BOARD OF DIRECTORS
OPEN SESSION MINUTES

Thursday, February 8, 2018 at 4:00 p.m.
South Muskoka Memorial Hospital Boardroom
Approved March 8, 2018

PRESENT:				*(T) denotes participation via teleconference*
Elected Directors:	Evelyn Brown	Philip Matthews	Brenda Gefucia	Moreen Miller
	Don Eastwood(T)	Beth Goodhew	Frank Arnone	Christine Featherstone
	Bob Manning(T)	Michael Walters		
Ex-Officio Directors:	Dr. Dave McLinden	Natalie Bubela	Dr. Biagio Iannantuono	Esther Millar
Executive Support:	Tim Smith	Harold Featherston		
Staff Resource:	Tammy Tkachuk			
Guests:	David Batten, SMMH Auxiliary Donna Denny, Patient & Family Advisory Committee Chair Debbie Provan, Patient & Family Advisory Committee Member Bev Leslie-Suddaby, Manager, Support Services			
REGRETS:	Cameron Renwick	Dr. Anthony Shearing	Kathy Newby	Robert Alldred-Hughes

1.0 CALL TO ORDER

With a quorum present, the Board Chair, Evelyn Brown called the meeting to order at 4:01 pm.

1.1 APPROVAL OF AGENDA

It was moved, seconded and carried that the meeting agenda be approved.

1.2 DECLARATION OF CONFLICT OF INTEREST

Directors were reminded that conflicts of interest are to be declared for any agenda items and the Director is to excuse him/herself from the meeting for the duration of the discussion. Upon review of the agenda, there were no conflicts of interest declared.

1.3 PATIENT STORY

To provide context for the patient story, Esther Millar reminded the Board of the current challenges facing staff related to the impacts of consistently high occupancy, and rising Alternate Level of Care patients. A letter from a patient was read aloud where a patient expressed his gratitude with the recent care received at the South Muskoka Memorial Hospital Site. The patient noted the difficult times facing the hospital and communicated that in spite of those challenges all staff and physicians he encountered were happy and provided exceptional care.

1.4 PATIENT & FAMILY ADVISORY COMMITTEE

Evelyn Brown introduced representatives from the Patient and Family Advisory Committee – Donna Denny, Chair, Debbie Provan, Member and management support Bev Leslie-Suddaby, Manager of Support Services. Donna Denny outlined the recruitment process undertaken to form the 10 member Committee and explained that one of the mandatory criteria for the members is to be a patient or a family member of a patient at MAHC. Members are expected to provide their input from the patient perspective into recommendations, processes, and changes. Over the past year the Committee has been involved in discussions related to the patient entertainment system, the corporate menu, grief and dying brochure, Quality Improvement Plan, Patient & Family Handbook, Family Presence Policy, Patient Feedback policy, Leader Rounding initiative, a pictorial resource booklet and the Med-AID policy. They have also received a number of presentations from management on various topics including the patient whiteboards, MAHST, MAHC Facebook, order sets, stroke education clinics and ethics. Ongoing agenda items for the Committee include Accreditation, medication reconciliation, patient feedback, leader rounding, patient satisfaction, and real time surveying options. For the coming year focus will continue on these items as well as building health literacy and MAHC literacy in the community, developing patient experience community of practice, mental health and patient

advisors. Bev Leslie-Suddaby and Debbie Provan each provided comments with respect to the positive impact that the Committee has had since its inception. The floor was open for question. It was explained that the membership of the Committee has a Muskoka-wide reach including Severn, Huntsville, Gravenhurst and Bracebridge. There is one vacancy at this time, and potential upcoming vacancy. Board members were encouraged to refer any interested community members to submit an application. The Chair thanked the presenters.

Donna Denny, Debbie Provan, and Bev Leslie-Suddaby left the meeting at this time.

