Summary of the QHC Board of Directors Meeting

March 22, 2016

The following is a synopsis of some of the topics of discussion at the March meeting:

Interprofessional Patient Care Team (IPCT) roll-out will be complete on all QHC units by May. We have received positive feedback from patients about: hourly rounding, shift handover occurring at the bedside, and the use of patient-specific communication boards. Click here to view a *two minute video explanation of IPCT is available in the news section of the QHC website.*

Acute Care for the Elderly Unit will open on Quinte 4 at BGH April 12th. The 30 bed unit (20 ACE and 10 ALC) will provide medical care while focusing on maintaining the patient's independence and loss of functional abilities. QHC is now NICHE designated. NICHE stands for Nurses Improving Care for Healthsystem Elders. It is the only national designation indicating a commitment to elder care.

Every hospital in Ontario must develop a Quality Improvement Plan (QIP), submit it to Health Quality Ontario by April 1st - then monitor and report on the progress including actions taken to make improvements. The official progress report for 2015/16 will include: achieving the target of 65 per cent set for medication reconciliation at admission (review of all medicines a patient is taking to reduce the risk of medication errors); Alternate Level of Care (ALC) rates remain high at QHC and across the SELHIN; and ER wait times remain above this year's target, but has improved compared to last year and remains under the provincial average. The 2016/17 QIP submission was approved.

186 improvements have been made within 28 work teams at QHC hospitals. For example, the diagnostic imaging team at BGH managed to reduce wait times for patients needing non-urgent MRI from an average of 54 days to 24. *This improvement is featured in the latest Vital Signs newsletter available on the QHC website.* Click here to view.

The Medical Advisory Committee (MAC) has approved a policy reinforcing its top three improvement priorities: physician rounding schedules in the emergency department, rounding timing on in-patient units and response time of consulting physicians to see cases in the emergency department.

Improving the patient experience and work life of our physicians and staff in the coming year will be a focus as part of the ongoing implementation of the QHC strategic plan.

Work continues on QHC's master program as part of the PECM Hospital Redevelopment project. The Ministry of Health and Long Term Care (MOHTC) requires the master program before approving the pre-capital submission. The master program outlines the 20-year plan for providing services at the four QHC hospitals, including how a new PECMH would fit into the overall service delivery plan. Completion of the master program is scheduled for June 2016. The next update to the community newsletter will be posted on our website by April 4th.

The TMH Implementation Task Force continues to meet regularly to address the recommendations of the Brighton/Quinte West Health Services Advisory Committee. Engineers and architects have been at TMH in March. They are looking at the space and structure of the TMH building to determine if it's suitable and what renovations would be needed to make the space work to create a health hub of co-located hospital and community services. The task force will submit its final report to the LHIN by May 1st.

The MRI requires an upgrade; the board approved an upgrade to the Magnetic Resonance Imaging (MRI) is located at BGH, which services patients from across the region. The upgrade would cost just over 1 million dollars. The hospital foundations will be approached to help support the costs based on each community's usage.

The Nominations Ad-Hoc Committee received eleven applications for the five vacant Board positions for 2016/17. Eight candidates will be interviewed in April.

Visit the QHC news page to remain updated between board meetings: www.qhc.on.ca

QHC Board of Directors
Tuesday, March 22, 2016
5:00 – 7:00 p.m.
Boardroom, QHC Prince Edward County Memorial Hospital

AGENDA

OUR VISION: QHC WILL PROVIDE EXCEPTIONAL AND COMPASSIONATE CARE. WE WILL BE VALUED BY OUR COMMUNITIES AND INSPIRED BY THE PEOPLE WE SERVE.

Time	Topic	Lead	Policy Reference	Decision-Making	Monitoring	Information/ Education
5:00	***Minutes***					
	3.1 Board Minutes from January 26, 2016	T. Anderson	By-law 3.2	X		
	Reports					
	3.2 Report of the Chair					
	3.2.1 Collaborative Governance		V-B-8			X
	Committee Update					X
	3.3 Report of the Chief Nursing Officer					
	3.4 2015/16 Quality Improvement Plan					X
	Progress Report		III-1		X	
	3.5 Insurance Coverage					
	3.6 Hospital Sector Accountability		IV-3	X		
	Agreement (HSAA)		IV-1	X		
	Committee Updates					
	3.7 Quality of Patient Care					
	3.8 Audit & Resources					X
	3.9 Governance, Communications &					X
	Strategy					X
	3.10 Nominations Ad-hoc					
						X
5:10	**Report of the Chair**					
	4.1 Celebrating Nurses Improving Care for Health System Elders (NICHE) Designation	T. Anderson	V-A-8			X
5:20	**Building Relationships**					
	5.1 Report of the President & CEO	M.C Egberts	VI-1			X
	5.2 Balanced Scorecard		I-2			X
	Ensure Program Quality and Effectiveness					
	Quality of Patient Care Committee					
5:30	6.1 2016/17 Quality Improvement Plan	O. Hoye	III-1	X		

Time	Topic	Lead	Policy Reference	Decision-Making	Monitoring	Information/ Education
5:55	6.1.1 2016/17 SLT Goals Linked to Compensation 6.2 Report of the Chief of Staff & Medical Advisory Committee 6.2.1 Medical Advisory Committee Recommendations Report (March)	D. Zoutman	III-2 By-law 8.04	X X		X
6:10 6:25	**Ensure Financial & Organizational Viability** *Audit & Resources Committee* 7.1 January 2016 Financial Statements 7.2 Magnetic Resonance Imaging (MRI) Upgrade*	K. Baker	IV-1 IV-4	X X		
6:30	**Adjournment** **Next Meeting:** **April 26, 2016 Board Meeting (Location TBD)**	T. Anderson		X		
	In Camera Session 9.1 With President & CEO 9.2 Elected Directors	T. Anderson	V-B-8			

Quinte Health Care
Board of Directors Meeting Minutes
January 26, 2016

A meeting of the Board of Directors of Quinte Health Care was held on Tuesday, January 26, 2016 in the Belleville General Hospital Education Centre. Mrs. Anderson chaired the meeting.

Present:
Mrs. Tricia Anderson, Chair
Mr. Doug McGregor
Ms. Karen Baker
Mrs. Mary Clare Egberts
Dr. Dick Zoutman
Mrs. Kim Stephens-Woods
Mr. Patrick Johnston
Mrs. Darlene O'Farrell
Mr. Stuart Wright
Mrs. Odila Hoye
Mr. David MacKinnon
Ms. Karen Tiller
Ms. Lynda Mungall

Regrets: There were no regrets.

Staff Present:
Mr. Brad Harrington
Mr. Jeff Hohenkerk
Mr. Paul McAuley
Mrs. Susan Rowe
Ms. Catherine Walker
Mrs. Jennifer Broek, Recorder

1.0 Call to Order
Mrs. Anderson welcomed everyone and called the meeting to order.

1.1 Approval of Agenda

Motion: **To approve the open session agenda of January 26, 2016.**
Moved by: Ms. Baker
Seconded by: Mrs. Hoye
Carried

1.2 Declaration of Conflict of Interest
There were no declarations of conflict of interest.

2.0 Closed Session

2.1 Motion to go into closed session

Motion: **Motion to go into the closed session.**
Moved by: Ms. Baker
Seconded by: Mr. Johnston
Carried

3.0 Deputation
Mr. Mike Cowan, Chair of OurTMH addressed the QHC Board of Directors by way of deputation. Mr. Cowan showed the board copies of letters supporting TMH and extended an invitation to the group's first anniversary celebration to be held February 2nd from 4:00 – 7:00 p.m. at the Trent Port Marina. Mr. Cowan also read one of the form letters aloud for board members.

A board member expressed concern regarding the tone of public criticism of QHC to-date given QHC's efforts to advocate for increased funding while decreasing expenses and maintaining quality of care. Another board member suggested that OurTMH could help advocate for transportation solutions for the region given community feedback in both the OurTMH and SE LHIN survey responses. The board also discussed the need for municipal leadership support to address transportation barriers.

On behalf of the board, Mrs. Anderson thanked Mr. Cowan and Ms. Betty Clost for sharing the letters with the board and for the presentation.

4.0 Consent Agenda
Mrs. Anderson reviewed the consent agenda items.

4.1 Board Minutes from November 24, 2015
A board member requested the following revision to the third paragraph within item 6.2.1 2016/17 Draft Operating Plan:

The board had a robust discussion regarding the need to carefully monitor and measure the proposed changes and interprofessional care model implementation. The board's Quality of Patient Care Committee will be accountable for identifying and monitoring significant risks and escalating to the board's attention when appropriate. Mrs. Stephens-Woods indicated that QHC will continue to closely monitor key indicators and noted that implementing the interprofessional model at QHC has been planned at a pace to ensure that best practices learned from other hospital site visits and the first unit implementation at QHC are utilized in future roll outs on other units. Mrs. Stephens-Woods highlighted the importance of education and learning opportunities as another significant factor for successful implementation.

4.3 Report of the Chief Nursing Officer
The board discussed the limited loss of utilities ("code grey") which occurred at BGH on January 15th and affected portions of Quinte 7 Maternity and Quinte 6 In-patient Surgical unit emergency back-up power. It was noted that the defective cable was replaced within 10 hours and that patients were able to be transferred to new beds with limited interruption.

A board member asked if there was potential risk in other areas of the hospital with aging power cables. It was noted that the board's Quality of Patient Care (QPC) Committee would receive an update on the outcome and action items following the incident debrief at their March QPC committee meeting.

4.6 Nominations Ad-hoc Committee Update
As chair of the Nominations Ad-hoc Committee, David MacKinnon provided the board with a verbal update on actions undertaken following the January committee meeting to address the upcoming five board vacancies. It was noted that the strategy developed through board and advisory feedback is designed to address 2016/17 and future-year vacancies. Mr. MacKinnon also noted that the strategy is expected to attract a broader group of community members with required skillsets.

Mr. Johnston recognized Mr. MacKinnon for his leadership in the initiative as well as fellow board and advisory members who contributed to the recruitment strategy.

Approval of the following items was included within the consent agenda:

4.1 Board Minutes from November 24, 2015 (with recommended changes as outlined above)

Motion: **To approve the consent agenda of January 26, 2016**
Moved by: Mrs. Hoye
Seconded by: Ms. Tiller
Carried

5.0 Report of the Chair

5.1 Patient Story
Mrs. Anderson invited Lisa Hildebrand, Interim Patient Experience Specialist to share a patient story with the board. The story identified a patient's concern with length of time he spent waiting to been seen in the BGH ED. The manager of the BGH ED reviewed the patient's concern and the patient received both a telephone and written follow up.
The board discussed and emphasized the importance of educating patients on wait times and keeping them informed throughout their visit. It was noted that QHC is currently exploring options for visual display tools to be used in ED waiting rooms to help patients understand wait times and levels of acuity. It was suggested that explaining terms such as triage, could help patients appreciate why they are waiting.

6.0 Building Relationships

6.1 Report of the President & CEO

Balanced Scorecard
Mrs. Egberts informed the board that QHC has been unable to meet the target for ER length-of-stay. QHC has experienced high occupancy within in-patient units since last June, which puts increased pressure on the emergency rooms, particularly at BGH.

As the number of ALC patients waiting for long-term care at a QHC hospital steadily increased between March and June of 2015, QHC has not met the target for percent of ALC patient days.

Mrs. Egberts reported that QHC's performance for expected costs per weighted case is moving closer to the annual target. Employee and physician engagement improvement initiatives are now being tracked and will be reported to the Board in Q3.

Ontario Hospital Association (OHA) Pre-Budget Release Advocacy
Mrs. Egberts advised the board that the OHA has begun advocacy work to raise awareness of the fiscal challenges Ontario hospitals are facing in advance of the Ontario budget. The board was provided with a document outlining the OHA's priorities and messages that will be included in their submission to the Standing Committee on Finance and Economic Affairs. It was suggested that many hospitals are reaching a point that they can no longer operate the same way and will need to consider service changes. Mrs. Egberts noted that the messages accurately reflect QHC's financial pressures.

