Summary
QHC Board of Directors
March 26, 2019

Recognitions
This board year, at the beginning of each meeting the board recognizes the good work done by individuals and teams at QHC hospitals. This month the board has two recognitions.

1) Chair Stuart Wright recognized the service of Board Member Karen Baker as her tenure with the Board ends in June of this year. Karen has served on the QHC Board of Directors since 2010, serving as treasurer for 7 years. Before joining the board 9 years ago, Karen served as a member of QHC's Advisory Council.
2) Board Member Kimberly Woodhouse recognized the good work of the patient flow team. *Refer to pg. 2 for full story*

Operational assessment and operating budget
The Operational Assessment (OA) reinforces that QHC teams have significantly improved operational efficiency over the last 6 years. The report makes a compelling case for a base funding adjustment and shows QHC is more efficient than 16 of the 18 comparator hospitals. The OA recommends providing the hospital with a base funding increase of a minimum of $5 million-dollars. Without a base adjustment, a 5-million-dollar deficit is projected for 19/20 - based on the assumption QHC receives inflationary funding and surge funding at a similar level at this year. *Refer to pg. 3 for report summary.*

Capital budget
The QHC Board approved the 2019/20 Capital Plan up to a total of $10.3 million dollars. The 2019/20 Capital plan recommends an expansion of QHC's regional Intensive Care Unit (ICU), located at BGH. Renovations are required to expand capacity. The average ICU occupancy is 96% - which means ICU patients continue being treated in the BGH ER until a bed becomes available in the ICU. A pre-capital submission was presented to Health Capital (HCIB) in late February. The anticipated capital cost of the renovation is $4 million-dollars. As recommended in the BIG Healthcare report, QHC will advocate for the funding to operate an additional bed, which will mean the ICU will go from 15 to 16 beds (with the resources and space available to "surge" to accommodate 18 patients as needed). Additional items include ICU bedside monitors, defibrillators and infusion pumps.

Patient satisfaction on discharge
Supporting Seamless Care is one of QHC's strategic priorities for 2018-2021. Patients have indicated through surveys that, upon discharge, they don't always feel well-informed about their condition, their medications, or symptoms to look for that may indicate they're getting sick again. To remedy that, a multi-disciplinary working group, including a Patient Experience Partner, began researching and determining the most helpful information to include in discharge packages for patients. We want to ensure patients leave feeling supported and informed and to improve the transition home for the patient/family. Increasing a patient's ability to manage after hospital discharge may reduce the risk of re-admission. The Patient Oriented Discharge Summaries (PODS) are being provided to patients with COPD, Pneumonia, Congestive Heart Failure, Hip Fracture and will soon be rolled out to our Stroke and Diabetes patients. These are provided across all medicine and surgical units, although in varying degrees of implementation.

Accreditation 2019:
Accreditation Canada surveyors will be onsite at QHC hospitals May 6 -10. The Accreditation process is an opportunity for hospitals to assess themselves using national best practice standards for quality and patient safety. During the scheduled on-site assessment, surveyors will evaluate how QHC is meeting over 2200 standards. Surveyors spend the majority of their time on the floors speaking with staff, physicians, students, volunteers, patients and families.

Staff recognition – Patient Flow

This Board year, we begin each meeting with a story that reminds us of the exceptional care extended by staff, volunteers and physicians each and every day at QHC hospitals.

Today we are recognizing unsung heroes – a team of hard-working staff who certainly deserve recognition for the vital role they play.

The patient flow team supports all four QHC hospitals in ensuring patients are discharged in a safe and timely manner with the community supports they need. The team consists of nine patient flow coordinators, two social workers and manager Lisa Hildebrand.

Many of our patients have complex care needs and face social barriers that may prevent or delay their discharge. The patient flow team advocates for patients so they have what they require to safely return home or to the community. They look at what the patient needs and wants, what their family wants, what resources they have, and what community resources may be available to them. Keeping the QHC value of “Respect Everyone” in mind, they negotiate a plan that aims to honour the patient’s wishes and connect them with the supports they need to discharge safely from hospital.

Manager Lisa Hildebrand explains that a big part of the patient flow role is educating families and promoting the concept of Home First. They explain to families that patients who no longer need the acute care of a hospital setting often heal better at home if they have the right support. The patient flow team then works with community partners like LHIN Home and Community Care and Health Links to help the patient and their family navigate supports that the patient may require.

