Hamilton Board Committee

Thursday, June 27, 2013
15:30 pm
Dofasco Boardroom – Juravinski Innovation Tower

Open Session

St. Joseph's Villa Dundas

St. Joseph's Healthcare Hamilton

St. Joseph's Home Care

St. Joseph's Healthcare Hamilton | St. Joseph's Home Care | St. Joseph's Villa Dundas

Hamilton Board Committee – Open Session - Agenda

Date:	Thursday, June 27, 2013
Time	1530-1605 hours
Location:	Dofasco Boardroom, Juravinski Innovation Tower, Charlton Campus, St. Joseph's Healthcare Hamilton
Members:	B. Gould, Chair, M. Dow, W. Doyle, H. Fuller, M. Guise, J. Kelton, J. LoPresti, S. Monzavi, R. Rocci, C. Santoni, M. Taylor, T. Thoma, P. Tice, I. Schachler, J. Gauldie.
Resource:	D. Higgins, S. Filice-Armenio, M. Ellis, J. Fry, F. Ros.
Guests:	D. Russell, M. Crowther, C. Finlay (for Dr. G. Chaimowitz).
Regrets:	G. Chaimowitz.

Item	Topic	Page	Responsibility	Time
1.0	**PROTOCOL**			1530-1535
1.1	Call to Order		Mr. B. Gould	
1.2	Opening Prayer		Ms. W. Doyle	
1.3	Introduction of Guests		Mr. B. Gould	
1.4	Declaration of Conflict of Interest		All	
2.0	**AGENDA & MINUTES**			
2.1	Approval of the Agenda		Mr. B. Gould	
2.2	Additions to Agenda		Mr. B. Gould	
2.3	Approval of Minutes – May 30, 2013	1-3	Mr. B. Gould	
2.3.1	***Motion for Approval by Hamilton Board Committee: THAT THE OPEN MINUTES OF THE MAY 30, 2013 HAMILTON BOARD COMMITTEE BE APPROVED***			
3.0	**REPORTS**			1535-1555
3.1	Chair's Report		Mr. B. Gould	
3.2	President's Report	4-6	HBC Presidents	
3.3	President of the Medical Staff Association		Dr. G. Chaimowitz	
3.4	Presidents of SJH Foundation and SJV Foundation		Ms. S. Filice-Armenio Ms. M. Ellis	
4.0	**NEW BUSINESS**			1555-1600
5.0	**INFORMATION ITEMS**			
5.1	HBC Summary	7-8		
5.2	Article – Three Missions – One Future – Optimizing the Performance of Canada's Academic Health Sciences Centres	9-14		
5.3	Article – Health Wait Times Still Fail to Meet Patient Demands	15-16		
6.0	**ADJOURNMENT** ***Motion for Approval by Hamilton Board Committee: THAT THE OPEN SESSION OF THE HBC BE ADJOURNED***		Mr. B. Gould	1600
7.0	***Motion - Move into the Annual General Meeting – St. Joseph's Home Care***			1600-1605

Note: Trustees who wish to have items moved from the Consent Agenda to the Closed/Open Agenda should contact the SJHH President's Office prior to the Board Meeting. Trustees also have an opportunity to make this request when the open agenda is presented at the Board Meeting.

St. Joseph's Villa Dundas | St. Joseph's Healthcare Hamilton | St. Joseph's Home Care

Committee:	**Hamilton Board Committee – OPEN SESSION**	Date: May 30, 2013
Called to order at:	1530 hours	Adjourned: 1550 hours
Location:	Dofasco Boardroom – 2nd Floor Juravinski Innovation Tower	
Present:	Mr. B. Gould, Chair, Mrs. M. Taylor, Mrs. M. Dow, Mr. R. Rocci, Mr. S. Monzavi, Mr. P. Tice, Dr. G. Chaimowitz, Mr. C. Santoni, Mrs. I. Schachler, Dr. J. Gauldie, Dr. T. Packer.	
Regrets:	Dr. J. Kelton, Ms. W. Doyle, Dr. H. Fuller, Dr. M. Guise, Mr. T. Thoma, Mr. J. LoPresti.	
Resource Staff:	Dr. D. Higgins, Ms. F. Ros, Ms. J. Fry, Mr. S. Gadsby, Mrs. S. Filice-Armenio, Ms. M. Ellis.	
Guests:	Mr. J. Woods, Mr. B. Herechuk, Ms. S. Hollis, Dr. K. Smith, Mr. R. Gercone.	
NEXT MEETING	June 27, 2013	