The board discussed the likelihood of the OHA's recommendation being approved by MOHLTC to support inflationary funding for hospitals. Mrs. Egberts was asked to provide the board with an update following the OHA's deliberation to the MOHLTC. The board requested that Mrs. Egberts provide the following additional suggested messages to the OHA for consideration:

1. The expected rate of change is a struggle for hospitals like QHC from a resource perspective and could be introducing quality risks.
2. Hospitals do not have the fiscal resources to invest in the required changes causing cash flow concerns.
3. The capacity in the community is not growing as quickly has expected for our region further challenging QHC's ability to manage the pace of change.

7.0 Ensure Program Quality and Effectiveness: Quality of Patient Care Committee

7.1 Critical Events Update
An update was given on the two critical events that occurred in Q1 & Q2 at QHC. The board was informed that reviews were conducted for both events with two recommendations identified and implemented.

7.2 BGH Emergency Department Patient Flow
Mrs. Hoye noted that the Quality of Patient Care Committee held a robust discussion on the challenges with wait times and patient flow within the BGH ED. A recommendation was made for the board to hold a generative discussion to better understand the challenges with the ED.

Mrs. Hoye invited Jeff Hohenkerk, Vice President, to share some of the current initiatives in place at BGH to improve wait times and patient flow in the ED.

A board member raised a past practice of utilizing patient flow coordinators to divert patients from the ED who do not require medical care rather, community service support. It was expressed by some board members that reverting to this model requires the appropriate community supports to be available to the patient. Management, staff and physician leadership are currently trialing a variety of initiatives in the ED with an emphasis on those that can be sustained.

A board member requested that management includes the Canadian Triage Acuity Scale (CTAS) level for patients who leave the ED without being seen. It was recommended that requests for additional ED data be submitted through the Chair of the Quality of Patient Care Committee.

A suggestion to consider sending some ED physicians to Southlake Hospital to further explore strategies to decrease the number of patients leaving the ED without being seen given Southlake's positive performance was made.

A board member asked management whether at the next board meeting, the board can expect a timeline for the balanced scorecard metrics to be on target. Another board member suggested that setting a timeline is less important that finding the right solutions through testing the current initiatives. The senior leadership team recognized the complexity of patient flow and noted the intent to engage external support. Mrs. Egberts committed to keeping the board informed on progress and will reach out for board support as needed.

The board discussed the importance of ensuring accountability for senior leadership, management, staff and physicians to continue improving quality of care for patients.

7.3 Report of the Chief of Staff & Medical Advisory Committee (MAC)

Quality Improvement
Dr. Zoutman advised the board that the MAC reviewed the top three ED physician practices identified for improvement in December. They included: consultant physician rounding schedules in the ED, in-patient unit rounding timing and response time of consultants to see cases in the ED. The opportunities were further discussed at the MAC in January with a consensus that they are important areas to focus on and standardize.

Medical Leadership Design at QHC
Dr. Zoutman noted that the current medical leadership structure is being reviewed with a view to create a new structure to meet the needs of QHC as a whole that strengthens operational and medical collaboration. A working session will be held in late-February for physicians to consider and discuss the structure and possible models.

Physician Recognition
The MAC has recommended that the board recognize Dr. Rob Devins for his leadership in introducing bedside ultrasound imaging to QHC's EDs and many other emergency departments. A formal recognition letter will be sent to Dr. Devins from the QHC Board of Directors.

7.4 Medical Advisory Committee Recommendations Report
Dr. Zoutman presented the recommendations from the MAC.

Motion:	**That the QHC Board of Directors' appoint Dr. Chris Perkes as Department Chief of Anaesthesiology as recommended by the Medical Advisory Committee on December 22, 2015.**
Moved by:	Mrs. O'Farrell
Seconded by:	Mr. MacKinnon
Carried	

Motion:	**That the QHC Board of Directors' appoint Dr. Daniel Steinitz as Division Head of Orthopaedic Surgery in the Department of Surgery, Dr. Kevin Lachapelle as Division Head of Ophthalmology in the Department of Surgery and Dr. Sylvain Duchaine as Division Head for TMH in the Department of Anaesthesiology as recommended by the Medical Advisory Committee on January 19, 2016.**
Moved by:	Mrs. Hoye
Seconded by:	Mr. Johnston
Carried	

8.0 Ensure Financial and Organizational Viability: Audit and Resources Committee

8.1 November 2015 Financial Statements
Ms. Baker presented the year-to-date financial results for the eight months ended November 30, 2015, which show a deficit of $93K versus a negative variance of $577K to the budgeted year-to-date surplus of $483K.

QHC has received a formal funding letter which includes $3.5M of alleviation funding for 2015/16. QHC had requested $4M plus severance costs. It was noted that QHC is forecasting a possible year-end deficit of $518K given the confirmation of not receiving the full amount of

alleviation funding requested and continued occupancy pressures. Management indicated that QHC is actively pursuing all options to close 2015/16 in a balanced position.

Ms. Baker informed the board that occupation levels in the Behavioural Support Transition Unit continue to be lower than anticipated. It was noted that the average length of stay has been 55 days compared to the expected 90 days and that QHC is working with the SE LHIN to referrals and occupancy levels. The board discussed the potential claw back in funding from the SE LHIN as the lower occupancy levels negatively impact QHC's rehab cost per weighted case and ultimately future funding.

The balance sheet shows the current ratio at November 30, 2015 is 0.76. The total margin at November 30, 2015 is -0.07%.

Motion: **That the QHC Board of Directors' approve the November 2015 financial statements.**
Moved by: Ms. Baker
Seconded by: Mr. McGregor
Carried

8.2 2016/17 Operating & Capital Plan
Ms. Baker invited Brad Harrington, Vice President and Chief Financial Officer, to share a presentation on the 2016/17 Operating and Capital Plan.

The board discussed the impact of the staff planning process on the operating plan and it was noted that there were no material changes. Management indicated that the process was productive in reducing the impact on individual people.

A board member expressed pleasure that QHC is undertaking a process of master clinical services program development to be submitted to the Ministry of Health and Long-Term Care.

The board also discussed the open sessions held to obtain additional feedback from the professional staff. It was noted that changes were made to the operating plan and Dr. Zoutman indicated that professional staff were given feedback from management on their potential ideas and input.

A board member noted that the proposal to delay the transfer of gynaecology cases from surgery to the paediatric unit could negatively impact the 2016/17 operating plan assumption. Mr. Harrington indicated that the proposal is currently under review while physicians and departments are consulted as it involves a transfer of resources.

Mrs. Anderson expressed satisfaction with the proposed plan and noted that the best possible plan has been developed given the financial challenges. It was also noted that the board must carefully monitor the quality of patient care metrics.

Motion: **That the QHC Board of Directors' approves the 2016/17 Operating and Capital Plan.**
Moved by: Ms. Baker
Seconded by: Ms. Mungall
Carried

9.0 Adjournment

Motion: **To adjourn at 7:30 p.m.**
Moved by: Mr. McGregor
Carried

Next Meeting: **March 22, 2016 at QHC Prince Edward County Memorial Hospital**

Action Items:

i. Management was asked to confirm whether the ED length of stay for admitted patients is reported to the Ministry of Health and Long-Term Care by hospital or by corporation.
Responsible: Mr. Harrington **Due: March 8, 2016**

ii. Mrs. Egberts provide the following additional messages to the OHA for consideration:

- The expected rate of change is a struggle for hospitals like QHC from a resource perspective and could be introducing quality risks.
- Hospitals do not have the fiscal resources to invest in the required changes causing cash flow concerns.
- The capacity in the community is not growing as quickly has expected for our region further challenging QHC's ability to manage the pace of change.

Responsible: Mrs. Egberts **Due: March 8, 2016**

iii. Management was asked to provide annual ED visit data comparison for the board's Quality of Patient Care Committee to review and discuss.
Responsible: Mr. Hohenkerk **Due: March 8, 2016**

iv. A recognition letter will be sent to recognize Dr. Rob Devins for his leadership in introducing bedside ultrasound imaging to QHC's EDs and many other emergency departments.
Responsible: Mrs. Anderson **Due: March 8, 2016**

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Tricia Anderson, Chair
Board of Directors

Mary Clare Egberts
President and CEO and Board Secretary

To:	QHC Board of Directors
From:	Tricia Anderson, QHC Board Chair
Topic:	Report of the Chair
Date of Meeting:	March 22, 2016
For:	Information

Events and Meetings Attended

February 3, 2016 – Viewed webinar on 2016-17 Hospital Service Accountability Agreements.

February 5, 2016 – Phone meeting with Mrs. Egberts.

February 9, 2016 – Phone meeting with Mrs. Egberts.

February 9, 2016 – Attended QHC Board Governance Committee Meeting.

February 9, 2016 – Meeting with Mr. McGregor and Dr. Zoutman.

February 9, 2016 – Meeting with Mr. McGregor and Mrs. Egberts.

February 10, 2016 – Attended TMHF Board Meeting with Mrs. Egberts.

February 22, 2016 – Phone meeting with Ms. Segal, Chair SELHIN.

February 23, 2016 – Follow up phone meeting with Ms. Segal, Chair SELHIN.

February 23, 2016 – Phone meeting with Mrs. Egberts.

February 23, 2016 – Meeting with Mr. McGregor, Mr. Johnston, Dr. Zoutman, Mr. McAuley and Mrs. Egberts.

February 24, 2016 – Phone meeting with Dr. Zoutman

February 24, 2016 – Attended South East LHIN Hospital/CCAC Chairs' Forum Governance Webinar Session with Mrs. Baker, Mrs. Hoye, Mr. Johnston, Mr. McGregor, Mrs. Tiller, Mr. Wright, Dr. Zoutman and Mrs. Egberts.

March 1, 2016 – Phone meeting with Mr. McGregor and Mrs. Egberts.

March 8, 2016 – Meeting with Dr. Zoutman and Mr. McGregor.

March 8, 2016 - Meeting with Mr. McGregor and Mrs. Egberts.

March 8, 2016 – Attended QHC Board Audit & Resources Committee meeting.

March 8, 2016 – Attended QHC Board Quality Committee meeting.

March 9, 2016 – Phone meeting with Dr. Zoutman.

March 9, 2016 – Phone meeting with Mr. Huras.

March 10, 2016 – Phone meeting with Dr. Zoutman.

Foundation News

OHA Webcast – Improving the Governance Relationship Between Hospital and Foundation Boards
An invitation has been extended to each of QHC's hospital Foundations and Fund Development Committee to join QHC's Board of Directors on March 29th. The event will be held at BGH in the Education Centre Boardroom from 12:00 -1:00 p.m. with time for a generative discussion to follow. Please rsvp to Jenn Broek (jbroek@qhc.on.ca or 613-969-7400 X2199) by March 25th.

BGHF Butterfly Run
The Butterfly Run was organized by three local moms wanting to fundraise and support families who have experienced a loss during pregnancy or the loss of a child. All funds will go directly towards resources for Quinte 7/Labour & Delivery and the Emergency Department at BGH. The one or five kilometer family walk/run is on May 1, 2016. For more information, please visit: http://bghf.ca/event/butterflyrun/

BGHF Swing Fore Cancer
BGHF will be hosting their Swing Fore Cancer on June 2, 2016 at the Black Bear Ridge Golf Club. For more information, please visit: http://bghf.ca/event/register-for-the-swing-fore-cancer-dr-mac-open-and-support-cancer-care-at-bgh-2/

Prince Edward County Memorial Hospital Foundation (PECMHF) Golf Classic
The Prince Edward County Memorial Hospital Foundation (PECMHF) will be hosting their Teeing Up Fore Health Care Golf Classic on June 14, 2016 at the Picton Golf & Country Club. For more information, please contact Briar Boyce at extension 4425 or at bboyce@qhc.on.ca

TMHF Golf Classic
Trenton Memorial Hospital Foundation (TMHF) will be hosting their Golf Classic on August 12, 2016 at the Timber Ridge Golf Course. For more information, please contact Lynn Thibedeau at 613-392-2540, extension 5401.