2.0 REPORTS

2.1 CHAIR'S REMARKS

Evelyn Brown updated the Board of Directors regarding the presentation to the District of Muskoka's Corporate and Emergency Services Committee on January 19, 2018. The purpose of the presentation was to demonstrate the urgent need to engage Council and the Community with respect to supporting capital needs financially both today and in the future. The presentation was provided by Phil Matthews and set out three points for consideration - current and immediate infrastructure needs, affordability and community acceptance. The physical condition of MAHC's facilities was reviewed and it was impressed upon the Committee the magnitude of the potential local share required for future redevelopment plans; the range of costs from $84-114 million based on the local share of the 2015 models. The Committee was urged to create a 15-year reserve fund to generate the community share to demonstrate a commitment toward future redevelopment. In terms of community acceptance, it was pointed out that in the fall survey results showed favourable support of financial support through taxation. The Board was informed that they were treated very respectfully and after the presentation, the committee asked questions of clarification. Since the presentation there has been fair and accurate media coverage and there have been a few opinion pieces that are unfortunately misrepresenting aspects of the presentation and fueling speculation. The Board was assured that there was no mention of a preferred model and the statement to "build a major asset we don't have right now" has been taken out of context and interpreted more literally than it was intended. Board members were encouraged to view the webcast from the meeting that is archived on the District's website. It was also explained that discussions regarding local share have been ongoing since 2012. Discussion ensued and it was explained that the Ministry definition of the local share is 10%; however the community is also responsible for all furnishings and equipment that equates to approximately 14%. It was suggested that the communications plan needs to incorporate clarifying this as well as the inaccuracies.

2.2 REPORT OF THE CHIEF EXECUTIVE OFFICER

The February report of the Chief Executive Officer was received for information. In addition to the report, the CEO informed the Board that Dr. Roger Strasser, Dean of the Northern School of Medicine highlighted the significant efforts of the Huntsville Local Education Group in a broadcast email. The Minister of Health and Long-Term Care has corresponded with each Local Health Integration Network outlining that the government will continue to support the investments for increased bed capacity through the 2018/19 fiscal year; there are no further details available regarding this support or impact on MAHC at this time. It has also been announced that the legalization of cannabis could be delayed.

3.0 ENSURE PROGRAM QUALITY & EFFECTIVENESS

3.1 REPORT OF THE CHIEF OF STAFF & MEDICAL ADVISORY COMMITTEE

The February report of the Chief of Staff and Medical Advisory Committee was received. There were no questions arising from the report.

3.2 BALANCED SCORECARD, Q2 RESULTS

On behalf of the Quality & Patient Safety Committee, Beth Goodhew presented the pre-circulated Balanced Scorecard and informed the Board that the Committee reviewed in depth medication reconciliation on discharge and readmissions. A new electronical module is expected to be implemented in March that will provide more accurate tracking related to medication reconciliation on discharge. As well it was explained that the wide variability with respect to the readmission targets is often the result of having low n's therefore the Committee has requested management include the n's in future reports. A question was raised with respect to having the Patient and Family Advisory Committee review and provide feedback on patient satisfaction; it was explained that they participated in an education in January and will be brainstorming around this topic with the intent of providing feedback to the senior leadership team. It was noted that the past year for patient satisfaction was around establishing a baseline and this in

the new Quality Improvement Plan a new target will be set. As well, it was highlighted that MAHC continues to perform better than peers on this metric. Management is also in the process of establishing an improved action plan that ensures the appropriate Committees are receiving the verbatim comments in order to develop more robust action plans that will provide a positive impact on these results. The results of the wait time metric were noted, and praise was expressed to staff and physicians regarding these results in spite of the increasing Alternate Level of Care numbers.

3.3 Clinical Services Resources Plan

Beth Goodhew presented the Clinical Services Resources Plan and explained that the Quality & Patient Safety Committee discussed the area of Family Physicians. This is an area that is challenging to clearly outline given that the number of bodies is not equivalent to the service provide as not all practice at full time capacity. This is an area that will continue to be worked on and refined. It was also highlighted that the Plan reflects resources for both the Hospital and the Community.