Subject	Discussion
1. PROTOCOL	
1.1 CALL TO ORDER	The meeting was called to order at 1530 hours by B. Gould.
1.2 OPENING PRAYER	C. Santoni opened the meeting with a prayer.
1.3 GUESTS	All guests in attendance were introduced.
1.4 DECLARATION OF CONFLICT OF INTEREST	There was no declaration of conflict of interest.
2. AGENDA AND MINUTES	
2.1 APPROVAL OF AGENDA	It was MOVED by C. Santoni, SECONDED by S. Monzavi, VOTED AND CARRIED: **THAT THE HAMILTON BOARD COMMITTEE AGENDA BE APPROVED AS CIRCULATED**
2.2 ADDITIONS TO THE AGENDA	There were no additions to the agenda.
2.3 APPROVAL OF THE MINUTES	It was MOVED by M. Dow, SECONDED by P. Tice, VOTED AND CARRIED **THAT THE (OPEN) MINUTES OF THE HAMILTON BOARD COMMITTEE OF APRIL 25, 2013 BE APPROVED**
3. REPORTS	
3.1 Chair's Report	B. Gould reported the following: • On April 27th Sister Joan O'Sullivan passed away at the St. Joseph's Motherhouse. Sister Joan was appointed CEO of St. Joseph's Hospital in 1979 and served with distinction over a 10 year period. In all her work and endeavours she served our hospital and community with great distinction, vision and humility; always ensuring

Subject	Discussion
	that in every decision we remained true to our mission and cared particularly for the poor and marginalized. Her death leaves a void but also a reminder and inspiration for each of us to consider the legacy that she and the Sisters have given to all of us. • A reminder to members to please complete the HBC meeting evaluation, which can be found on the last page of the agenda package
3.2 President's Report	• The Mission Legacy Awards will be held on Thursday June 20th. All HBC members are invited to attend. Recipients include staff, physician, volunteer, and board members. M. Dow is the recipient from the Hamilton Board Committee. • A joint letter with respect to the Hamilton Transportation Plan to the City of Hamilton from SJHH, HHS, Hamilton Family Health Team and the Hamilton Academy of Medicine was shared with the HBC. The letter outlines the importance and the positive impact on health of a comprehensive transport plan which shifts transportation use from vehicles towards walking, cycling, and transit. • It was noted that SJVD will be examining changes in the delivery of physiotherapy services. This is in response to the changes in the method of funding from the Ministry of Health and Long Term Care.
3.3 President of the Medical Staff Association	• The Medical Staff Association Exemplary Service Award will be presented at an upcoming departmental reception to an employee who goes above and beyond normal work duties. The Award is presented by a member of the MSA Executive
3.4 St. Joseph's Healthcare Foundation and St. Joseph's Villa Foundation	**St. Joseph's Healthcare Foundation** • The five year Strategic Plan for the Foundation has been approved by the Board of Directors. • A naming event honouring Bishop Anthony Tonnos in his support of Catholic health care took place this morning. The Rehabilitation and Palliative Care Programs have been renamed in his honour. Staff were very pleased that Bishop Tonnos has been associated with these two programs. • In response to a question, it was noted that funding for the DaVinci Robot primarily relies on funding the disposables for the robot. Great outcomes with surgeries using the robot have been realized. • The Capital Campaign has surpassed the $65M mark. **St. Joseph's Villa Foundation** • The Capital Campaign has raised $754K to date against a $2M goal • A proposal has been submitted to Hamilton Future Fund and the Foundation is expecting to hear shortly on whether they will be making a presentation. • The SJVD Annual Gala raised over $120K and was attended by over 440 guests, making it the most successful gala to date. • St. Mary's High School and the Villa have had a long time partnership in the school's health care program. The Foundation sponsors 2 scholarships for exceptional students who are pursuing a career in health care. New this year is the "Rays of Light" award at the school. This award is fashioned after the SJHS Mission Legacy Award. It recognizes a student for outstanding volunteer service in health care. • For the first time the Foundation will be a community partner in the Road2Hope Marathon in November. The event takes place on Nov. 2 & 3rd with a 1K, 5K and 10K run or walk on the Saturday and the ½ Marathon and full Marathon on the Sunday.

Subject	Discussion
4. NEW BUSINESS	There was no new business.
5. INFORMATION ITEMS	• HBC Summary • Article – The Hamilton Spectator – Sister Joan O'Sullivan
6. ADJOURNMENT	It was MOVED by R. Rocci, SECONDED by M. Taylor, VOTED AND CARRIED **THAT THE OPEN SESSION OF THE HBC BE ADJOURNED AND THAT THE HBC MOVE INTO THE CLOSED SESSION**
	Ben Gould, Chair David Higgins, Secretary Fadia Ros , Recorder

OPEN REPORT TO THE HAMILTON BOARD COMMITTEE – JUNE 2013

1. Environmental Scan

1.1 SJHC: Personal Support Worker (PSW) Training Standards

- The Ministry of Health and Long-Term Care is moving forward to establish a single PSW educational standard. Currently there are three recognized standards that are used by various training organizations.
- In light of this, the MOHLTC had launched the PSW Technical Working Group (TWG). The mandate of this working group is to provide expertise and to actively participate in the review and development of a common PSW educational standard. Their objectives are to:
    - Provide expertise on PSW training and/or duties/functions
    - Advise on the development of a common educational standard that will apply to all PSW training institutions
    - Ensure that the educational standard is: at an entry level position in the health care sector and are aligned with the Certificate III credential level of the Ontario Qualifications Framework

1.2 SJHC: Ontario Home Care Association (OHCA) 2013 Symposium

- SJHC presented the Integrated Comprehensive Care (ICC) project at the OHCA symposium on March 23, 2013.
- The presentation was very well received.