Respectfully submitted,

Tricia Anderson, Chair

To:	QHC Board of Directors
From:	Kim Stephens-Woods, Interim Vice President & Chief Nursing Officer
Topic:	Report of the Chief Nursing Officer
Date of Meeting:	March 22, 2016
For:	Information

Interprofessional Care Team

The Interprofessional Care Team (IPCT) roll out continues across QHC. Full implementation will be complete by May 2016. Additional staff supports have been put into place to ensure continued success of the new model of care. We are developing a dashboard that will identify quality metrics associated with the implementation of the new model of care and the senior's strategy.

To ensure that all our RNs, RPNs and PSWs are functioning at the top of scope, the professional practice team along with the unit managers will be asking all staff to complete a self-evaluation using Patricia Benner's model from 'Novice to Expert' to determine areas for growth and development. The professional practice team will develop learning opportunities and educational sessions once this information is gathered.

Implementation of the model of care changes has gone well. We are looking forward to Phase 2 of implementation leveraging the strengths of our allied teams and physicians.

NICHE Designation

Quinte Health Care has received NICHE (Nurses Improving Care for Health System Elders) designation. NICHE is the largest geriatric nursing program available and the only national designation indicating a commitment to elder care. NICHE is a clinical education program, 4 QHC staff have completed the NICHE leadership training program. There is also approximately 60 staff (RNs, RPNs, PSWs and allied professionals) that have been identified as NICHE champions. This group will complete a 20 hour education certificate program which will earn them a Geriatric Resource Nurse Certificate or a Geriatric Patient Care Associate Certificate. NICHE education and resources will be available to all staff and physicians at QHC electronically.

Acute Care for the Elderly (ACE)

Planning is well underway to create a new unit on Quinte 4 at QHC. The ACE unit, a 20 bed acute medical unit will provide an evidence based approach to care to meet the needs of the elderly patient that requires hospitalization. It will focus on reducing patients' functional decline and prevent the need for long-term care placement. This philosophy of care as well as some environmental changes will eventually be rolled out across all of QHC's acute care units. The key to the ACE program is that the care and the environment support treating the patients' medical illness while maintaining independence and loss of functional abilities. The target date to open the ACE unit is April 12th.

Infection Control

On Thursday February 11 and Sunday February 16, a VRE (Vancomycin Resistant Enterococcus) outbreak was declared on Quinte 5 and the ICU at BGH respectively as there were a number of patients testing positive for VRE (none infected, only colonized). Additional precautions were put into place and continued the diligence in our infection control practices have been implemented. Currently there are no restrictions on admission or transfer of patients from these units. As of Tuesday March 15 the outbreak on the ICU has been declared over and the Quinte 5 VRE outbreak is winding down and we continue to measure VRE colonization on the unit until it is entirely resolved.

To:	QHC Board of Directors
From:	Odila Hoye, Chair of the Quality of Patient Care Committee
Subject:	2015/16 Quality Improvement Plan (QIP) Progress Report
Date of Meeting:	March 22, 2016
For:	Monitoring

Issue

The annual Quality Improvement Plan (QIP) Progress Report, as legislated by the Excellent Care for All Act, is an obligation for every Ontario hospital. The Quality of Patient Care Committee is responsible for the development of the QIP at the beginning of each fiscal year and monitors the progress of the plan during the year. This is the official QHC progress report for the 2015/16 QIP providing performance data as defined by Health Quality Ontario (HQO).

Background

According to board policy III-2 Ensure Program Quality and Effectiveness: Performance Monitoring, the board is accountable for:

“ii) Monitoring organizational and Board performance against Board approved performance targets and performance metrics; and

iii) Ensuring that management has plans in place to address variances from performance targets and overseeing implementation of remediation plans.”

The QIP Progress Report helps to inform the creation of the next year’s QIP.

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INDICATOR	PERFORMANCE			COMMENTS
	STATED IN PREVIOUS QIP	TARGET AS STATED IN PREVIOUS QIP	CURRENT	
Medication reconciliation at admission: The total number of admitted patients with medications reconciled on admission (all four hospitals) compared to the total number of patients admitted to the hospital.	64.2	65.0	65.9 (Q3)	The percentage of patients having medication reconciliation on admission has exceeded target in the two most recent quarters (Q2 & Q3 2015/16). Medication reconciliation software is now implemented at all four hospitals. Achieving the 65% target has been successful with the use of temporary full-time pharmacy students in the final years of their professional program.
CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000. Average for Jan-Dec. 2015, consistent with HQO's Patient Safety public reporting website.	0.31	0.40	0.34 (Jan – Dec 2015)	Control measures for CDI remain ongoing. Targeted cleaning resources and appropriate use of sporicidals are being utilized. Improvement initiatives undertaken in 2015/16 include: • Signage and public awareness enhancements. Continued from previous year • Antimicrobial steward review prioritization process with real time notification. Continued from previous year • Same day notification of symptomatic patients ensuring prompt communication to IPC, interprofessional care teams, housekeeping and dietary staff. • Regular and consistent coaching and monitoring to ensure housekeeping and dietary staff use appropriate PPE equipment and hand hygiene practices. • Active review of work practices of housekeeping staff to ensure compliance with cleaning standards on transfer and discharge.

INDICATOR	PERFORMANCE			COMMENTS
	STATED IN PREVIOUS QIP	TARGET AS STATED IN PREVIOUS QIP	CURRENT	
Hand Hygiene before Patient Contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100.	91.4	95.00	85.53 (Jan – Dec 2015)	Hand hygiene is an important indicator of quality care. In Q2 of 2015/2016, Infection Control altered its auditing methodology from known to unknown auditors. Utilizing unknown auditors is an important step as findings more accurately reflect current physician and staff practice. The practice of using unknown auditors is being widely adopted within the hospital sector province wide. QHC recognizes this as an important patient safety initiative.
Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	-0.23	0.00	0.02% Q3 FY 2015/2016 (cumulative of Q1-Q3 2015/ 2016)	QHC continues to be negatively impacted by the implementation of Health System Funding Reform (HSFR) which may have a material impact on QHC's reported year-end margin. The cost structure of the regional Behavioural Supports Transition Unit (BSTU) has resulted in a further negative impact on QHC's financial situation. QHC continues to match direct care staffing, care supports, and number of beds to meet patient needs. QHC will continue to implement approved changes into 2016/2017 fiscal year.
Readmission Rate within 30 days for Case Mix Groups COPD and CHF: number of patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) readmitted to any QHC hospital for non-elective inpatient care within 30 days of discharge for any reason, compared to the number of expected non-elective readmissions.	13.1	12.80	11.46 (July 2014 - June 2015)	QHC has implemented a number of initiatives to improve readmission rates including piloting electronic order sets for physicians, pathway interventions, 24 hour pre-discharge/education checklist, implementing an interprofessional patient care team model with the goals of planning for discharge beginning at admission. Implementing a follow-up discharge phone protocol to contact patients 24-48 hours post discharge continues to be a goal for 2016/2017.

<table>
<tr><th rowspan="2">INDICATOR</th><th colspan="3">PERFORMANCE</th><th rowspan="2">COMMENTS</th></tr>
<tr><th>STATED IN PREVIOUS QIP</th><th>TARGET AS STATED IN PREVIOUS QIP</th><th>CURRENT</th></tr>
<tr><td>Patient Satisfaction in the Emergency Department (ED): From NRC Canada satisfaction surveys, percentage of ED-patients who responded positively to their overall quality of care. ("Overall, how would you rate the care and services you received at the ED?" with ratings good, very good, excellent).</td><td>88.12%</td><td>87.30%</td><td>88.93% (Oct 2014 – Sept 2015)</td><td rowspan="2">QHC continues to establish strong foundations and practices to support the QHC strategic priority to Provide an Exceptional Patient Experience.
➢ Working with Program Leadership and Advisory Committees to establish processes for analysis and response to patient satisfaction (NRCC) and patient relations (compliments/ complaints) data at the program and unit level
➢ Implementation of an Interprofessional Patient Care Team model; currently implemented in 7 of 14 units
➢ Provision of Patient & Family Centered Care training for direct care teams
➢ Adoption of three key patient-centered processes with the implementation of the Interprofessional Patient Care Team model:
o Shift handover occurring at the bedside with patients and their families
o Purposeful hourly rounding
o Patient-specific communication boards for every patient (where appropriate)
➢ Updated Feedback Management Policy
➢ Implementation of real-time patient satisfaction surveys in 2015-2016 in all 4 emergency departments and 6 inpatient units. QHC has committed to expanding real-time surveys in 2016-2017.</td></tr>
<tr><td>Patient Satisfaction in the Inpatient Units: From NRC Canada satisfaction surveys, percentage of inpatients who responded positively to their overall quality of care. ("Overall, how would you rate the care and services you received at the hospital (inpatient care)?" with ratings good, very good, excellent).</td><td>92.94%</td><td>94.1%</td><td>90.75% (Oct 2014 – Sept 2015)</td></tr>
</table>

INDICATOR	PERFORMANCE			COMMENTS
	STATED IN PREVIOUS QIP	TARGET AS STATED IN PREVIOUS QIP	CURRENT	
Alternate Level of Care (ALC) Rate - Acute and Post-Acute: total number of alternate level of care (ALC) inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) x 100 days. (corporate definition)	18.1	15.00	15.29 (Q3 FY 2014/2015 – Q2 FY 2015/ 2016)	ALC rates at QHC and across the SELHIN remain high. QHC continues to focus on patient flow strategies including a refresh of Home First, prevention of ALC conversion, and processes to minimize time from ALC LTC designation to LTC admission. With the implementation of the Interprofessional Patient Care Team model, planning for discharge now begins at the time of admission and the full care team participates in supporting the patient to return to their 'home'. QHC continues to engage as an active participant in the SELHIN ALC strategy committee formed with the SE LHIN, SE hospitals and SECCAC to develop regional level actions to address escalating rates of ALC-LTC.
Emergency Department (ED) Wait times for Admitted Patients: 90th percentile ED length of stay for admitted patients. Measured YTD.	23.85	21.00	23.00 (Q4 FY 2014/15 – Q3 2015/2016)	ED wait times for admitted patients fluctuated over the past 4 quarters. Contributing factors include: time to physician initial assessment (PIA), over capacity across the organization and increased acuity and length of stay for ALC patients. Improvements were seen in Q1 as the wait time dropped to 20.50 hours. Although YTD score remains above target it is an improvement from the previous fiscal year. Current provincial average is 28.8 hours.

To:	QHC Board of Directors
From:	Karen Baker, Treasurer and Chair of the Audit and Resources Committee
Subject:	Insurance Coverage
Date of Meeting:	March 22, 2016
For:	Decision
Motion:	*That the QHC Board of Directors' approve the renewal of Healthcare Reciprocal of Canada (HIROC) as QHC's insurance and risk management provider. The estimated annual premium for fiscal 2016/17 is $990,541.*

Issue

QHC went to market in 2013/14 and engaged HIROC to be QHC's insurance and risk management provider for a term of forty eight months. The term of this agreement expires in 2018/19.

Experience with HIROC

The transition to the new insurance and risk management provider, HIROC has been a positive experience. Since that date QHC has reported 59 events. This includes both those events with a Statement of Claim and those that have been reported on a cautionary basis. The total incurred claims cost is $954,415. Of the 59 reported events, 31 are closed (non-active) and 28 remain open (active). Note that all 3 claims with a Statement of Claim are closed (non-active) with total incurred claims cost of $17,408. Note that there are no deductibles under our coverage with HIROC.