“The patient flow role is incredibly important to the care we provide at QHC,” explains Carol Smith Romeril, Vice President and Chief Nursing Officer. “They are helping us with our quest for integrated care – they help create the seam between hospital and community for our most complex patients. We want them to know that we feel really lucky to have such a great group as part of the QHC team.”

I ask that the members of the patient flow team who have joined us today please come up to accept a certificate of recognition, as well as our thanks for all that you do to support seamless care at QHC.

BIG Healthcare Operational Assessment Summary
3/26/2019

In July of 2018, with the approval of the South East Local Health Integration Network (SE LHIN), Quinte Health Care (QHC) engaged BIG Healthcare to conduct an Operational Assessment to examine how to meet our mandated services, while ensuring a strong fiscal position going forward. This report also delves into operations at QHC hospitals to provide us with feedback not only on our finances, but also opportunities for improvement in how we operate on a day-to-day basis as one system of four QHC hospitals.

The report makes the following key points, conclusions and recommendations.

- QHC has dramatically improved operational efficiency over the last 6 years. QHC is more efficient than most peer hospitals – having less opportunity for cost savings than 16 of the 18 peer hospitals.
- While operating as a four-site hospital system is undoubtedly more efficient than operating four separate hospitals, the report estimates that the cost of maintaining multiple hospitals is over $7 million-dollars each year. In the current funding formula, the majority of hospitals QHC is compared to are large single-site hospitals with comparative patient volumes to QHC as a whole. The funding formula does not appropriately account for the realities of operating a multi-hospital organization.
- QHC funding between 2013 and 2017 has been flat. Through cost reduction efforts QHC has absorbed inflationary pressures and maintained a balanced position. For 2019/20 the QHC Board is being asked to approve a deficit budget.
- The Operational Assessment recommends a base funding increase of $8 million-dollars to address both the base funding inequities and the working capital issue. To bring QHC's base-funding level on par with other hospitals, without initially addressing the working capital issue, the report suggests providing the hospital with a base funding increase of a minimum of $5 million-dollars.
- The report recommends operational improvement initiatives that could result in $4 million-dollar annual savings, implemented over the next four-years (e.g. reducing sick time and supply costs).
- Current services provided at Belleville General Hospital (BGH), Trenton Memorial Hospital (TMH), Prince Edward County Memorial Hospital (PECMH) and North Hastings Hospital (NHH) are appropriate and required to serve the population. No service reductions or consolidations are recommended. In fact, the report suggests potential areas for increases including rehabilitation and the Intensive Care Unit (ICU) to better meet the needs of Hastings and Prince Edward County residents closer to home.
- While significant efforts have been made, QHC staff and physicians recognize there are continued opportunities for improvement within the BGH Emergency Department (ED). A working group has been established and has identified 15 improvement initiatives. Report recommendations include examining ways to divert some patients from the ED, improving the monitoring and reporting of turnaround times for diagnostic reports, clearly defining policies and procedures for transferring patients to the BGH ED for consultation, admission and/or diagnostics, and allow direct admissions to BGH from PECMH, NHH and TMH.
- Belleville and Trenton EDs have a high percentage of patients with no access to primary care (approximately 12% of ED visits). BGH had the 5th highest percentage of patients with no primary care, and TMH had the 6th highest of the 39 peer hospitals.
- Residents of the SE LHIN have the highest rate of Critical Care Unit usage per population of all Ontario LHINs. In April 2017 (the month used for comparison), the average QHC ICU bed occupancy was 96.2% - the 4th highest among peer hospitals. The report recommends a number of areas for improvements of the ICU at QHC BGH including an additional bed, an expansion of the physical space, professional practice education and support, and reviewing the medical coverage model.
- Like communities elsewhere in the province, QHC's catchment population is experiencing increasing demands for health care due to the aging of the "baby boom" population. However, QHC also serves an older population than the provincial norm, with more than 23% of the population 65 and over.

Recommendation themes:

QHC has built a culture of continuous improvement through our grassroots transformation efforts. We consider opportunities for operational efficiencies as a regular part of the planning process each year. The BIG Healthcare report is a valuable resource to help identify areas for improvement. The 2019/20 operating budget includes just under $1 million-dollars in cost reductions.

The 77 recommendations have been grouped into 12 main themes shown in the table below and when we anticipate the work and/or planning will begin.