1.3 SJHC: Provincial Benchmarking Survey on Home Care

- In last month's President's Report, SJHC reported that Ontario Home Care Association is conducting an industry benchmarking survey of home care service providers. The survey is being conducted by Sentiens Research and provides an opportunity for agencies to self-assess their performance. The purpose of the survey is to:
    - Provide participants with a snapshot of service provider organization (SPO) key metrics for the industry;
    - Allow participant SPOs to self-assess their performance to the aggregate results; and,
    - Establish a baseline for comparative purposes of home care services in future studies.
    - SJHC is participating in the survey. Data collection is underway. Due date is June 28, 2013.

1.4 SJHC: Invitation to Consult on New Community Investments

- The HNHB LHIN has invited LHIN-funded service providers that provide care and support to residents in the community to meet with the LHIN for the purposes of identifying areas for new investments that will address system pressures and identify creative solutions that will contribute to addressing these system pressures.
- In January 2013, the Minister of Health speaking on Ontario's Action Plan for Health Care, mentioned the need to improve the quality of patient care while also addressing fiscal and demographic challenges.
- Glenys Currie attended the engagement session on June 5th on behalf of SJHC.

1.5 SJVD: Ontario Strengthening Care for Long-Term Care Residents

The MOHLTC have increased the number of comprehensive inspections of long-term care homes to strengthen safety and improve care for residents. The Province is hiring more inspectors to perform more unannounced comprehensive Resident Quality Inspections (formerly known as annual inspections) in long-term care homes. All 633 long-term care homes in the Province will receive comprehensive annual inspections. This builds on the 6700 inspections conducted since 2010.

A Few Quick Facts:

- All long term care homes will receive a new Resident Quality Inspection by the end of 2014 and annually thereafter.
- 123 Resident Quality Inspections have been conducted in long term care homes since 2010.
- Long term care funding is projected to increase to $3.83 billion in 2013/14 from $2.12 billion in 2002/04. This includes a two per cent increase dedicated to resident care needs proposed in 2013/14 budget.
- Ontario has invested $43 million in Behavioural Supports Ontario to help care for residents with dementia and challenging behaviours and will invest $22.7 million over the next five years to establish Centres for Learning, Research and Innovation in Long-Term Care.

The MOHLTC recently forwarded the SJVD annual review for 2013 and will be following up shortly with the public report.

1.6 SJHH: Wait Times In The News

The CBC ran an article on June 11th focusing on the national progress on hospital wait times in Canada. The article cited a report from the 'Wait Times Alliance' which indicates that in order to achieve true improvement, a structural overhaul in the way we think about ED care is needed. The article outlines suggested structural changes. One item to note is that Ontario is the only province to have all grades of A or A+ in the 7 wait times reported in the article. The CBC article is enclosed in the 'information items' section of the Open Report for review.

2. Mission, Vision and Values Update

2.1 HBC: Thank you to Mr. Ben Gould

This meeting marks the final HBC session of 2012-13. This also marks our final meeting with Mr. Ben Gould as our Chair of the Hamilton Board Committee. We would like to sincerely thank Ben for his expertise, guidance and sincere passion for the governance of our organizations and the patients and communities we serve. Ben's imprint, particularly related to the advancement of our quality agendas at St. Joseph's Healthcare, St. Joseph's Home Care and St. Joseph's Villa will be long lasting. Thank you Ben.

2.2 SJHH: Mission Legacy Awards Ceremony

On June 20th, St. Joseph's Healthcare Hamilton held the Mission Legacy Award recognition event. To note, Ms. Mary Dow was recognized as one of the 11 recipients of the Mission Legacy Award this year. Thank you to Mary for your dedication to our organizations during your tenure as a member of our Board. Thank you also to all Board members who attended this special event.

3. Operational Information

3.1 SJHC: Accreditation

SJHC has received confirmation from Accreditation Canada that the dates for our 2014 accreditation survey have been set for April 23-25, 2014.

3.2 SJVD: Accreditation

SJVD will be participating in Accreditation Canada in June 2014 as a way to align all HBC organizations in a common accreditation process and standards. SJVD has always been fully accredited by the third party reviewers, however in recent years (2010-2013) SJVD has undergone accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF). Prior to this, SJVD was accredited through Accreditation Canada and 2014 will mark a return to this accreditation format. The Villa will be requesting the Board's input for the Governance Section of the Accreditation survey and will be in touch closer to the actual survey.

3.3 SJHH: Hand Hygiene Performance

Infection control and hand hygiene continue to be a top priority for the safety of our patients and families. We are pleased to report our rates of hand hygiene for the month of May where we had 17 units at or above 95% hand hygiene compliance and another 9 units between 90 and 95% compliance (hand hygiene compliance before and after patient contact). Many of these units have shown sustained rates of 90% or above for several months at a time and are being looked to for modeling and assistance by those units who need have yet to meet this target consistently.

3.4 SJHH: Leadership Convention

One June 4th the SJHH Leadership Convention was held at the Hamilton Convention Centre. More than 475 front line staff, managers, physicians and Board Members attended this event, which received very high feedback on effectiveness and learning opportunities. To note, we also had patient representatives in attendance at this year's event.