There are still eight claims that occurred prior to March 31, 2014 and are being monitored by QHC. These claims will be handled by our previous insurance carrier Marsh.

Coverage for 2016/17

Attached in Appendix A is a listing of insurance coverages and estimated annual premiums for 2016/17.

Recommendation

The Audit and Resources Committee recommends renewing the existing coverage as per Appendix A.

To:	**QHC Board of Directors**
From:	**Karen Baker, Treasurer and Chair of the Audit and Resources Committee**
Subject:	**Hospital Sector Accountability Agreement (HSAA)**
Date of Meeting:	**March 22, 2016**
For:	**Decision**
Motion	***That the QHC Board of Directors' approve the amending agreement extending the terms of the existing Hospital Services Accountability Agreement to June 30, 2016.***

Issue

Hospital Service Accountability Amending Agreement (HSAA).

Background

In 2008, QHC signed a HSAA with the South East Local Health Integration Network (SE LHIN). The agreement has been amended and extended numerous times.

QHC management received from the SE LHIN on Friday February 27, 2015 the proposed amending agreement to extend the existing HSAA to June 30, 2016. The last HSAA was approved by the QHC Board of Directors on March 24, 2015.

QHC management has negotiated with the SE LHIN the performance indicators encompassed within and is satisfied QHC can meet the expected performance obligations. QHC management has also negotiated the local obligations section of the HSAA and is satisfied QHC can meet the obligations contained within. The attached agreement also fully reconciles to the board approved 2016/17 Operating Plan.

To:	QHC Board of Directors
From:	Odila Hoye, Chair of the Quality of Patient Care Committee
Subject:	Quality of Patient Care Committee Update
Date of Meeting:	March 22, 2016
For:	Information

The Committee discussed and received the following updates from management at their March 8, 2016 meeting:

1. **Quality of Patient Care Scorecard – Quarter 3**
   Please see attached scorecard. Clarification was sought related to HSMR reporting and hand hygiene results.

2. **BGH Emergency Department (ED) Patient Flow Update**
   A discussion took place on the progress of BGH ED Patient Flow initiatives. Additional information will be brought back to the Quality of Patient Care Committee at their April meeting with a further update to the board.

Quality of Patient Care Board Scorecard
Fiscal 2015/16

	Measure	2014/15 Target	2015/16 Target	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	NOTES
Safe	Medication Reconciliation - Quarter	62.00	65.00	55.70	64.20	71.20	78.70	57.80	65.90	67.70	.	(QIP)
	Medication Reconciliation - YTD	62.00	65.00	55.70	60.00	63.80	67.80	57.80	61.80	65.90	.	.
	Hospital Standard Mortality Rate - Quarter	100.00	100.00	89.00	63.00	85.00	99.00	.	.	.	.	2014/15 Q4 is most recent data available from the Minsitry.
	CDI Rate per 1000 Patient Days - Quarter	.44	.40	.60	.16	.37	.28	.44	.16	.42	.	(QIP)
	MRSA Rate per 1000 Patient Days - Quarter	.01	.01	.00	.10	.00	.08	.00	.00	.00	.	.
	CLI Rate per 1000 Patient Days - Quarter	2.00	2.00	.00	.00	.00	.00	.00	.00	.00	.	.
	VAP Rate per 1000 Vent Days - Quarter	1.00	1.00	4.31	7.96	3.95	.00	.00	4.31	2.33	.	less than 5 cases / total vent days * 1000.
	Surgical Safety Check List - Quarter	99.00	99.00	99.80	99.80	99.70	99.80	99.80	99.90	99.90	.	.
	Surgical Site Infection Preventions - Quarter	95.00	95.00	96.61	96.86	98.30	97.10	96.90	97.30	98.60	.	.
	Hand hygiene - after Patient Contact - Quarter	85.00	85.00	92.30	90.88	94.25	93.74	89.60	88.10	87.50	.	.
	Hand Hygiene - before Patient Contact - Quarter	85.00	95.00	91.50	91.99	91.39	88.43	89.90	80.80	81.03	.	(QIP)
Effective	Financial Margin (%) YTD	.00	.00	-1.78	.40	-.23	.08	-3.23	.31	.02	.	(QIP)
	Re-admission Rate within 30 Days for case mix groups COPD and CHF	12.80	12.80	8.50	14.60	5.53	10.92	11.64	.	.	.	(QIP)
Patient Centered	Patient Satisfaction % - ED - Quarter	87.30	87.30	85.90	89.60	93.10	83.30	83.90	86.90	91.10	.	(QIP)
	Patient Satisfaction % - Inpatient - Quarter	94.10	94.10	95.60	94.40	95.60	88.80	87.60	92.60	91.80	.	(QIP)
Timely	Alternate Level of Care (ALC) Rate all Open and Closed - Quarter	15.10	15.00	17.60	17.80	17.10	13.10	14.00	16.80	16.08	.	(QIP)

	Measure	2014/15 Target	2015/16 Target	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	NOTES
Timely	Alternate Level of Care (ALC) Rate Acute Open and Closed - Quarter	.	15.00	16.80	17.40	17.30	14.90	15.30	17.95	18.64	.	new for 2015/16.
	ED Wait Time Admitted Patients - Quarter	17.50	21.00	24.70	25.40	24.00	22.10	20.50	23.00	25.00	.	(QIP)
	ED Wait Time Admitted Patients - YTD	17.50	21.00	24.70	25.00	24.70	24.10	20.50	22.00	23.30	.	(QIP)
	ED Wait Time - CTAS I-III - Quarter	6.30	6.30	6.90	7.30	7.00	7.20	6.70	6.80	6.90	.	.
	ED Wait Time - CTAS IV-V - Quarter	3.60	3.70	4.40	4.70	4.50	4.70	4.40	4.80	4.70	.	.
	Cancer Surgery Wait Time % (Belleville) - priority 4 - Quarter	90.00	90.00	100.00	95.00	100.00	100.00	100.00	100.00	100.00	.	.
	Cancer Surgery Wait Time % (Trenton) - priority 4 - Quarter	90.00	90.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	.	.
	Cataract Surgery Wait Time % (Trenton) - priority 4 - Quarter	90.00	90.00	91.00	93.00	90.00	93.00	94.00	95.00	99.00	.	.
	Hip Replacement Wait Time % - priority 4 - Quarter	90.00	90.00	.	100.00	100.00	100.00	100.00	100.00	100.00	.	.
	Knee Replacement Wait Time % - priority 4 - Quarter	90.00	90.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	.	.
	CT Scan Wait Time % (Belleville) - Priority 4 - Quarter	90.00	90.00	86.00	95.00	91.00	95.00	99.00	100.00	100.00	.	.
	CT Scan Wait Time % (Trenton) - Priority 4 - Quarter	90.00	90.00	92.00	98.00	98.00	99.00	100.00	100.00	100.00	.	.
	MRI Scan Wait Time % - Priority 4 - Quarter	90.00	90.00	91.00	56.00	28.00	27.00	42.00	34.00	64.00	.	.

Note: The 2014/15 Q1-Q4 colouring is done based on the 2014/15 Target.

Report: quality_commitee_indicators_F1516

Quality of Patient Care Indicators
Board Scorecard
Definitions and Thresholds
Fiscal 2015/16

	Measure	Accountability	2014/15 Target	2015/16 Target	Green Range	Yellow Range	Red Range	DEFINITION
Safe	Medication Reconciliation - Quarter	QIP	62.00	65.00	>=65.0	58.5-65.0	<58.5	Medication Reconciliation on Admission: total # of admitted patients with medication reconciliation on admission (all four hospitals) compared to the total # of patients admitted (all four hospitals) excluding labour and delivery patients, measured at each quarter.
	Medication Reconciliation - YTD	Balanced Score Card	62.00	65.00	>=65.0	58.5-65.0	<58.5	Medication Reconciliation on Admission: total # of admitted patients with medication reconciliation on admission (all four hospitals) compared to the total # of patients admitted (all four hospitals) Excluding labour and delivery patients, measured as year to date.
	Hospital Standard Mortality Rate - Quarter	Ministry	100.00	100.00	<100	>=100-110	>110	Number of observed deaths / number of expected deaths x 100 . Expected deaths are determined by the Canadian Institute for Health Information (CIHI).
	CDI Rate per 1000 Patient Days - Quarter	Ministry, QIP	.44	.40	<=0.40	>0.40 - 0.44	>0.44	Cardidium Difficile Infection (CDI): rate per 1000 patient days. Number of patients newly diagnosed with hospital acquired CDI, divided by the number of inpatient days in that month, multiplied by 1000.
	MRSA Rate per 1000 Patient Days - Quarter	Ministry	.01	.01	<=0.01	NA	>0.01	Staphylococcus aureus is a type of bacterium that lives on the skin and mucous membranes of healthy people. When S. aureus develops resistance to certain antibiotics, it is called methicillin-resistant Staphylococcus aureus, or MRSA. If infected with MRSA, the antibiotics which can be used are limited. This indicator measures how many patients per 1000 patient days acquired MRSA bacteraemia while in the hospital.
	CLI Rate per 1000 Patient Days - Quarter	Ministry	2.00	2.00	<=2.0	NA	>2.0	the total # of newly diagnosed CLI (Central Line Infection) cases in the Intensive Care Unit (ICU) after at least 48 hours of being placed on a central line, divided by the # of central line days in that reporting period, multiplied by 1,000. Central line days are the number of days spent on a central line for all patients in the ICU 18 years and older.

Quality of Patient Care Indicators
Board Scorecard
Definitions and Thresholds
Fiscal 2015/16

	Measure	Accountability	2014/15 Target	2015/16 Target	Green Range	Yellow Range	Red Range	DEFINITION
Safe	VAP Rate per 1000 Vent Days - Quarter	Ministry	1.00	1.00	<1.0	NA	>1.0	total # of newly diagnosed VAP (Ventilator Assisted Pneumonia) cases in the ICU after at least 48 hours of mechanical ventilation, divided by # of ventilator days in that reporting period, multiplied by 1,000. Ventilator days are the number of days spent on a ventilator for all patients in the ICU 18 years and older.
	Surgical Safety Check List - Quarter	Ministry	99.00	99.00	>=99	90-99	<90	The total number of surgeries in which all three phases of the surgical safety checklist was performed divided by the total number of surgeries during the reporting period, multiplied by 100.
	Surgical Site Infection Preventions - Quarter	Ministry	95.00	95.00	>=95	<95-85.5	<85.5	The total number patients who received antibiotics within the appropriate time period prior to surgery divided by the total number of surgical patients during the reporting period, multiplied by 100. Included are patients 18 years or older who undergo primary hip or knee joint replacement surgery, including total, partial or hemi arthroplasty.
	Hand hygiene - after Patient Contact - Quarter	Ministry	85.00	85.00	>=85	76.5-85	<76.5	The number of times that hand hygiene was performed after initial patient/patient environment contact divided by the number of observed hand hygiene indications for after initial patient/patient environment contact multiplied by 100.
	Hand Hygiene - before Patient Contact - Quarter	Ministry, QIP	85.00	95.00	>=95	85.5-95	<85.5	The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100.
Effective	Financial Margin (%) YTD	Balanced Score Card, QIP	.00	.00	> 0	-1 - 0	< -1	Total Margin (consolidated): percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.