Operational Assessment Recommendations – Key Themes	**Implementation**
1. Advocacy with LHIN and Ministry to secure a base funding increase and an additional Intensive Care Unit (ICU) bed and capital project.	Underway
2. Implement operational efficiencies over next four years.	Underway
3. Reconstitute Quality and Utilization Advisory Committee (QUAC) to focus on appropriate, consistent utilization.	Underway
4. Review and update the medical leadership structure to better meet goals.	Underway
5. Enhance physician accountability structures.	Underway
6. Improve physician engagement.	Underway
7. Re-examine the Hospitalist model.	Underway
8. Implement standardized patient rounds.	2019/20 or 20/21
9. Define clear guidelines for patient transfers to BGH ED, then to inpatient units. Improve non-urgent transfer.	2019/20
10. Advocacy with LHIN and partners for home-based Chronic Obstructive Pulmonary Disease (COPD) programs and a community chronic ventilation service.	Underway with LHIN leading
11. Improve team functioning within the ICU and update the Code Stroke coverage.	Underway
12. Program specific opportunities for efficiencies - medicine, obstetrics, surgical, emergency, medical affairs	2019/20

Recommendations listed by theme:

The following is a detailed breakdown of each of the 12 themes - listing the corresponding recommendations from the BIG Healthcare Operational Assessment report.

1. *Advocacy with LHIN and Ministry to secure a base funding increase and an additional ICU bed and capital project.*

- The CEO and CFO should work with the LHIN and Ministry of Health and Long-Term Care towards a base funding increase sufficient to ensure a balanced operating position through 2022/23; such a base increase is estimated to be between $5.0M and $8.0M.
- The CEO and COS should work with the LHIN to achieve agreement on one additional funded CCU *(Critical Care Unit)* bed for a total of 16 to address immediate challenges with occupancy, care closer to home, allow an appropriate code response model and facilitate proper physician coverage.
- The CEO should work with the LHIN to investigate the feasibility and approval of a capital project to expand CCU capacity adjacent to the current unit.

2. *Implement operational efficiencies over next four years.*

- The Director of Materials Management should pursue opportunities to reduce operating costs by $150,000.
- The CEO and VP/CFO should investigate opportunities for reduced Materials Management costs in the medium term through participation in a larger Shared Service Organization.
- The Director of Health Records should pursue opportunities to reduce operating expenses by $100,000.
- The Director of Plant Operations/Maintenance should pursue opportunities to achieve a performance level equivalent to the 75th percentile of the peer hospitals.
- The Program Director and Manager of Birthing should identify and implement opportunities to work toward a median LDRP *(Labour, Delivery, Recovery and Post-Partum*) performance of 10.68 hours per patient day.
- The Program Director and Manager of inpatient Medicine should work towards peer median performance of 5.99 worked hours per patient day.
- The Program Director and Manager of inpatient Medicine should examine the approach to supply use and work towards peer median performance of $21.50 per patient day.
- The Program Director and Manager of Rehabilitation should identify and implement opportunities to work toward median performance.
- The Director of Clinical Laboratories should conduct an analysis to determine the cost benefits of outsourcing Microbiology Services or alternatively attracting workload from other organizations to improve productivity.
- The Director of Clinical Laboratories should pursue opportunities to achieve a savings of $230,000 through improved productivity, reduced MOS *(Management and Operations Support)* structures and changes to skill mix.
- The Director of Medical Imaging and Chief of Nuclear Medicine should conduct a risk management and efficiency assessment of current approaches for preparing radioactive materials.

- The EDs at NHH, TMH and BGH should work towards median peer performance in productivity over the next four years.
- The VP/CFO and Director of Health Records undertake a review of ALC coding and documentation practices to ensure all ALC *(Alternate Level of Care)* patients are being properly recorded.
- The CEO and CFO should develop a proposal to the MOHLTC that the BSTU *(Behavioural Support Transition Unit)* beds be re-categorized from Rehabilitation to Chronic, and that the number of formally designated Rehabilitation beds at QHC be expanded.
- The VP/CNO should ensure that Physiotherapy and Occupational Therapy workload reporting is accurate.
- The VP/CNO should work towards median performance in Occupational Therapy in both worked hours/attendance and in FTE.