3.5 HBC Orientation Update

HBC orientation sessions will be taking place in early July for new members to the HBC, new community members as well as new committee Chairs. Please also note that the 2013-14Education Plan has been included in your Board package for information. This document contains a list of session available to members for education and orientation.

Hamilton Board Committee (HBC) – Summary of April 25th, 2013 Closed Meeting Session

Motions Summary

Recommending HBC Committee	Motion Summary
Governance, Mission and Values Committee	It was voted that the: ▪ Minutes of the Governance, Mission and Values Committee of April 2nd, 2013 be accepted for information (Hamilton Board Committee).
Quality Committee	It was voted that the: ▪ Minutes of the Quality Committee of April 9th, 2013 be accepted for information (Hamilton Board Committee).
Resource and Audit Committee	It was voted that the: ▪ Minutes of the Resource and Audit Committee of April 17th be accepted for information (Hamilton Board Committee). ▪ St. Joseph's Home Care Consolidated Budget for the year of April 1, 2013 to March 31, 2014 be approved (Hamilton Board Committee – St. Joseph's Home Care Voting Members).
The Medical Advisory Committee	It was voted that the: ▪ Minutes of the Medical Advisory Committee of April 4th 2013 be approved (Hamilton Board Committee – St. Joseph's Healthcare Voting Members) ▪ Recommendations on research from the Medical Advisory Committee of SJHH of April 4th 2013 be approved (Hamilton Board Committee – St. Joseph's Healthcare Voting Members) ▪ Recommendations on credentials of the April 4th 2013 Medical Advisory Committee be approved (Hamilton Board Committee – St. Joseph's Healthcare Voting Members)

Presentations and Reports to the HBC – Summary

- The Board heard a presentation from the St. Joseph's Healthcare Redevelopment program highlighting the progress on the new Margaret and Charles Juravinski Centre for Integrated Healthcare at the St. Joe's West 5th Campus. The presentation focused on details about the actual building, the operational readiness for our patient move, and specific patient safety and quality of care design features in this new state of the art facility. Specific details included:
  - Programs planned for the new facility: mood disorders, geriatric psychiatry, forensics, schizophrenia, mental health rehabilitation services, acute mental health, medical outpatient clinics, diagnostics
  - Key dates:
    - Substantial completion: December 6, 2013
    - Ribbon Cutting / Grand Opening: Late Jan 2014
    - Patient Move: February 9, 2014
  - Safety and quality of care design features:
    - Personal alarm system
    - Security monitoring cameras
    - Intercoms
    - Transition apartments
    - 70 % Natural light - optimized patient views
    - Single patient bedrooms + en suite bathrooms, card access
    - Self contained secure seclusion rooms
    - Secure lockers inside patient rooms
    - Secured access to outside space from each unit
    - Centralized nursing stations - 24 bed units composed of 8 bed pods
    - Security zones (inpatient, neighborhood, downtown and public areas)

- Post Occupancy Evaluation Research:
  - Effect of the new facility on the quality and quantity of patients' sleep
  - Effect of increasing our security process in patient/ staff/physician feelings of safety
  - Effect of new facility on patient / staff / visitor / learner / physician sense of well being, productivity
- Detailed discussion took place on progress to date and future plans for this state of the art facility and its impact on patient care in the Mental Health and Addictions program.

- The Governance, Mission and Values committee of the Board was highlighted this month. The committee provided an update on the following matters being discussed at the committee level:
  - Board education plan: The committee has developed and oversees a Board Education Plan to ensure that new and current members are able to attend educational sessions relevant to their position within the HBC.
  - Nominating committee update: The nominating committee of the Board has completed the process of recommending membership for 2013-14.
  - Board orientation plan: The committee is in the process of developing a Board Orientation plan for 2013-14 as per OHA Guide to Good Governance.
  - Legislative Compliance Process: The committee has undertaken work in conjunction with the St. Joseph's Health System to develop a comprehensive list of all legislation applicable to the governance of the 3 HBC organizations.

- The Board received an update from Dr. Adili and the Peri-operative program on an initiative to standardize Venous Thromboembolism (VTE) prophylaxis for post operative patients. There is sound evidence that VTE prophylaxis for post operative patients and VTE is known to be one of the most common causes of preventable death in hospital. The focus of the talk was on the details of implementation, standardization and sustainability of this process. The Board urged Dr. Adili and the MAC to continue to translate other important recommendations, guidelines and research into practice to ensure that care provided to our patients and communities is high quality and evidence based.

- The Board heard a presentation from Dr. Higgins on the HBC Strategic Planning Process with detail on our four strategic directions; 1) Transforming How We Work; 2) Research and Innovation; 3) Engaged People; and 4) Breaking Down Barriers. These strategic directions will ultimately guide the cultural change required to radically transform care for our community. At the core of this plan are 12 demonstration projects within each of our clinical 'clusters'. The Board heard detail on these projects which are in the planning and initial implementation stages. Detailed discussion took place on engagement, communication, measurement and governance of the strategic plan.

