate shared responsibility between all partners

Communication (*How will they share information?)*

- Leverage local communication strategies that are effective
- Be innovative in the development of new communication strategies
- Align key messages with the South West LHIN's communication and engagement plan
- Distribute key messages in a timely, accurate, clear and objective manner
- Support each other to ensure capacity for sharing of key messages

Reporting Relationship (*Who are they accountable to?)*

- The sub-region integration tables are accountable to the LHIN CEO or delegate.

Membership *(Who belongs and what are they responsible for?)*

Sub-region integration tables will be supported by the LHIN sub-region Lead and Clinical Lead. Time-limited work groups may also be formed to support the work of the Sub-region integration tables. The tables will each consist of 10 to 15 members (tables with large populations and/or specific priority populations may increase to 18 members). The Chairperson will be initially be appointed from the membership by the LHIN. Overtime, the position will be elected by the members. Members will reflect the following perspectives:

- Addictions and mental health
- French Language Service representative (London/Middlesex)
- Hospital
- Home and community care
    - CCAC direct service functions
    - Community support services (start-up – CSS lead agency in sub-region, long-term - nomination)
- Indigenous representative (Grey/Bruce; London/Middlesex; Elgin)
- Long-term care
- Patients/Family/Caregivers (consider 3 per sub-region)
- Primary care administration
- Primary care clinical: (Start-up - sub-region Clinical Lead. Longer term - co-chairs of sub-region Primary Care Network)
- Public Health

Other perspectives to consider inviting based on priority are:

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

Recruitment

Members will be appointed by the LHIN CEO and where appropriate, will be nominated by their peers. See Appendix 1 for details of ongoing recruitment strategies (under development).

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
- 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 Lead 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, we will support the use of an identified sector-based delegate. To support this process alternate sector-based delegates will be jointly identified by LHIN staff and the members. Should a delegate need to be asked to attend a meeting to represent the sector, every effort will be made to apprise them of relevant information prior to the meeting occurring.

Appointment term

- Inaugural members will receive 3 or 4 year terms to accommodate for the time required to develop relationships, processes, tools, and plans
- Terms will be staggered to ensure succession planning
- Longer term - terms will be 3 years
- The Chair will be appointed by the LHIN CEO.

Ethical Framework and Conflict of Interest

Please see Appendix 2 for further information on Committee member requirements.

Decision Making

Members may make decisions via consensus or by a vote of greater than 50%. Quorum is greater than 50%. Group recommendations /advice will be made by consensus leveraging the Consensus Model for Decision-Making. Please see Appendix 3 for detailed information on the Consensus Model. 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.

Meetings

Meetings will be held in person on a monthly basis for three hours and will leverage technology where needed to optimize participation.

Accountability (*How will they move to shared responsibility?)*

- The LHIN is responsible to set and evolve the responsibilities of the sub-region integration tables
- The mechanism to support increasing shared responsibility and clear accountability will be to:
    - Initially focus on building relationships and processes
    - Evolve from communication and cooperation to being jointly responsible for integrating care
    - Sign a shared commitment statement to indicate agreement to work towards the overall aim and improvement plan priorities

- Reflect the shared commitment statement in individual Service Accountability Agreements as local conditions
- Consistently reflect the shared commitment statement in like organizations in each sub-region e.g. hospitals
- Mature over time to a formal accountability agreement

- 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

Monitoring/Reporting (*How will they know they are making a difference?)*
The sub-region integration tables will use the Health Equity Impact Assessment as a tool to apply an equity lens as measures are developed.

Sub-region measures will

- Align to system level Patients First outcomes and the Integrated Health Service Plan
- Reflect areas where multiple sectors must contribute to realize improvement
- Evolve to include measures that reflect the overall objective of 'living well in the community'

To start, the sub-region integration table will review the following measures:

Overall Objective (sub-regions)	**While**	**Integrated Measures**
To support people to live well at home in their community, and if necessary provide right, most efficient level of care - *avoiding hospital use* where possible	*Living in the community*	Rate of hospitalization for ambulatory care sensitive conditions (per 100,000 people)
	In hospital	Alternate level of care rate
	Upon discharge from hospital	Hospital readmission rates within 30 days of leaving hospital for medical treatment *(new to include mental health and addictions)* Rate of follow-up with a doctor within seven days of leaving hospital by high users
	Other key cross sector quality measures	Cross sector outcome measures associated with Quality Standards (to be developed in coordination with Integrated Clinical Care Council)

See Appendix 4 (in development) for alignment of existing South West LHIN Integrated Health Service Plan interventions with the above noted areas.

A standard sub-region dashboard will be leveraged 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 evolve over time.

Appendix 1: Ongoing Recruitment Strategy (in development)

Appendix 2: Ethical Framework and 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.

Appendix 3: 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"

Appendix 4 Integrated Measures and the Integrated Health Services Plan (in development)