BOARD OF DIRECTORS

OPEN SESSION MINUTES

January 9, 2014 at 5:30 p.m.
Huntsville District Memorial Hospital Boardroom
Approved February 13, 2014

PRESENT:

Elected Directors:	Larry Saunders	Charlie Forret	Philip Matthews	Evelyn Brown
	Donna Denny	Christine Featherstone	Gregg Evans	Joe Swiniarski
	Catherine King	Cameron Renwick	Eric Spinks	
Ex-Officio Directors:	Dr. Jan Goossens	Dr. Steven Herr	Bev McFarlane	Natalie Bubela
	Dr. K. Kents			
Executive Support:	Tim Smith	Vivian Demian	Harold Featherston	Robert Alldred-Hughes
Resources:	Tammy Tkachuk			

REGRETS: Kevin King

1.0 CALL TO ORDER

With a quorum present, the Chair, Larry Saunders called the meeting to order at 1729 hours.

1.1 APPROVAL OF AGENDA

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

1.2 DECLARATION OF CONFLICT OF INTEREST

Upon review of the agenda, there were no declarations of conflict of interest declared.

1.3 EDUCATION SESSION - MORE^{OB} (MANAGING OBSTETRICAL RISK EFFICIENTLY) PROGRAM

Bev McFarlane introduced Anne Handley and Shelly McMurray, both Registered Nurses, part of the core team that is implementing the Managing Obstetrical Risk Efficiently Program. It was explained that MORE^{OB} is a three-year patient safety, professional development and performance improvement program that addresses risk and patient safety issues in birthing units. The mission of MORE^{OB} is to develop effective teamwork and communication, embrace learning, knowledge sharing and evaluation, and promote collaboration with trust and respect. The program aims to improve patient safety and create a consistent level of care among obstetrical staff through standardized procedures and care pathways, while fostering intense collaboration and open relationships between all obstetrical team members including physicians, midwives and nursing.

Anne Handley and Shelly McMurray left the meeting at 1740

1.4 CHAIR'S REMARKS

The Chair thanked staff, physicians and volunteers for efforts over last several weeks with the various challenges presented included poor winter weather conditions, power failures and the increased volumes.

2.0 CONSENT AGENDA

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

- ***2.1 Approval of the Minutes from December 17, 2013***
- ***2.2 Receipt of the Governance Committee Report***
- ***2.3 Approval of the revised Board Agenda Development & Use of Consent Agenda Policy***
- ***2.4 Receipt of the Quality & Patient Safety Committee Report***
- ***2.5 Receipt of the Patient Satisfaction Survey Results***

3.0 ENSURE PROGRAM QUALITY & EFFECTIVENESS

3.1 PATIENT & FAMILY CENTERED CARE/SERVICE EXCELLENCE PROGRAM

Bev McFarlane and Robert Alldred-Hughes presented an overview of the planned approach to advancing the organizations quality and safety journey. The next phase involves connecting three dimensions of quality and safety - technical quality, service excellence and patient and family centred care. An overview of the objectives of the patient family centred care dimension was provided and it was explained that the approach is changing the culture to work with patients and families rather than just doing to or for them. The framework and strategies presented aim at improving the experience of care and enhancing safety, quality and efficiency. Several examples were provided as to how this will be achieved. In addition an overview of the strategies related to service excellence were provided. Discussion ensued and in response to a question from the floor it was explained that philosophies vary throughout Ontario but the Kingston Hospital are currently the leaders in implementing the patient and family centred care approach. It was also explained that the implementation will be an ongoing journey. Board members were reminded that the service excellence is one of the strategic objectives; implementation of the program was delayed given the new information around the patient centred approach. The work group that considered the various approaches believed that the patient and family centred approach complemented the service excellence program.

3.2 REPORT OF THE CHIEF OF STAFF / MEDICAL ADVISORY COMMITTEE

The report of the Chief of Staff and Medical Advisory Committee was pre-circulated with the meeting package. In addition to the report, Dr. Jan Goossens thanked Board members for attending the recent Joint Board/Physician/Administration meeting. It was stated that the meeting was productive in terms of promoting an open conversation. It was noted that the meeting at the SMMH Site is scheduled for January 16th and Board members were encouraged to attend. Dr. Goossens also noted that there is another engagement session scheduled for February 12th in the evening. In terms of the Congestive Heart Failure (CHF) and COPD quality based procedures, the interdisciplinary team has developed order sets and will be 'going live'. It was further noted that MAHC is ahead of many of the other Hospitals in the LHIN with the implementation of these order sets.