Three Missions One Future: Optimizing the Performance of Canada's Academic Health Sciences Centres

The following article is abstracted from the 2010 Report from the National Task Force on the Future of Canada's Academic Health Sciences Centres.

Executive Summary

Recognizing that the health system is experiencing rapid change in times of economic challenge, the purpose of this report is to ensure that Canada's Academic Health Science Centres (AHSCs) are in a position to reach their potential and optimize their performance. This, however, presents both challenges and opportunities. Changes in governance and long-standing concerns about alignment of missions and resources have all put strains on the AHSC. At the same time, new approaches to patient care, teaching and research that are changing the traditional AHSC model offer the potential for significant benefits to patients and society as a whole.

These concerns and possibilities prompted 22 of Canada's national health provider and academic healthcare organizations to endorse and create the National Task Force on the Future of Canada's Academic Health Sciences Centres. The work of the task force, made up of 19 leaders in the Canadian and international academic health science community, was funded by Health Canada.

The terms of reference of the Task Force required it to identify the internal and external factors that will allow AHSCs to achieve excellence and innovation in patient care and service delivery, education, and research, and to recommend the means – including governance structures, accountability relationships and resource requirements – by which this should happen. Its mandate also called for setting out next steps for implementation of its recommendations.

Canada's Academic Health Sciences Centres (AHSCs) are comprised of a health sciences university's faculty of medicine, plus one or more health faculties or professional schools (including, nursing, pharmacy, dentistry, health sciences and rehabilitation sciences), colleges and other educational institutes, and their linkages to one or more academic healthcare organizations (including teaching and research hospitals and their research institutes, provincial and/or regional health authorities, rehabilitation institutions, specialty psychiatric centres, long-term care facilities, and nursing homes).

AHSCs deliver three related missions: (1) providing Canadians with timely access to advanced patient care services; (2) training the next generation of health care professionals; and (3) conducting leading-edge research and making it available to clinicians, administrators, policy makers and the public. It is the integration of patient care, education and research that uniquely defines the AHSC mission and differentiates it from other organizations in the health system that focus predominantly or exclusively on the provision of health and health care services. Each mission serves to reinforce the other two, with the objective of providing Canadians with access to world-class patient care, well-trained health care professionals, and state-of-the-art research.

This mandate positions AHSCs as engines of health innovation through the interplay between research, education and clinical practice which accelerates the translation of new knowledge into cost-effective leading practices, new models of organizing and delivering care, breakthrough drugs and/or medical devices that can revolutionize diagnosis, treatment and improve health outcomes.

The integration of education, research and patient care in the same milieu provides a fertile environment where students can learn and apply state-of-the art knowledge from the classroom, to the laboratory, to the bedside. At the same time, AHSCs have a crucial role to play in converting new knowledge into a range of innovative products and services to the marketplace.

Through their strategic focus on innovation and knowledge translation, AHSCs have the potential to ensure that the health system remains accessible and flexible, and can rapidly adapt to changing health needs while placing it on a firmer fiscal foundation for the future. Knowing that the benefits that flow from Canada's AHSCs extend well beyond local, regional, and provincial and territorial boundaries, the National Task Force believes they should be acknowledged as a national resource in the system.

In carrying out its work and as required by its terms of reference, the Task Force drew on an extensive review of academic literature, an e-environmental scan, and in-depth interviews of health professional leaders across the country, as well as the experiences and knowledge of its own members. Through this process, the National Task Force identified three central themes that encapsulated AHSCs' challenges in fulfilling their current and future mission and mandate: (1) while *changing governance models* in the health system are sometimes acting as a catalyst for improved integration across all three missions of the AHSC, in other instances they are creating barriers; (2) *new integration mechanisms* are required, both within AHSCs and between AHSCs and government, to better align plans, strategies, processes and outcomes; and (3) *continued resourcing pressures,* uncoordinated funding, and multiple funding sources including the different levels of government, present a significant challenge to optimize all aspects of the care-teaching-research mission.

The Task Force has concluded that in order to optimize their performance and improve patient and population health outcomes it is essential to identify a common path forward for AHSCs that is clear, strategic and achievable. Moreover, such a common path is critical to the next step in their evolution: into Academic Health Science Networks (AHSNs).

At the same time, there is a significant responsibility for the AHSN community to improve the ways in which they are organized, governed and deliver their mission. We have also concluded that Canadians and their governments need to support AHSCs, and the networks into which they are evolving, because of their central role in the health care system.

Taking the path we have set out would strengthen a crucial pillar that supports the well-being of Canadians. It would enhance Canada's future well-being and prosperity by improving health and health outcomes, ensuring better educated health care professionals in Canada's future workforce, more effectively translating the benefits of research, innovation and commercialization, and identifying new opportunities and settings to introduce cost-effective innovations. Without acting now, Canada risks diminishing, if not losing, the value these organizations create together – value that in many cases has accumulated over more than a century.