Quality of Patient Care Indicators
Board Scorecard
Definitions and Thresholds
Fiscal 2015/16

	Measure	Accountability	2014/15 Target	2015/16 Target	Green Range	Yellow Range	Red Range	DEFINITION
Effective	Re-admission Rate within 30 Days for case mix groups COPD and CHF	QIP	12.80	12.80	<=12.8	>12.8-14.1	>14.1	The number of patients with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) readmitted to any facility for non-elective inpatient care within 30 days of discharge for any reason, compared to the number of expected non-elective readmissions
Patient Centered	Patient Satisfaction % - ED - Quarter	QIP	87.30	87.30	>=87.3	78.5-87.2	<78.5	Overall Emergency Department (ED) Patient satisfaction: percentage of ED-patients who responded positively to their overall quality of care (good, very good, excellent)
	Patient Satisfaction % - Inpatient - Quarter	QIP	94.10	94.10	>=94.1	84.7-94.1	<84.7	Overall Acute Inpatient satisfaction: percentage of in-patients who responded positively to their overall quality of care (good, very good, excellent)
Timely	Alternate Level of Care (ALC) Rate all Open and Closed - Quarter	QIP	15.10	15.00	<=15.0	>15.0-16.5	>16.5	Alternate Level of Care (ALC) Rate measures the total number of inpatient days designated as ALC, divided by the total number of inpatient days x 100, open and closed cases. This is a Corporate defintion.
	Alternate Level of Care (ALC) Rate Acute Open and Closed - Quarter	Balanced Score Card	.	15.00	<=15.0	>15.0-16.5	>16.5	ALC Rate Acute Open and Closed measures the total number of inpatient acute days designated as ALC, divided by the total number of acute inpatient days x 100, open and closed cases. This matches the HSAA definition.
	ED Wait Time Admitted Patients - Quarter	QIP	17.50	21.00	<=21	>21.0-23.1	>23.1	90th Percentile Emergency Department (ED) Length of Stay (LOS) for Admitted patients at all four hospitals. Measured in hours.
	ED Wait Time Admitted Patients - YTD	Balanced Score Card , QIP	17.50	21.00	<=21	>21.0-23.1	>23.1	90th Percentile Emergency Department (ED) Length of Stay (LOS) for Admitted patients at all four hospitals. Measured in hours.
	ED Wait Time - CTAS I-III - Quarter	Ministry	6.30	6.30	<=6.3	>6.3-6.93	>6.93	The 90th Percentile Emergency Department (ED) LOS for non admitted patients with high acuity or Canadian Triage Acuity Scale (CTAS) levels 1, 2, or 3. Measured in hours.
	ED Wait Time - CTAS IV-V - Quarter	Ministry	3.60	3.70	<=3.7	>3.7-4.07	>4.07	The 90th Percentile Emergency Department (ED) LOS for non admitted patients with low acuity or Canadian Triage Acuity Scale (CTAS) levels 4 and 5. Measured in hours.

Quality of Patient Care Indicators
Board Scorecard
Definitions and Thresholds
Fiscal 2015/16

	Measure	Accountability	2014/15 Target	2015/16 Target	Green Range	Yellow Range	Red Range	DEFINITION
Timely	Cancer Surgery Wait Time % (Belleville) - priority 4 - Quarter	Ministry	90.00	90.00	>= 90	>81-<90	<81	This indicator shows the % of Cancer Surgery Priority 4 patients that meet the wait time target of 84 days.
	Cancer Surgery Wait Time % (Trenton) - priority 4 - Quarter	Ministry	90.00	90.00	>= 90	>81-<90	<81	This indicator shows the % of Cancer Surgery Priority 4 patients that meet the wait time target of 84 days.
	Cataract Surgery Wait Time % (Trenton) - priority 4 - Quarter	Ministry	90.00	90.00	>= 90	>=81-<90	<81	This indicator shows the % of Cataract Surgery Priority 4 patients that meet the wait time target of 182 days.
	Hip Replacement Wait Time % - priority 4 - Quarter	Ministry	90.00	90.00	>= 90	>=81-<90	<81	This indicator shows the % of Hip Replacement Surgery Priority 4 patients that meet the wait time target of 182 days.
	Knee Replacement Wait Time % - priority 4 - Quarter	Ministry	90.00	90.00	>= 90	>=81-<90	<81	This indicator shows the % of Knee Replacement Surgery Priority 4 patients that meet the wait time target of 182 days.
	CT Scan Wait Time % (Belleville) - Priority 4 - Quarter	Ministry	90.00	90.00	>= 90	>=81-<90	<81	This indicator measures the % of Priority 4 CT Scan patients that meet the wait time target of 28 days.
	CT Scan Wait Time % (Trenton) - Priority 4 - Quarter	Ministry	90.00	90.00	>= 90	>=81-<90	<81	This indicator measures the % of Priority 4 CT Scan patients that meet the wait time target of 28 days.
	MRI Scan Wait Time % - Priority 4 - Quarter	Ministry	90.00	90.00	>= 90	>=81-<90	<81	This indicator measures the % of Priority 4 MRI Scan patients that meet the wait time target of 28 days.

Note: The range colouring is defined using the 2015/16 targets

Report: quality_indicator_F1516_definitions

To:	QHC Board of Directors
From:	Karen Baker, Treasurer and Chair of Audit and Resources Committee
Topic:	Audit and Resources Committee Update
Date of Meeting:	March 22, 2016
For:	Information

In addition to the items on the board agenda, the Committee also discussed and received the following updates from management at their March 8, 2016 meeting:

1. **Hospital Service Accountability (HSAA) Performance Indicators**
The committee reviewed and discussed the HSAA performance indicators. The HSAA indicators and definitions are attached with the regular report.

2. **Legal Claims Update**
The committee received the annual update on legal claims. Since HIROC has been our insurance provider for the last two years QHC has reported 59 events. This includes both those events with a Statement of Claim and those that have been reported on a cautionary basis. Of the 59 reported events, 31 are closed (non-active) and 28 remain open (active). There have been 3 events that have led to a statement of claim. All 3 claims are closed (non-active) with total incurred claims cost of $17K.

3. **Environmental Liability Update**
This committee received a summary of issues relating to environmental liability at each of the four QHC hospitals. There is no material change in circumstances from the prior year.

4. **Capital Projects Update**
The committee received its regular capital projects briefing which included updates on the Medical Device Reprocessing Department (MDRD) and the Prince Edward County Memorial Hospital Re-development.

5. **Labour Relations Update**
Jeff Hohenkerk provided an update on local bargaining. Unifor and SEIU unions have both ratified multi-year labour agreements. ONA local issues bargaining will commence here at QHC later in the winter of 2016. QHC will start local issues negotiations with OPSEU local in the late spring to early summer. Mr. Hohenkerk also provided the committee an update on the staff planning meetings which have occurred with our unions.

6. **Legislative Requirements Reporting**
There are a number of legislative requirements that guide the policies and procedures associated with the services provided within the Human Resources portfolio. The committee received an update on changes that have impacted QHC in relation to the Occupational Health & Safety Act; OHS Regulation 860 (Whimis); Stronger workplace for a stronger Economy Act; Accessibility for Ontarians with Disabilities Act (AODA) and the Labour Relations Act.

7. **Payroll Fraud Investigation**
   The committee received a briefing on an isolated payroll fraud involving one employee. The situation involved a QHC employee who is also employed by another health service provider.

8. **Compensation & Benefits Update (including Public Sector Salary Disclosure)**
   The committee received an update on the Broader Public Sector Executive Compensation and the latest with respect our central and local bargaining process with each union.

   Also, In accordance with the Public Sector Salary Disclosure Act, a summary of the list of all QHC employees who earned over $100,000 was reviewed by the committee. This list is submitted to the Ministry of Finance annually and is based on information from the T_4 reports.

To:	QHC Board of Directors
From:	Patrick Johnston, Chair of the Governance, Communications and Strategy Committee
Topic:	Governance, Communications and Strategy Committee (GCSC) Update
Date of Meeting:	March 22, 2016
For:	Information

The Committee discussed and received the following updates from management at their February 9, 2016 meeting:

1. **Governance Collaboration Update**
   The committee received an update on governance collaboration specifically around progress on Addictions and Mental Health and the Ministry's 'Patient First' plan. Patient First material is included in the February 9th, 2016 GCSC package on the Board portal for review.

2. **Advisory Council Meeting & Plans**
   The committee received an update on the upcoming plans for Advisory Council meetings:
   - Tuesday March 29 4:00 - 6:30 p.m.
     - Health Care Tomorrow - update
     - Health Care for Seniors – understanding QHC's Senior Friendly initiatives – discussion
   - Tuesday May 10 4:00 – 6:30 p.m.
     - Improving the ER experience – update
     - Community Partner Panel Discussion – participants TBD

3. **Board Evaluation Surveys**
   The committee confirmed that we would be using the OHA's Self-Assessment governance survey this year. This will permit the board to better measure its functioning against other hospital boards. We will also be performing our regular individual director assessment survey. The surveys will be sent out after the April committee and board meetings with GCSC reviewing the results at their June meeting.

4. **Policy Review**
   The committee identified the following policy areas that should be reviewed for changes:
   - Creation of a "whistle blower" policy
   - Clarification of policy regarding attendance at meetings using teleconference or videoconference
   - Review and clarification of "excluded persons" for the board and advisory council
   - Policy regarding police background checks

   Policy changes will be discussed at the April GCSC committee meeting.

5. **Board Recruitment**
   The committee reviewed the recruitment process and is pleased that it is proceeding appropriately.

To:	QHC Board of Directors
From:	David MacKinnon, Chair of Nominations Ad-hoc Committee
Topic:	Nominations Ad-hoc Committee Update
Date of Meeting:	March 22, 2016
For:	Information

The Nominations Ad-hoc Committee discussed the following at their March 8, 2016 meeting:

1. **Review of Applications for Director Positions and Short-list**
   The Nominations Ad-Hoc Committee received 11 applications for the five vacant Board positions for 2016/17 and will be interviewing eight candidates on April 19/20. Candidates for the short-list were selected primarily on their ability to bring a high priority skill to the Board, as identified by the Governance, Communications and Strategy Committee.

To:	QHC Board of Directors
From:	Mary Clare Egberts, President & CEO
Topic:	Report of the President & CEO – Discussion
Date of Meeting:	March 22, 2016
For:	Information

Balanced Scorecard
The balanced scorecard results for the third quarter of 2015/16 are attached. As previously reported to the Board, we will not meet our targets for ER length-of-stay or ALC patient days. We are putting increased focus on improving ER wait times and patient flow at BGH, which is described in more detail below.

Employee and physician engagement for this year is 'Number of improvements implemented by the team' with the target for this measure being 'The 28 teams at QHC each implement 3 improvements (84) in Q4'. Each team is encouraged to implement as many improvements as possible however from a reporting perspective each team is capped at 3 per quarter. The logic to 'capping' is to ensure all teams are implementing improvements, and not just a few. In Quarter 3 we achieved 46/84 improvements 'capped', overall in Quarter 3 there were 186 improvements, some units had over 20 improvements in the quarter. I have been extremely impressed with the enthusiasm and creativity that the teams have shown in the 186 improvement initiatives. With this positive momentum, we already know that we meet this target in Q4.

Our performance for expected costs per weighted case continues to move closer to the annual target.

Focus on Process Improvement at QHC
As part of the ongoing implementation of the QHC strategic plan, we will be working to improve the patient experience and the work life of our physicians and staff in 2016/17 and beyond, in spite of the challenges within the entire hospital system. To this end, the Senior Leadership Team has determined that we needed to invest in external supports to move QHC's quality/process improvement efforts to the next level. This includes additional improvement development, training, tools and skills to all levels of staff and physicians in order to involve the entire team an increased focus on quality improvement and creating a better work environment.

The initial focus will be on reducing the BGH ER length-of-stay and improving patient flow between the ER, ICU and Quinte 5. This will be launched at a three-day value stream mapping session in late-April to focus on uncovering the key improvement opportunities to meet these goals.

To support these efforts, we are very fortunate to have Mike Elias join us as an external quality improvement coach and expert. Mike is well-known throughout the Ontario hospital sector and has helped hospitals such as North York General and Rouge Valley Health System. He is currently helping the South East Cancer Care Program and Cancer Centre in Kingston to make system improvements.