It was moved, seconded and carried that the Clinical Services Resources Plan be approved.

3.4 Credentialing Policy Review

Upon review of the recommendation to remove the requirement for professional staff to attach details of their continuing medical education in the re-appointment process, it was explained that the requirement was often a barrier to completion of the MAHC application as the timing to submit the information to the College occurred after MAHC's timeline. Discussion ensued with respect to ensuring that submission to the Colleges are occurring and it was requested that the Medical Affairs office conduct a random audit of every fifth application to confirm that the professional staff member has in fact submitted the required CME to the respective College.

It was moved, seconded and carried that the requirement for professional staff to attach details of their CME for the past year be removed from the Re-Application for Privileges form.

4.0 CONTRIBUTE TO STRATEGIC DIRECTION

4.1 Capital Plan Development Task Force

The pre-circulated report of the December 11th and January 15th meetings, Natalie Bubela informed the Board of the public consultation event scheduled for March 1, 2018. The purpose is to ensure members of public have an opportunity to speak to Task Force before finalizing its recommendation. The event will take place in the District Chambers and will be live streamed. Directors were encouraged to attend as well. The Board was also reminded of the workshop scheduled for February 27, 2018. Further workshops are being planned for March.

4.2 Annual Strategic Assessment

Natalie Bubela presented the recommendation to remove Strategic Objective 5 given that the activities will be encompassed into Strategic Objective 7. The Board was assured that management will continue to develop its current partnerships with learning institutions. Upon review by the Strategic Planning Committee there was support for the recommendation. There were no questions from the floor.
It was moved, seconded and carried that Strategic Objective 5 – Strengthen and leverage existing partnerships with learning institutions be remove for Year 4, 2018/19

4.3 2015-2018 Strategic Plan Status Report – Year 3, Q3

The Year 3, third quarter Strategic Plan Status Report was received. There were no questions from the floor.

5.0 ENSURE FINANCIAL VIABILITY, IN ACCORDANCE WITH THE STANDARDS APPLICABLE TO THE DIRECTORS AT LAW

5.1 Financial Results

Brenda Gefucia presented the year-to-date December 31, 2017 financial results and explained that volumes continue to exceed budget as it relates to inpatient and at the end of December the organization is reporting a $124k surplus. It was also noted that the two most recent funding announcements have not yet been recognized in these results as the funding has yet to flow to the organization. Expenses continue to trend consistent with past months. The patient

receivables are lower than 2016 but are higher than the beginning of the year. There have been higher than usual out of country patients. In terms of the Line of Credit, it was clarified that the e additional $3.5 million is a considered a demand loan from the bank, and is shown as such on the balance sheet. Any draws on our line of credit would show separately from this amount, and would need to be added together to arrive at our total borrowings.

It was moved, seconded and carried that the Financial Results Year To Date December 31, 2017 be approved.

6.0 CONSENT AGENDA

It was moved, seconded and carried that the following items be approved or received as indicated:

- ***6.1 Approval of the Board of Director Meeting Minutes from January 11, 2018***
- ***6.2 Receipt of the Quality & Patient Safety Committee Report of January 25, 2018***
- ***6.3 Receipt of the Clinical Research Report***
- ***6.4 Receipt of the Strategic Planning Committee Report of January 24, 2018***
- ***6.5 Receipt of the Resources & Audit Committee Report of December 22, 2017***
- ***6.6 Receipt of the Compliance Report for December 31, 2017***
- ***6.7 Receipt of the Nominations Committee Report of January 19, 2018***
- ***6.8 Approval of the Nominations Committee Work Plan for 2017/18***

7.0 ADJOURNMENT

It was moved that the open session be adjourned at 5:28 pm and the Board of Directors proceed into the in-camera session following a short recess.

Evelyn Brown, Chair

Natalie Bubela, Secretary