Evolution to Academic Health Sciences Networks (AHSNs)

With the emergence of new health care organizations with broad regional responsibilities for health as well as health care combined with emerging trends in academic medicine such as distributed medical education, eLearning, and collaborative inter-professional models of care across a broader range of organizations and institutions, the National Task Force embraced the new model of the Academic Health Sciences Network (AHSN), for which it developed the following definition: *"a set of formal partnerships created by health sciences universities, academic healthcare organizations and other provider organizations with the goal of improving patient and population health outcomes through mechanisms and structures that develop, implement and advance integrated health services delivery, professional education, and research and innovation. At the core of this network is the AHSC, working closely with other academic healthcare organizations who focus, in whole or in part, on the care-teaching-research mandate."*

The National Task Force believes that Canada's health sciences universities, colleges and other educational institutes, and the academic healthcare organizations with which they have formal affiliation agreements will continue to constitute the critical nuclei of these emerging networks. However, we have also concluded that a more contemporary and inclusive definition is needed that builds on the traditional core mission and mandate of the AHSC and also accurately reflects the new relationships that are emerging among a variety of health services organizations working together on the some or all of the components of the care-teaching-research mandate.

Using this definition, there are 17 AHSNs in Canada at present, one centered on each of the country's university medical schools and at least one affiliated teaching/research hospital.

To guide subsequent discussions at the local level as to who should be a member of the Network, the National Task Force highlighted four models across the country as possible examples: *les Réseaux Universitaires Intégrés de Santé* (RUIS); the Toronto Academic Health Sciences Network (TAHSN); the Saskatchewan Academic Health Sciences Network (SAHSN); and the British Columbia Academic Health Sciences Council (BCAHC).

At the same time, the National Task Force also identified some of the issues and challenges that AHSNs will need to reflect on, and proposed a series of metrics that capture a range of outcomes produced by the AHSN and more clearly articulate its overall value proposition.

AHSN Vision

Looking forward, the National Task Force saw a clear need to define the future vision for Canada's AHSNs. This vision should build on the existing leadership role in academic networking of today's AHSCs, ensure that they achieve the same or a greater degree of international recognition, and like them are able to attract and retain the world's best health practitioners, educators and researchers. The vision is as follows: *"Academic Health Sciences Networks (AHSNs) will improve the health of Canadians and enable Canada to be a global leader in health care, education and research."*

To fulfill this vision and enable the evolution from the traditional AHSC model, the National Task Force concluded that these new networks must be appropriately structured, mandated, governed, resourced and enabled.

Recommendations to Optimize the Performance of AHSN

The National Task Force strongly believes that the recommendations set out in this report are key to transforming the structure of the AHSN and placing it on a path of superior performance and long-term sustainability, and providing the greatest value possible for Canada and Canadians. High-level implementation strategies for each recommendation are set out in Chapter 7.

The AHSN Community...

To think and act like cohesive organizations delivering their missions and commitments, AHSNs need to develop new organizational frameworks to facilitate planning, priority-setting, resource allocation and decision-making. The National Task Force believes that we can learn from some of the recent inter-organizational structures that have been introduced in Quebec, Ontario, Saskatchewan and British Columbia.

Recommendation 1

"The National Task Force recommends that all Academic Health Sciences Networks (AHSNs) establish formal inter-organizational structures and governance mechanisms to support the development of integrated strategies, plans and policies, and ensure more effective planning, information-sharing, coordinated decision-making and policy implementation."

Fully embracing the network model will require a diverse array of health care organizations to recognize and accept a more collective responsibility for leadership in delivering on the care-teaching-research mission. This shift can take place only if it is backed up with mechanisms that recognize the single-entity nature of the AHSN and support integration and planning across it.

Recommendation 2

The National Task Force recommends that each of Canada's Academic Health Sciences Networks (AHSNs) commit to developing integrated plans and strategies that will:

a. Guide its overall process of transforming to the network model;

b. Achieve the vision of the AHSN set out in this report (which is "to improve the health of Canadians and enable Canada to be a global leader in health care, education, and research") by:

- *leading the development of innovative and value-added health care services, education and research, evaluation and knowledge translation;*
- *accelerating the dissemination of research-based evidence into clinical practice to implement leading practices to enhance the quality, accessibility and affordability of health care services and improve patient and population health outcomes; and*
- *integrating innovative collaborative models of education with health care delivery and research; and*

c. Identify appropriate performance measures to assist in monitoring their progress and performance.

Because AHSNs are relatively new, and developing in a rapidly changing environment, it would be valuable to leverage existing national mechanisms, such as those provided by national health organizations, to meet on a regular basis to exchange information, lessons learned, and leading practices; review the structural design of AHSNs and their strategic objectives; and consider the breadth of metrics to express their impact.

Recommendation 3

"The National Task Force recommends that the relevant national associations establish the appropriate structures, processes and forums for Canada's AHSNs to meet on a regular basis. The objectives of these meetings would be: (1) to strengthen AHSN relationships; (2) to identify gaps or duplication in their mandates, plans, policies and/or programs; and (3) to share lessons learned and leading practices."

The National Task Force was strongly of the view that all of Canada's emerging AHSNs need to better communicate and promote their value, an exercise which some have already undertaken. This would involve creating an appropriate brand for a number of target audiences, including the public, media, governments, healthcare organizations, the charitable sector and the private sector.

Working With Governments...