Trenton Memorial Hospital Implementation Task Force
This task force continues to meet regularly to address the recommendations stemming from the Rainbird Report, with a particular focus on examining options to create a health hub of co-located hospital and community services. While each health care partner would remain distinct in terms of operation, the collocation model sets a basis for integration and collaboration in patient care.

Part of the business case for moving forward with the Trenton Health Centre model is looking at the space and structure of the TMH building to determine if it's suitable and what renovations would be needed to make the space work. Engineers have been onsite at TMH in March as part of that process.

The task force still expects to deliver their final report to the LHIN by May 1.

PECMH Redevelopment Update
The MOHTLC told QHC and our PECMH redevelopment project partners in Fall 2015 that they would require a corporate master program from QHC before they could provide approval of the pre-capital submission. The master program will outline the 20-year plan for providing services at the four Quinte Health Care Hospitals, including how a new PECMH would fit into the overall service delivery plan. Detailed information about the four QHC hospitals will include services, patient volumes (current and projected future volumes), population demographics and space requirements. Planning meetings with the program consultants and staff were held in January, February and into early March. Completion of the corporate master program is scheduled for June 2016.

The following is a summary of the PECMH redevelopment approval process to-date:

- January 2015: Pre-capital submission sent to the MOHLTC
- April 2015: MOHLTC issued questions on the pre-capital submission and QHC responded in June
- November 2015: Teleconference with the MOHLTC to discuss the submission, with the MOHTLC requesting additional information
- December 2015: QHC issued pre-capital submission addendum to the MOHLTC
- January 2016: MOHLTC issued additional questions
- February 2, 2016: Representatives from QHC, the LHIN and consultants met with MOHLTC to discuss questions and provide responses. MOHLTC will formally review and reply to the responses
- March 2016: The architect will be selected by the end of the month as QHC prepares for the next phase of the process

Health Care Tomorrow – Hospital Services Update
On February 3, hospital leaders from across the South East LHIN came together to receive an update on the Health Care Tomorrow – Hospital Services phase 2 planning that has been underway since October 2015. The session – called Vision 2020 – provided an opportunity to hear the progress of their business case development for moving towards a regional shared services model in the areas of information technology, finance, human resources, facilities management, diagnostic imaging, pharmacy and laboratory services. The clinical working group

has prioritized the need to focus on redesigning care for complex, frail, vulnerable patients, but are working on a longer time frame and is not expected to deliver a business case as part of this phase of the project.

There will be continued engagement with staff, physicians and patients in March and April to help inform the final business cases that will go to the hospital, CCAC, SE LHIN and 3SO boards in June, for potential approval to move to the implementation planning stage.

Clinical Manager Changes
The QHC Program Directors have made extensive changes to the portfolios of QHC clinical managers following a careful review of portfolio size and complexity and looking for ways to support the Managers' growth and development at QHC. The changes were made in order to: support the new Acute Care for the Elderly Unit and the shift in CCC and ALC units between BGH and TMH; improve collaboration between clinical programs; ensure all of our teams and services have the best possible leadership support, in spite of our very lean management numbers at QHC; and broaden the breadth of experience within QHC's management group.

The changes were effective March 11, with the exception of the surgical managers who will transition to their new responsibilities to coincide with the shift of surgical services in the fall. This will be a significant adjustment for the eight managers taking on new responsibilities, and for their teams, at a time when we are already undergoing a considerable amount of change throughout the organization.

Scheduled Power Outage
Board members may have heard about a power outage at BGH on March 5 and 6 through radio reports. This was a routine power outage that had been planned weeks in advance. We typically schedule this every spring to allow for routine testing and maintenance of our electrical systems and replace equipment as needed. Another planned outage will occur in April.

Generator power is used for the duration of the outage so that there is very minimal disruption for our patients or staff during this time.

QHC Balanced Scorecard – Q3 2015/16

Strategic Directions	Enhance Quality of Care	Create an Exceptional Patient Experience	Provide Effective Care Transitions	Be an Exceptional Workplace	Improve Strategic Enablers
QHC Goals	**Enhance Care for Seniors**			**Increase Staff & Physician Engagement**	**Become More Cost Efficient**
QHC Measures	ER Length-of-Stay	Alternate Level of Care Patient Days		Number of improvements implemented by the team	Departmental costs ÷ equivalent patient days
QHC Targets	90th Percentile ER Length-of-Stay for Admitted Patients ≤ 21 hours	% ALC Patient Days ≤15%		The 28 teams at QHC each implement 3 improvements (84) in Q4	≤ $1,432
Q1 Performance	20.5 (green)	15.3% (yellow)		Note 1	$1,515 (yellow)
Q2 Performance	22.0 ytd (yellow)	17.95% (red)		Note 1	$1,456 ytd (yellow)
Q3 Performance	23.3 ytd (red)	18.64% (red)		Note 1 46	$1,452 ytd (yellow)

1. In quarter 3 we have seen tremendous success in adoption and implementation of team based improvements, with an adoption rate of 57% of teams. Note that many teams exceeded the reportable cap of 3 improvements per team as we tallied a total of 186 improvements. There are many examples of adoption and cultural shift across the hospitals, two notable teams are; Mental Health who implemented 52 improvements, and Diagnostic Imaging at 25. * Data collection began in August.

To:	**QHC Board of Directors**
From:	**Odila Hoye, Chair of the Quality of Patient Care Committee**
Subject:	**2016/17 Quality Improvement Plan**
Date of Meeting:	**March 22, 2016**
For:	**Decision**
Motion:	***That the QHC Board of Directors' approve the 2016/17 Quality Improvement Plan as presented.***

Issue
The 2016/17 Quality Improvement Plan (QIP) for Quinte Health Care (QHC) must be approved by the Board Quality of Patient Care Committee and the full Board of Directors, and submitted to Health Quality Ontario (HQO) by April 1, 2016. The 2016/17 QIP submission includes both a narrative report (attached) and work plan (list of indicators) that are embedded in the report.

Background
According to board policy III-2 Ensure Program Quality and Effectiveness: Performance Monitoring, the Board is accountable for:

"i) Ensuring that management has identified appropriate performance metrics (measures of performance)."

The *Excellent Care for All Act (2010) (ECFAA)* mandates hospitals in Ontario submit a board-approved QIP to HQO by April 1, 2016 and ensure the QIP is available to the public.

HQO provides organizations with a guidance document that identifies priority and alternate indicators. Organizations are required to create a QIP comprised of the priority HQO indicators as well as any HQO alternate indicators and/or indicators of the hospital's choosing. The QIP will form one part the QHC's overall quality agenda.

In September 2015, new regulations under ECFAA came into effect. ECFAA now requires hospitals to engage patients and their caregivers in the development of annual QIP. In addition, hospitals are also required to take the findings of their patient-relations processes into consideration when developing their QIP.

New this year is an increased emphasis to align QIP indicator targets with H-SAA targets.

QHC's QIP development process involved:
- Review of all HQO indicators (priority & alternate);
- Review of QHC current performance (over previous 4-8 quarters) and comparison to provincial benchmarks;
- Review of patient relations trends (compliments and complaints);
- Discussions regarding QHC's broader quality mandate;
- Discussions regarding Pay-for-Performance metrics;
- Identification of recommended performance targets for 2016/17 (aligned with H-SAA target where appropriate);
- Discussion at Advisory Council; and
- Vetting of the draft QIP by Nursing Practice Council, Interprofessional Practice Council, Medical Advisory Council, Corporate Quality & Patient Safety Committee and the Senior Leadership Team.

Proposed 2016/17 Quality Improvement Plan

	Indicator	Priority or Alternate	Current Performance	2016/17 Performance Target
1	CDI Rate	Priority	0.34% Jan–Dec 2015	0.40%
2	Med Rec on Admission	Priority	65.9% Q3 2015/16	68%
3	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)	Priority (regional custom indicator)	9.78% Jan-Dec 2014	9.29%
4	90th Percentile ED LOS for Admitted Patients	Priority	23.00 Jan-Dec 2015	21.85 hours
5	Positive Patient Experience – ED – Percentage of ED patients who responded positively to their overall quality of care	Priority	NRCC 88.93% Oct 2014 – Sept 2015 BG ED Real-Time Survey Q2 – 70% Q3 – 84%	80%
6	ALC Rate – Acute & Post-Acute – Open & Closed	Priority	15.29% Oct 2014 – Sept 2015	15%
7	Readmission within 30 Days for Selected HBAM Inpatient Grouper	Priority (custom indicator)	16.2% Q2 2014 – Q1 2015	15.4%
8	Hand Hygiene Before Patient Contact	Alternate	85.53% Jan–Dec 2015	85%

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Let's Make Healthy
Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

3/31/2016

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Quinte Health Care (QHC) is dedicated to the delivery of exceptional and compassionate care and to continually enhancing the quality and safety of care in an environment that reduces risk for patients and staff. We are accountable for and committed to providing care and services to our patients and families that reflect our values:

- Imagine It's You
- Respect Everyone
- Take Ownership
- We all help provide care
- Always strive to improve

Our strategic directions are:

1. Enhance the quality and safety of care
2. Create an exceptional patient experience
3. Provide effective care transitions
4. Be an exceptional workplace

QHC's corporate quality improvement goals for 2016/2017 which aim to support our strategic plan and directions are:

1. Create an exceptional patient experience for every patient
2. Improve the work experience for staff, physicians and volunteers

Over the course of the next year QHC will continue to build on the initiatives from 2015/2016 Quality Improvement Plan to further enhance the quality and safety of care and services delivered at all four hospitals. The hospital's overall quality improvement agenda, of which the 2015/2016 QIP is a subset of, has been built on clear priorities, leadership accountability, process improvement methodology, setting measurable & achievable targets, and establishing action plans.

In order to support these priorities, QHC will strive to further improve the capacity of the organization's quality agenda through:

- Strengthened reporting processes to the Program-based Advisory Committees,
- Enhanced process improvement capacity,
- Continuation of the Human Resources talent management plan focused on leadership development and capacity building, and
- Participation in joint process improvement projects with key South East (SE) LHIN partners such as the six regional hospitals, Community Care Access Centre, Family Health Teams, Community Health Centres, and Health Links.

By March 31st 2017, QHC will achieve the following aims and measures indicated on our 2016/2017 QIP in alignment with our four strategic directions.

QI Achievements From the Past Year

Enhance the quality and safety of care

Our aim is to improve the overall safety of care we deliver to our patients. QHC has, over the past 2-3 years, focused on several key areas of improvement, specifically:

1. Medication Reconciliation
2. Senior's Care
3. Interprofessional Patient Care Team

Medication Reconciliation

Medication reconciliation is one strategy that contributes to the safe prescribing and administration of medications and thus safer care. Increasing the number of admitted patients with completed medication reconciliation on admission has been a corporate priority for the past four fiscal years.

This fiscal year we completed the implementation of electronic medication reconciliation software in all four of our hospitals. This software has increased our ability to perform medication reconciliation subsequently allowing us to exceed our 2015/2016 performance target in Q2 and Q3. QHC will continue a corporate focus on increasing the number of admitted patients receiving medication reconciliation as required by Accreditation Canada by 2019. The full implementation of an electronic medication reconciliation program will provide a more efficient process and provide the necessary processes to complete medication reconciliation at transfer and discharge.

Senior's Care

QHC has experienced a shift in the patient demographics, notably in the past four years. In 2014, it was noted that the average age of patients has increased from 69.3 years to 70 years over the previous two fiscal years, including a 7% growth in the number of patients who are over 90 years old. This population has an increased need for health care services, as shown by their average total length of stay of 20 days compared to less than 5 days for patients less than 60 years of age. The number of patients with 2 or more co-morbidities (concurrent diseases) has more than doubled in the past 3 years, and the proportion of patients who required home care support post discharge has grown considerably from 15% to 31%.