3. Reconstitute Quality and Utilization Advisory Committee (QUAC) to focus on appropriate, consistent utilization.

- The MAC should review the Terms of Reference for the QHC Quality and Utilization Advisory Committee and amend as necessary to ensure the goals of this committee are fully aligned with the strategic goals of the Organization.
- The VP/CNO and the Chief of Radiology should investigate approaches to improve turnaround time for image reporting to the BGH ED; turnaround times should be reported and reviewed regularly by the QHC Quality and Utilization Advisory Committee.
- The COS and VP/CNO should establish (and regularly review with the QHC Quality and Utilization Advisory Committee) reports on comparative laboratory (and Diagnostic Imaging) usage by individual physicians.
- The QHC Utilization Advisory Committee should review ED visits for “Examination and Investigation” to determine whether there are opportunities to divert some of this activity from the ED.
- The COS (and the MAC / QUAC as appropriate) should monitor adherence to an evidence-based COPD pathway and HQO COPD Quality Standards.
- The COS and QHC Utilization Advisory Committee should ensure that there is regular monitoring of diagnostic imaging procedures and incorporate “Choosing Wisely” guidelines and principles in utilization review activities.
- The Director of Decision Support should implement a monitoring and reporting approach for turnaround times and ordering practices for diagnostic imaging reports to be reviewed regularly by the QHC Utilization Advisory Committee.

4. Review and update the medical leadership structure to better meet goals.

- The COS, working with Administration and MAC members, should work to ensure, on a priority basis, that the Medical Leads from PECMH and NHH are appointed to the MAC.
- The CEO and COS should re-assess the role of the Chief / Medical Director of Family Medicine to include enhancing relationships between QHC and community Family Physicians.
- Upon retirement of the incumbent, the COS should discontinue the role of Chief / Medical Director of Primary Care and appoint a Medical Lead for TMH, with a seat at MAC.

- The COS and CEO should explore the potential advantages of implementing a physician compensation mechanism for Chiefs / Medical Directors that is based on hours worked.
- The COS and CEO should explore the potential advantages of changing the compensation of Medical Leads to an hourly rate.
- The CEO should revisit the goals of the Program Management model to ensure alignment with QHC strategic directions and enhanced medical staff engagement in operations.
- The COS should work with the Chiefs / Medical Directors of Surgery and Obstetrics and Gynecology to resolve any ambiguities regarding reporting lines for Gynaecology.
- The CEO and COS should consider the creation of a separate Critical Care Program.

5. Enhance physician accountability structures through the Behaviour at Work Policy and updated Rules and Regulations

- The COS, Program VP and Director, and the Chiefs / Medical Directors of each Program should work together under a strengthened accountability framework to ensure that physician behavioural challenges are consistently addressed and expectations of service are met.
- The COS should initiate a review of MAC policies to ensure clear expectations regarding physician behaviour (and escalating consequences for misbehaviour), timeliness for consultations and transfer of care, and processes for both dispute resolution and escalation of unresolved issues in a timely fashion.
- The COS should expand work underway (e.g. Physician Compact, Behaviour Committee) to ensure ongoing strengthening of the accountability framework for physicians.

6. Improve Physician Engagement, including through a robust Professional Staff Association

- The CEO and COS work with members of the QHC Professional Staff to promote physician engagement and ensure that there is a robust Professional Staff Association (PSA), the Executive of which will sit on the QHC Board.

7. Re-examine the Hospitalist models to ensure we are optimally meeting patient needs

- The COS should explore the risks/benefits of providing post-operative Hospitalist care to Orthopaedic Surgery patients.
- The VP/CNO and COS should review and revise, as required, the medicine physician coverage model to ensure: a reasonable number of patients to be covered by each Hospitalist; and optimized standardization of care (eg. admission criteria, discharge criteria, order sets, antibiotic usage, etc.).
- The COS and Chief/Medical Director Critical Care should review the medical coverage model for the CCU including the necessity of the Nocturnist Program as currently structured.

8. Supporting Seamless Care – implement standardized patient rounds

- The VP/CNO and COS should implement standardized multidisciplinary patient rounds to ensure early engagement of all services required to facilitate discharge, full participation of physicians in daily case planning rounds, establishment of an estimated day-of-discharge; reduction of patients staying in hospital waiting for tests (Grey Days); and discharge before 11 am.

9. *Define clear guidelines for patient transfers to BGH ED, and then to inpatient units. Improve non-urgent patient transfer service.*

- In the most recent Strategic Plan, QHC has identified 'Supporting Seamless Care' as a strategic priority. This priority includes a focus on transitions between QHC units. Explicitly recognizing in this strategic priority, the importance of the transition from the Emergency Department to other units in the hospital would improve the focus on such efforts while giving voice to the concerns raised by the ED.
- The CEO and COS, along with the LHIN, should undertake a review of the regional model for non-urgent patient transports and transfers with the goals of minimizing the necessity of such transports, and ensuring timely, cost effective and safe transfers when they are necessary.
- The COS and MAC should define clear policies and procedures for transferring patients to the Belleville ED for consultation/admission/diagnostic imaging.
- The COS should meet with the Chiefs/Directors of Surgery and Emergency Medicine to definitively resolve the ongoing issue of whether there should be 'direct admits' to Surgery.
- The MAC should develop and implement policies and processes that would allow direct admissions to BGH from the PECMH, NHH and TMH EDs.
- The MAC should review and revise the current BGH policy allowing consultants to whom patients in the ED have been admitted to not assess and admit those patients at night.