Like AHSCs, AHSNs are involved in a complex set of relationships with Canada's provincial/territorial and federal governments. Responsibility for the delivery of health services and post-secondary education rests with the provincial and territorial governments, which generally also provide some of the funding for research and innovation, along with a series of direct and indirect investments in health care, education and research, innovation and commercialization by the federal government that are complementary in nature.

Each provincial and territorial government has its own model for supporting and overseeing the organizations that deliver the care-teaching-research mission of the AHSN. Typically, responsibilities are spread across a number of ministries. This risks reducing the ability of AHSNs to successfully achieve their missions and fully benefit the communities they serve. Indeed, health care leaders interviewed for the National Task Force's work frequently identified problems with competing agendas, conflicting policies and fragmented priorities.

The introduction of new AHSN-inter-Ministerial mechanisms would improve the alignment of activities across AHSNs, allowing for a more complete discussion of their accountabilities and deliverables, and examine ways of fully leveraging resources invested in them. The results would include less duplication of effort, improved policy coverage of key issues, better integration of policies, and greater return-on-investments in our health care system.

Recommendation 4

"The National Task Force recommends that AHSNs work with their respective provincial and territorial governments to create mechanisms through which AHSNs and all relevant ministries can more effectively communicate, share information and make decisions, and develop, coordinate and implement policies."

At the federal level, the government directly provides close to 80 cents of each public dollar invested in health research, as well as making transfer payments to provinces and territories for their health and education priorities. Given the range of areas in which the federal government can support and complement the role of the provinces and territories, and the national impact of AHSNs, the National Task Force identified a need to improve policy consultation and coordination with the national organizations that represent AHSNs.

In considering a mechanism for consultation and dialogue at the federal level that supports the AHSN, the National Task Force would make it clear that this is in no way intended to supplant or diminish the constitutional responsibilities of the provinces and territories. Where there is an identified role for the federal government to invest in the tripartite mission of AHSNs, it must be done in close consultation with the provinces and territories and aligned with their priorities. The National Task Force is sensitive to the added complexity that is associated in establishing a mechanism that extends across two levels of government.

Recommendation 5

"The National Task Force recommends that the federal, provincial and territorial governments collectively recognize AHSNs as a national resource in the health system by working with the relevant national associations and bodies to create mechanisms through which AHSNs and federal ministries and agencies can more effectively communicate, share information and make decisions, and develop, coordinate and implement policies."

Thus far, the recommendations have focused on the need to develop integrated plans and strategies and effectively align structures within and between AHSNs and with relevant government bodies to improve patient and population health outcomes. While these priorities are vital to the future of the AHSN, they cannot be disconnected from a discussion on resourcing the elements that underpin the AHSN enterprise: patient care; education; research; and infrastructure – with the provinces and territories playing a primary role in terms of overall stewardship, funding and accountability.

The National Task Force believes that AHSNs should be able to demonstrate the value they achieve with the funding they receive, which is often criticized and to some degree misunderstood for being higher compared to community health provider organizations. Including performance measures in their plans, as we have recommended, AHSNs will continue to demonstrate that they accept their accountability for wise and responsible stewardship of public funds and scarce resources.

Funders must also recognize and begin to address significant and legitimate resource problems among AHSNs and their members. Funding concerns – lack of alignment, fragmentation and in some instances inadequacy – together make up perhaps the biggest challenge they face. As provinces and territories seek to contain the growth of health care costs, AHSNs will need to work closely with their funding partners to address this challenge in ways that support better health and health care outcomes.

Recommendation 6

"The National Task Force recommends that AHSNs and provincial and territorial governments ensure that the appropriate financial resources, mechanisms and programs are aligned to fulfill their agreed upon missions."

While provincial and territorial governments are the predominant funder of AHSNs, it will also be crucial to find ways in which investments by the federal government are aligned with local care-teaching-research priorities to provide maximum value. Regardless of the funding mechanism, discussions would be required among the federal, provincial and territorial governments and AHSNs to determine how any funding arrangement would effectively work and meet pre-determined common policy objectives.

Recommendation 7

"The National Task Force recommends that AHSNs and the federal government, in close consultation and ongoing dialogue with the provinces and territories, ensure the appropriate federal financial resources, mechanisms and programs are aligned with provincial and territorial government priorities, to fulfill their agreed missions."

AHSNs and the International Community...

Canada's reputation for excellence in delivering on the care-teaching-research mission and as an "honest broker" positions it well to assume an international leadership role in advancing the AHSN concept. Inviting the best and brightest minds in the world to regularly share experiences, leading practices and lessons learned, and thoughts about structures and processes would help to enrich Canadian AHSNs and further contribute to Canada's international stature.

The National Task Force believes that implementation of the recommendation is an enabler to the vision we propose and would ensure that Canada's AHSNs are relevant, globally competitive, and properly positioned internationally to contribute our experiences to improving health, health care and health systems worldwide, and also benefit from the knowledge and leading practices developed elsewhere.

Recommendation 8

"The National Task Force recommends that Canada's Academic Health Sciences Networks and their national organizations create an international meeting place, or host an annual forum, that brings together global leaders committed to the collective advancement of the issues and opportunities in the academic health sciences."