As well, the number of patients with dementia and other behavioral issues is increasing as the elder population grows. This group of patients presents a unique challenge in discharge planning as many families are ill-equipped to care for them at home and long-term care homes have few secure beds to offer a safe environment. Therefore, the number of these patients tends to grow within hospitals as there are few options for discharge.

Evidence demonstrates that the needs of frail elderly patients are best met in an environment where they are encouraged to maintain their independent functionality, that is, the ability to mobilize and meet needs for activities of daily living such as toileting, grooming and dressing. It is estimated that an elderly patient loses up to 5% of their functionality for every day they are bedridden. Other studies have found that for every day that a frail elderly patient remains in hospital, they require a month of rehabilitation if there is no focus on maintenance of functionality.

To address this challenge QHC has developed a plan for 2016/17 that meets the specific care needs of this seniors population with a seniors' care strategy that will also support financial efficiencies.

Seniors care is a strategy to focus our resources on the specific needs of this population, created through the implementation of interprofessional staffing models of care delivered by teams with specialized knowledge and skill. In addition, QHC recently received NICHE designation, specifically 'Nurses Improving Care for Heathsystem Elders'. This designation will enable up to 160 QHC staff and physicians to complete 3-days of interprofessional clinical training related to elder care, as well as provide bi-monthly webinars open to all staff focused on specific issues that relate specifically to the needs of seniors.

Positioned well with the recent shift to interprofessional staffing models and achievement of NICHE designation, QHC will open an Acute Care for the Elderly (ACE) unit at the Belleville General Hospital in April 2016 and maintain a strong focus on the appropriate use of the regional-Behavioural Support Transition Unit (BSTU).

This robust senior's strategy couples the creation of two key senior-focused units with wide-spread interprofessional clinical training in senior's care. As QHC develops senior-friendly processes and environmental designs for the ACE & BSTU units, key learnings will be rolled out to all acute care areas over time. The physical environmental changes will be guided by the recommendations from the Senior Friendly Hospitals framework created by the Regional Geriatric Program of Toronto. It is anticipated that this will positively impact the percent of ALC across QHC and Emergency Department (ED) wait times.

The Seniors Care Strategy was developed to focus on the needs of the acute frail elder patients and those who are behaviorally challenged. The strategy will:

- Improve quality of care, including reduced pressure ulcers and catheterization rates;
- Reduce the length of stay and loss of functionality of acutely ill frail elders that frequently leads to conversion to alternate level of care for long-term care (ALC LTC);
- Provide appropriate care for elders with significant behavioral challenges that prohibit discharge; and
- Reduce costs.

Interprofessional Patient Care Teams

In 2015-2016, QHC embarked on a significant staff restructuring process on the clinical units to better align patient care needs with the right skill mix and number of staff as well as an ambitious adoption of new patient-centered care processes across all units, including the Emergency Departments. This plan saw the introduction of Personal Support Workers (PSWs) on most units to increase the staff:patient ratio and ensure patients' daily needs, such as mobilization, are met in an effort to reduce hospitalized deconditioning, increased length of stay, and increased ALC conversion. This plan also saw the introduction of four patient-centered care processes:

1. shift handover at the bedside where staff have the opportunity to discuss a person's plan of care with the person and his/his family;
2. purposeful hourly rounding to proactively meet patient's needs;
3. enhanced use of patient-specific wall-mounted communication boards to enhance communication between patients & families and their care teams; as well as,
4. enhanced processes for planning of discharge that begin at the time of admission.

The implementation of Interprofessional Patient Care Teams was phased in unit-by-unit over most of 2015-2016, with the remaining three units scheduled for implementation in Q1 of 2016-2017.

Create an exceptional patient experience

Our aim is to create an exceptional patient experience through seamless patient flow and reduced wait times in the Emergency Department (ED). QHC measures the amount of time patients wait in our EDs from the time the patient is triaged to the time they are either discharged home or admitted to the hospital and moved to an inpatient bed. Extended lengths of stay in the ED are a common and significant issue for most Ontario hospitals and require multiple years of work to significantly impact. ED wait times have consistently remained high since Q1 of 2014-2015. Factors contributing to these wait times include access to inpatient beds as a result of overcapacity across the organization, increased acuity, and increased ALC length of stay. QHC will continue to implement focused improvement projects led by emergency and inpatient staff and physicians to further reduce emergency wait times in 2016/2017.

In order to achieve a reduction in our ED wait times we will focus on several improvement strategies including:

- Daily monitoring of site specific PIA times and evaluate against a target of 3.9 hours at BGH and 2.8 hours at TMH.
- Report PIA times to physicians.
- Review the model of care delivery for BGH ED.
- Refine Medicine Program processes for predictive dates of discharge, proactive identification of discharge barriers, and monitoring physician length of stay data.
- Monitor daily the time span from 'decision to admit' in the ED to 'admission to inpatient bed' for all inpatient units.
- Enhance planning for discharge processes on all inpatient units.

Provide effective care transitions

Our aim is to ensure that we are consistently seeking integration opportunities with our community partners so that patients experience effective care transitions within QHC and between QHC and other health care providers. This will result in patients and their families finding it easier to move through the healthcare system and access to the care they need. We will continue to focus on increasing the availability of inpatient beds by reducing the number of patients with chronic obstructive pulmonary disease (COPD) who are readmitted to hospital 30 days after discharge. Further integration and uptake of clinical pathways for COPD are essential to our success as they include the various health care services (acute and community) that patients with these conditions require to optimize their ability to manage their own care. Across the SE LHIN, all acute care organizations and the SECCAC are committed to working together to improve care and services for those with COPD. In addition to the COPD patient population, we will also focus on ensuring all in-patient medicine patients are cared for using the general medicine or diagnosis specific admission order sets; providing a standard of care for patients leading to improved efficiencies and meeting expected length of stay goals.

Be an exceptional workplace

Our aim is to provide an exceptional workplace at QHC where staff, physicians and volunteers are proud to recommend QHC as a place to work. This involves providing opportunities for all to learn and grow. QHC will provide enhanced access to educational opportunities in 2016-2017 through the creation of an annual education calendar, shared clinical education resources, and simulation training for high-risk clinical activities. In 2015-2016, QHC implemented a Critical Care Response Team (CCRT) to support physicians and direct care teams assess and care of patients with immediate critical care needs. While this team is currently funded and located only at the Belleville General Hospital, a pilot plan to expand services utilizing videoconferencing, via the Ontario Telemedicine Network, is underway.

Integration & Continuity of Care

With the continued roll-out of the Health Systems Funding Reform (HSFR) all members of the health care system are becoming more reliant on each other's services. In order to maintain the provision of safe, high-quality care within the current financial pressures, we continue to review the services we provide and rely more on our partners to provide the care at home or in other health care settings. We are most dependent on the Community Care Access Centre (CCAC) to provide services to assist in timely, efficient discharge; primary care to support the diversion of patients from the emergency rooms and support the transition of patients out of the hospital; and other hospitals and community agencies to provide specialized care. In 2015-2016, QHC in collaboration with the SECCAC and the SE LHIN, implemented an Integrated Community Assessment and Referral Team (iCart). This initiative is a proactive approach to streamline access to community-based services for the high-risk senior population. The anticipated outcomes include a decrease in unnecessary ED visits, a decrease in demand for Long Term Care Home beds and an increase in utilization of community-based services. Strengthening the use of the iCART program across QHC will remain a goal in 2016-2017.

As exemplified above, QHC believes that relationships with primary and community care partners are key to achieving health for all our communities. This is reflected in the QHC strategic plan and direction to "improve transitions of care".

QHC is an active partner in two Health Links initiatives, Rural Hastings and Quinte Health Links. The priorities of each of these health link initiatives support QHC's strategic directions in meeting needs of complex patients and decreasing readmissions for patients with chronic obstructive pulmonary disease, congestive heart failure and pneumonia in particular. In 2016-2017, QHC along with all other SE LHIN acute care hospitals and SECCAC have jointly agreed to focus on improving care pathways for persons with COPD and enhancing care within & across sectors.

Engagement of Leadership, Clinicians and Staff

Our aim is to provide an exceptional workplace at QHC where staff, physicians and volunteers are proud to recommend QHC as a place to work. This involves providing opportunities for all to learn and grow. Part of our success in achieving this objective in 2014-2015 and 2015-2016 was through the involvement and active participation of staff, physicians and volunteers in the improvement initiatives. In 2015-2016, 28 direct care and support teams across the organization were asked to identify improvements in their work flow or processes. The goal of this priority is to engage the minds and creativity of staff and physicians leading to improved quality of care & patient satisfaction, as well as physician, staff & volunteer satisfaction.

In 2016-2017, a renewed focus on LEAN methodology and Four Disciplines of Execution will be launched particularly focused on the Belleville General Hospital Emergency Department and Acute Medicine units.

Patient/Resident/Client Engagement

The QIP was developed with feedback from front line staff, physicians, and most importantly members of the Board of Directors and Advisory council. Trends identified through the Patient Relations office were reviewed to inform indicator selection. Throughout the year QHC provides regular progress reports on the QIP indicators to the Quality Committee of the Board and the Board of Directors.

Performance Based Compensation [part of Accountability Mgmt]

The QIP comprises one element of QHC's overall quality agenda. Other key quality drivers for QHC and its Board of Directors in 2016-2017 are to reach out to our patients & families to learn more from their lived experience, to embed the science of quality improvement broadly across the organization to all teams and individual staff & physicians, and to be fiscally responsible. The table below defines the indicators and targets as set out by QHC's Senior Leadership Team and Board of Directors.

Strategic Direction	Priority/ Initiative	Outcome Measure/ Indicator	Weight	Current Performance	2016/17 Target
Create an Exceptional Patient Experience	Reduce ED lengths-of-stay	**ED Length-of-Stay:** % patients meeting provincial target for time in the ED based on acuity (CTAS 1,2,3=8hrs CTAS 4,5= 4hrs)	20%	87%	90%
	Measure patient experience	**Patient Experience**: 20 patient care areas each complete 60 real-time patient surveys in Qtr. 4 (average of 20 per month in Qtr. 4)	20%	N/A	20 teams in Qtr.4
Provide Effective Care Transitions	Reduce unnecessary readmissions	***Readmission Rate:** Readmission within 30 Days for Selected HBAM Inpatient Grouper	20%	16.2%	15.4%
Be an Exceptional Workplace	Improve staff and physician engagement	**Engagement:** 28 teams implement 12 improvements each in 2016/17	20%	28 teams implemented 3 or more improvements in Qtr.4	28 teams
Improve Strategic Enablers	Improve organizational financial health	**Become More Cost Efficient:** Cost per weighted case	20%	TBD	TBD

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan.

Tricia Anderson
Board Chair

Odila Hoye
Quality Committee Chair

Mary Clare Egberts
Chief Executive Officer

To:	QHC Board of Directors
From:	Odila Hoye, Chair of the Quality of Patient Care Committee
Subject:	2016/17 Senior Leadership Team Goals Linked to Compensation
Date of Meeting:	March 22, 2016
For:	Decision
Motion:	***That the QHC Board of Directors' approve the 2016/17 Performance Goals Linked to Compensation as pay-for-performance as per the Excellent Care for All Act and their inclusion of the Quality Improvement Plan.***

Performance Goals

- As part of the annual planning process, the Senior Leadership Team (SLT) develops performance goals linked to compensation that are derived from the QHC strategic directions and initiatives or other key performance areas important to QHC success.
- For 2016/17, SLT has identified five strategic goals to be linked to compensation as identified in the attached document. These goals are aligned with the four Strategic Directions plus the strategic enabler of a balanced budget. These goals were identified by reviewing those initiatives that are part of the operating plan and were identified by SLT as the key strategies necessary for success. In addition, SLT considered the draft QIP that will be reviewed by Quality of Patient Care Committee;
- As per the requirements under Excellent Care for All Act (ECFAA) legislation, there must be a linkage between the QIP performance goals and Senior Leadership Team compensation and these goals will be included in the QIP that was reviewed and approved by Quality Committee at their March 8th meeting;
- As a reminder, pay-for-performance is paid above base salary for achieving the annual targets. The QHC SLT compensation plan is in keeping with all legislative requirements. Current Public Sector Salary Restraint legislation dictates that the total pay-for-performance envelope available to the Senior Leadership Team cannot be increased from the amount paid out in 2011/12.