10. *Advocacy with LHIN and Partners for home-based Chronic Obstructive Pulmonary Disease (COPD) programs and community chronic vent service.*

- The CEO should work with the SE LHIN to enhance the availability of Community and home-based COPD programs as well as post-hospital and rehabilitative COPD care with a goal of establishing the necessary supports to avoid disease exacerbation leading to ED visits, hospitalization and CCU admission.
- The VP/CNO and the LHIN CCU Lead, in collaboration with community stakeholders, should immediately investigate options for chronic ventilation services outside of the BGH CCU.

11. *Improve team functioning within the ICU and update the Code Stroke coverage*

- The COS and Chief/Medical Director of Medicine and Critical Care and the ICU lead should work towards optimizing protocols, medical directives, scope of practice and team rounds to offset the demands on the Intensivist.
- The COS and VP/CNO to convene a working Group with representation from Intensivists, Internists and Emergency Medicine physicians to develop and implement a policy regarding coverage of Code Strokes that facilitates timely response, but leaves no hospital clinical care area uncovered.
- The VP/CNO should develop and recruit to a role that will specifically support professional practice, education and the development of the inter-professional care team in the ICU.

12. *Opportunities for Improvement within Specific Programs*

- The Program Director and Manager of inpatient Medicine should examine the role of facilitator to ensure support for workload across the units.
- The VP/CNO should explore the provision of in-patient consults and consults to the ED by Respiratory Therapists working in the TMH Out-Patient Department.

- The VP/CNO should adjust professional schedules to ensure augmented presence of OT, PT and Social Work on weekends to facilitate weekend discharges.
- The VP/CNO should ensure that admission and discharge to and from inpatient rehabilitation is supported on weekends to facilitate improved patient flow from acute care to inpatient rehabilitation.
- The Obstetrics Program should explore resuming its participation in the MORE OB program.
- The CEO, COS and Chief/Medical Director of Surgery should work with the Surgery Program Advisory Committee to undertake a visioning exercise for the Program, that is to include a concrete five-year Physician Human Resource Plan in Surgery.
- The Chief of Surgery should ensure that the Surgery Program Advisory Committee explores the policies/processes related to allocation of OR blocks to services/physicians, ensuring these promote optimal OR efficiency.
- The QHC Utilization Advisory Committee (QUAC) should conduct an evidence-based review of the clinical indications for hysterectomy for non-cancer diagnoses, and implement a QHC standard care protocol for hysterectomy, including consideration of less invasive treatments.
- The COS should work with the Chief/Medical Director of Surgery to accomplish the shift of Urologic procedures such as Vasectomy out of hospital to physician offices.
- The COS should work with the Chief/Medical Director of Surgery to review the provision of all ambulatory procedures to determine opportunities to move some of this activity out of the OR, and / or out of the hospital.
- The COS should work with the Chief/Medical Director of Surgery to explore the provision of in-patient consults and consults to the ED by surgeons conducting ambulatory surgery procedures at TMH.
- The COS should review the Impact Analysis process, ensuring that agreements made at the time of initial appointment of physicians are monitored and adhered to post-appointment. Information on the above should be presented to MAC regularly.
- The CEO should establish links to the Rural Ontario Medicine Program (ROMP), so as to gain medical student and resident placements at QHC/NHH, these leading to recruitment opportunities.
- The Chief of Emergency should clearly define Physician accountability for seeing patients in Green Zone and for supervising Physician Assistants, along with appropriate medical directives for both Physician Assistants and Nurses.
- The Chief of Emergency, through an emergency department project team, should devise a uniform process to move patients off stretchers that would improve efficiency yet minimize risk for patients.
- The Chief of Emergency should develop combined educational rounds with other departments; especially those that provide frequent consultations to the emergency department.
- The COS and Chief of Emergency, in collaboration with Emergency Physicians should consider using the ED Alternative Funding Agreements to incentivize certain mutually agreed upon and standardized practices.
- The CEO should identify a high functioning Emergency Department a priority and responsibility of the entire organization.
- The Chief of Emergency should implement a performance review of all Emergency physicians on an annual basis.