Health wait times still fail to meet patient demands:
Health system needs structural changes to cut waits for procedures, Canadian doctors say

CBC News: Jun 11, 2013 11:36 AM ET

National wait-time grades haven't improved for medical treatments that federal and provincial governments agreed to provide more quickly, according to a new report card.

The Wait Times Alliance, which includes doctors from specialties such as emergency medicine, radiology and cardiology, released its annual report on wait times, titled "Canadians still waiting too long for health care," on Tuesday.

"Tackling the long waits for care in this country requires not just a tune-up but a major overhaul in health care," the group's chair, Dr. Chris Simpson, told reporters from Ottawa.

"Nationally, not only has there been no progress over the last year in wait times in all five priority areas, in fact, Canadians in many instances are waiting longer now than they were two years ago."

The report pointed to continued backsliding on the percentage of patients treated within government-approved benchmarks for wait times, which the group called the minimum acceptable time.

"We've seen in an increase in the number of surguries, but the demand has outstripped the number of procedures that are being done," said Simpson. "We've managed to tread water."

For example, the group's 2012 report card showed it often takes longer for patients to see a specialist than it does for them to start treatment.

Most provinces are trying to address wait times, but Simpson said "structural changes" are needed because "the money didn't buy change."

The group suggested:

- Addressing the needs of patients who are elderly and those needing "alternate level of care" — the 14 per cent of people in hospital beds who are waiting to be transferred to a long-term-care facility or back home with support services.
- Reorganizing how hospitals are funded, as British Columbia and Ontario are starting to, so money follows the patient and hospitals are offered an incentive to provide more services efficiently. The Netherlands used this model to actively search for hospitals with shorter wait times on behalf of patients.
- Developing patient-centred models of care from the ground up.
-

"In other jurisdictions, particularly in Europe, where information is available and patients are given a bit more of choice or at the very least they're given information on how long they have to wait, given information on outcomes, then they can act a little bit like consumers and distribute the demand a little bit differently," Simpson said. Simpson pointed to individual success stories in pilot projects.

Orthopedic wait questions

"But without a sort of national sensibility, we aren't able to translate that into something we can truly say is a Canadian improvement in a Canadian health-care system."

Last week for example, researchers at Toronto's Institute for Clinical Evaluative Sciences reported that four of five patients in Ontario did not receive surgery within 18 months of visiting an orthopedic surgeon, who are trained to perform hip and knee replacements.

Of the 477,945 patients, 49 per cent visited orthopedic surgeons for injury, and 24 per cent for arthritis, Elizabeth Badley, an adjunct scientist at ICES and her co-authors said in the journal PLoS One.

It's the first time this has been looked at in detail anywhere in the world, Badley said.

"Does this high volume of non-surgical patients increase waiting times for a first appointment with an orthopedic surgeon and therefore get in the way of individuals who are in urgent need of surgical care? That we don't know." The findings also raise questions about whether all of the patients need a surgeon's special skills. Perhaps some patients with joint and bone concerns could be seen by other health-care professionals such as sports medicine doctors, primary care physicians with an interest in musculoskeletal conditions, physiotherapists or chiropractors, Badley suggested.

"We need a comprehensive strategy to deal with the aging population," she said.

The alliance also called for Canada to adopt a national strategy on dementia that focuses on keeping elderly people out of hospital.

Access to primary care also continues to be an issue, particularly for individuals from low-income neighbourhoods who are more likely to report difficulties making appointments with their family doctor.

The alliance said it established wait-time benchmarks for 925 treatments, procedures and diagnoses that have the highest volumes, greatest potential for improvements or greatest potential return on investment.

Wait-time grades based on government and WTA benchmarks
Five initial areas:

	Diagnostic Imaging MRI	Diagnostic Imaging CT	Joint repl. Hip	Joint repl. Knee	Radiation therapy	Cataract surgery	Heart coronary artery bypass graft
	nb	nb	26 wks	26 wks	4 wks	16 wks	26 wks
NL	nb	nb	A	A	A+	A+	A+
PE		nb	B	F	A+		na
NS	nb	nb			A+	C	A+
NB	nb	nb	B	C	A+	A	A+
QC	nb	nb	B	B	A+	A	na
ON	nb	nb	A	A	A+	A	A+
MB	nb		B	D	A+	C	A+
SK	nb	nb	C		A+	C	A+
AB	nb	nb	B	B	A+	B	A+
BC	nb	nb	A	B	A+	A	A+
Nat'l	nb	nb	B	C	A+	B	A+

A+: 90%–100% of population treated within benchmark
A: 80%–89% of population treated within benchmark
B: 70%–79% of population treated within benchmark
C: 60%–69% of population treated within benchmark
D: 50%–59% of population treated within benchmark
F: Less than 50% of population treated within benchmark
nb: no benchmark

decrease in wait times over the previous year
increase in wait times over the previous year
no significant change over the previous year
insufficient data to make determination

Source: WTA (Wait Time Alliance)

(Courtesy Wait Times Alliance) With files from CBC's Kelly Crowe and Amina Zafar