To:	QHC Board of Directors
From:	Dr. Dick Zoutman, Chief of Staff
Topic:	Report of the Chief of Staff & Medical Advisory Committee
Date of Meeting:	March 22, 2016
For:	Information

Since my last report in January, the Medical Advisory Committee (MAC) has met twice, in February and in March.

Quality Improvement
The MAC top 3 priorities of consultant physician rounding schedules in the ED, in-patient ward rounding timing, and response time of consultants to see cases in the ED has been successfully addressed in a policy approved at the March MAC. We will be monitoring the application of these best practices to ensure their application and adjustment as needed to meet the needs of our patients. I am grateful for the tremendous support of the MAC on this issue.

With the endorsement of the MAC, QHC Decision Support has developed a robust dashboard on ED and consultant response times that will be sent regularly to our Medical Department Chiefs to allow close monitoring and continuous improvement.

I am very excited that we are embarking upon a process improvement journey with Breakthrough Horizons at QHC. We are holding a special evening meeting for the medical staff March 21 to introduce the Physicians to Mr. Mike Elias who is our lean coach (sensai). As we go forward it will be critical to have continuous physician input into our ongoing quality improvement activities. Having the understanding, tools and capacity to bring about sustained improvement in our work is very liberating to all front line providers.

Physician and Professional Staff Wellness at QHC
Being part of a helping profession also requires that we help one another. The fast pace and many challenges of medical practice can induce considerable stress in the work and private life of physicians.

<u>Some facts are:</u>

- 66% of QHC physicians feel burnout currently or have in the past year
- Most QHC physicians say their job is stressful - with 67% of the physicians saying their job most days is somewhat stressful, 23% quite stressful, and 5% extremely stressful (only 4% say their job is not at all stressful)
- Most QHC physicians (59%) work more than 40 hours per week, with some working in excess of 80 hours per week
- 84% of QHC physicians believe there is a link between their wellness and the care that is provided at QHC (all figures above from a survey in September 2015 sent to all QHC physicians, with 73 respondents)
- For the Physician Wellness Workshop with Dr. Mamta Gautam we had over 30 physician share suggestions for how QHC could help support their wellness through this program

Concerning women in medicine:

- 34% of QHC's physicians are women.
- The stresses faced by women doctors mean that rates of successful suicide and divorce are much higher than in the general public (Toronto study).
- Despite the increased number of women physicians in the work force, the experiences and challenges faced by these women have not evolved during the past 30 years. Women continue to experience the strain of their dual role as women and as physicians, discordance between career and lifestyle choices, difficulties with timing pregnancies, and some negative attitudes and behavior in the workplace (study of south-western Ontario female physicians).

Because QHC places such a high value on the work life and wellness of all who are part of QHC one of our Wildly Important Goals is to improve the work experience for staff, physicians and volunteers.

My office is supporting a 2 day Physician Wellness Workshop featuring Dr. Mamta Gautam, a specialist in physician mental health and wellness on April 2 and 3. We have had a large positive response to this event and are very much looking forward to a productive two days.

To further advance physician and professional staff wellness we will be conducting a survey of our medical staff to assess the issues that mater most to them in their work life at QHC. This information will be essential as we strive to build ever stronger engagement of our medical staff in the mission and work of QHC.

Medical and Professional Staff Leadership Role Changes:
I am pleased inform you that Dr. Andrew Pickle will be assuming the role of Division Head for Orthopaedic Surgery as of March 1st. Dr. Pickle is a highly respected member of the medical staff and has been in this role previously.

Respectfully submitted,

Dick Zoutman, MD, FRCPC
Chief of Staff

To:	**QHC Board of Directors**
From:	**The Medical Advisory Committee (MAC)**
Subject:	**Recommendations Report**
Date of Meeting:	**March 22, 2016**
For:	**Decision**
Motion:	**That the QHC Board of Directors appoint Dr. Andrew Pickle as Division Head of Orthopaedic Surgery in the Department of Surgery as recommended by the Medical Advisory Committee (MAC) on March 15, 2016.**

Recommendation for new Division Head

Dr. Andrew Pickle has been nominated by the membership of his Division. His appointment is effective March 1, 2016.

It was moved by Dr. Sean McIlreath and seconded by Dr. Chris Perkes that the MAC recommends to the Board of Directors that Dr. Andrew Pickle be appointed as Division Head of Orthopaedic Surgery in the Department of Surgery effective March 1, 2016 as recommended by the Medical Advisory Committee on March 15, 2016.

To:	QHC Board of Directors
From:	Karen Baker, Treasurer and Chair of the Audit and Resources Committee
Subject:	January 2016 Financial Statements
Date of Meeting:	March 22, 2016
For:	Decision
Motion:	***That the QHC Board of Directors' approve the January 2016 financial statements.***

Year-to-Date (YTD) January 2016 Financial Results

YTD results for the ten months ended January 31, 2016, show a surplus of $29K. This is a positive variance of $289K to the budgeted deficit of $260K.

The month of January was a busy month, with in-patient activity exceeding both budgeted and prior year levels in most units and across all 4 hospitals. Despite the incremental volumes and ongoing labour challenges (sick, overtime and staff shortages), the salary and benefit costs for the month remained on track.

QHC has now received the formal funding letter for fiscal 2015/16. The amounts are consistent with those previously provided by the SE LHIN. We have also recently received an additional funding letter from the SELHIN for further alleviation funding of $500K. This brings the total alleviation funding reported in the Ministry of Health – One Time line for fiscal 2015/16 to $4M.

Significant variances that have contributed to the January 2016 results are outlined below:

Revenue

Ministry of Health - Global and Ministry of Health – One Time – negative variance of $393K. (These two lines are combined as a large component of the variance in each category is the Cancer Care Ontario carve out for surgeries that has moved the allocation from global to one-time funding). The variance on these lines is also largely driven by the following:

- New Grad Initiative ($281K) – This is a program that funds the training of newly graduated nurses. YTD we have not had any participants in the program. As we have not had any participants we will not receive the originally budgeted revenue.
- Behavioral Support Transition Unit ($117K) – Given the low occupancy on the unit, actual salary and benefit costs are less than budget. The associated revenue received for this labour that has not been utilized has been deferred to QHC's Balance Sheet.

Recoveries & Other Revenue – positive variance of $544K. The largest driver of this variance is:

- Workplace Safety & Insurance Board (WSIB) NEER (New Experimental Experience Rating) rebate $373K. This had been budgeted as a $600K penalty in the Undistributed Expenses category.

Expenses

Compensation – Salaries – negative variance of $40K

- Note that although this is a small variance, there are significant large offsetting positive and negative variances that reflect the ongoing over capacity, sick and overtime issues (BGH medicine, ICU and emergency) and severance payments.

Drugs & Medicine – negative variance of $622K. The primary drivers of this variance are:

- Oncology drugs ($352K). There is incremental revenue of $267K from Cancer Care Ontario to offset these drug costs included in the Ministry of Health – One -time revenue.
- Increased drug costs on units experiencing over capacity (BGH medicine, ICU and surgical units of $180K).

Supplies & Other Expenses – negative variance of $466K. The most significant driver of this variance is:

- Utilities ($272K). Hydro costs are the primary driver of this variance.
- The remaining variance is a result of differences in US exchange rates, updates to our licensing with Microsoft and unspent funds from physician recruitment.

Undistributed Expenses – positive variance of $599K.

- The driver of this variance is the NEER penalty that was budgeted for $600K. As noted above, QHC received a rebate in the amount of $373K that has been reported in Recoveries & Other Revenue.

Balance Sheet

The current ratio at January 31, 2016 is 0.77. The total margin at January 31, 2016 is 0.02%.

Forecast

We are currently forecasting a small surplus of $56K at year-end. The recent announcement of the additional $500K of alleviation funding has impacted the forecast presented at the last committee meeting.

The attached forecast includes the following variables:

- Continued over capacity
- Financial statement recognition of funds held with Canadian Medical Equipment Protection Plan (CMEPP)
- Reversal of accrued benefits on vacation accruals
- Outstanding severance payments related to March 2015 staff planning
- Expected shortfall in revenue from Cancer Care Ontario for oncology program

To:	QHC Board of Directors
From:	**Karen Baker, Treasurer and Chair of the Audit and Resources Committee**
Subject:	**Magnetic Resonance Imaging (MRI) Upgrade**
Date of Meeting:	**March 22, 2016**
For:	**Decision**
Motion	***That the QHC Board of Directors' approve the upgrade of the current MRI machine at an approved cost of $1.015M.***

Issue
The MRI machine at the Belleville site is 8.5 years old and nearing end of life. Industry expected MRI replacement cycles are at the 9 to10 year point based on image quality degradation and technology enhancements. The MRI request was brought forward during the 2016/17 capital planning process. Additional review was required to assess the appropriate course of action and it was agreed that this request would be tabled separately from the 2016/17 capital plan. It has now been determined that we need to upgrade or replace the MRI machine within the 2016/17 fiscal year.

Background
The diagnostic and radiologist imaging teams consisting of operational management and staff have met to consider the options of an upgrade of the current machine versus purchasing brand new.

Options Considered:

Consideration	Upgrade of current machine	New machine
Cost of unit	$990,000	$2M plus
Renovation cost	$25,000	$150-200K
Performance of technology	1.5T Siemens technology, Excellent past performance	1.5T or 3T technology available at time of purchase
System downtime (service would have to be referred to KGH)	2-3 weeks	2-3 months
Machine status	All working parts replaced except for magnet	Everything is new including magnet
Machine capability once upgraded or replaced	All latest software and hardware as per factory delivery of a new machine is provided	New machine with latest software and hardware
Clinical impact	Improved image quality and faster scanning times; Enhanced imaging including prostate MRI, breast MRI, improved spine and extremity imaging, ability to diagnose smaller and smaller abnormalities	Same as upgrade
References	Princess Margaret Hospital, Toronto General Hospital, Sick Kids Hospital and 3 hospital sites in Calgary have all successfully and happily upgraded their MRI machines	N/A

Risks and Mitigation

Downtime to perform equipment upgrade will impact service access. Patients will need to go elsewhere for high priority MRI exams. This will be arranged well in advance with Kingston General Hospital. It should be noted that the upgrade plan will cause significantly less MRI downtime versus a new replacement machine. The upgrade downtime will not exceed 2-3 weeks versus 2-3 months for a new machine including major renovations.

Possible or perceived risk related to possibility getting less updated features with an upgraded machine vs a new machine. The project team has carefully reviewed this issue and is convinced based on other large provincial sites that have upgraded their MRIs that this is not an issue and that the upgrade will substantially provide features comparable to new machines.

Proposed Funding

QHC management will be approaching the three foundations and the North Hastings Fund Development Committee (NHFDC) to fund the MRI based on usage. The approximate request for each foundation is BGHF $454K; TMHF $363K; PECMF $162K and NHHFDC $36K

Recommendation

It is the view of the diagnostics and radiologist imaging teams that an upgrade of the current machine is the best course of action and a solid investment solution.

The Audit and Resources Committee recommends proceeding with the upgrade of the current MRI machine in the last quarter of fiscal 2016/17. This will save up to $1M in capital expenditure for the machine itself. It will also save approximately $150-200K related to renovations that would be required to install a new machine. Our recommendation will bring the current MRI to the most current technology and the new features will significantly improve patient care.