3.3 UTILIZATION REPORT

N. Bubela explained that within the Board packages an updated Utilization Report has been included which includes data up to January 8th. The reports were reviewed and it was highlighted that the Alternate Level of Care pattern at the sites are different. Staff have had a significant focus on ALCs working closely with the CCAC to shift culture and practice. It was recognized that that there are a variety of factors including the need to work with both the North Simcoe Muskoka CCAC as well as the North East CCAC who both have differing practices. Staff are meeting weekly to review and assess each individual case. N. Bubela explained that one of the upcoming tactics is to re-launch the Home First philosophy.

3.4 BALANCED SCORECARD RESULTS

Charlie Forret presented the Balanced Scorecard Results as pre-circulated and appended to the meeting package. The results include the Quality Improvement Plan and Patient Safety Plan metrics. It was noted that many of the metrics are not meeting target currently but there remains five months to bring into line. In terms of the readmissions, as noted previously, the CHF and COPD order sets are being launched and it is anticipated that this will aid in meeting the readmission target. It was also explained that the C-difficile results are related to antibiotic usage as opposed to environmental factors and transmission.

3.5 QUALITY BASED PROCEDURE UPDATE

The results regarding the Quality Based Procedure volume activity at MAHC was reviewed as pre-circulated and appended to the meeting package. The volumes are based on data from two years previous and there are discussions provincially as to if that is still a reliable predictor; this has yet to be validated by the Ministry of Health and Long-Term Care. It was also explained that the funding specifically related to these volumes is being put aside and recognized as the volume is achieved. It was also noted that the budget deficit does assume completion of the full volume allotment.

3.6 ACCESSIBILITY & SENIOR FRIENDLY PLAN

Charlie Forret presented the Accessibility and Senior Friendly Plan that was pre-circulated with the meeting package. It was explained that the Quality & Patient Safety Committee has complete a thorough review. This is a legislative requirement and there is a part of Accreditation that will also consider accessibility. It is the Board's oversight responsibility to ensure that MAHC is in compliance with legislation.

It was moved, seconded and carried that the Accessibility & Senior Friendly Plan be approved.

3.7 CLINICAL SERVICES RESOURCE PLAN

Charlie Forret explained that the Clinical Services Resource Plan pre-circulated with the meeting package has been a work in progress for some time and is intended to act as the Hospital's road map for physician recruitment decisions and will be revised as required. A question was raised around how and if the Plan takes into consideration the physicians that are in the community but do not hold Hospital privileges. It was noted that this Plan is intended to reflect the needs of the Hospital and the Family Health Teams are a barometer of the community needs. Following discussion it was agreed to add a column under 'Family Practice' to attempt to take into account the complete community needs.

It was moved, seconded and carried that the Clinical Services Resource Plan be approved as amended.

4.0 REPORTS

4.1 REPORT OF THE CHIEF EXECUTIVE OFFICER

N. Bubela presented the report of the Chief Executive Officer as pre-circulated with the meeting package and noted that the correspondence related to the Pay For Results program have been delivered to the Emergency Lead for the province. There has been no response to date.

4.2 REPORT OF THE PRESIDENT, MEDICAL STAFF

Dr. Herr highlighted that the recent Joint Board/Physician/Administration meeting was positive in terms of a good step forward to removing communication barriers. There were no other issues or concerns raised on behalf of the Medical Staff.

5.0 ENSURE BOARD EFFECTIVENESS

5.1 ANNUAL BOARD EVALUATION PROCESS

Catherine King explained that the Governance Committee has analyzed the new Board Self-Assessment Tool that the Ontario Hospital Association has launched. The rationale for proposing that the MAHC Board replace part of the Evaluation process with this new tool is twofold - it provides the Board with a means to benchmark its Governance practices against other Hospitals in the Province as well as assisting the Board in improving performance and learning from others. This new model will also achieve an Accreditation Standard that MAHC has not been to achieve previously. It was noted that the MAHC Board would continue to complete its own Peer/Self-Assessment evaluation as well as the individual Committee evaluation.

It was moved, seconded and carried that the Board of Directors approve the implementation of the Governance Centre of Excellence Board Self-Assessment Tool to replace Muskoka Algonquin Healthcare's Board Evaluation Tools #1 - Annual Evaluation of Board Performance, #2 - Annual Evaluation of the Board as a Team and #4 - Annual Board of Director Meeting Evaluation.

5.2 POLICE CRIMINAL RECORD CHECKS FOR BOARD APPLICANTS - NEW POLICY

Catherine King presented the new policy and explained that given staff, physicians and volunteers are required to have a Police criminal Record Check, it was prudent for Directors to undergo the same process. There is some concern around the time frame for receiving the report and thus there is a potential that Directors may be appointed on condition of receiving a clean report. The requirement will be advertised during the recruitment process. The policy will also be reviewed in one year and reassessed at that time. It was confirmed that this practice is not universal across the province but there are some hospitals doing it. The issue of current Board members being required to have a check complete was raised and discussed. It was noted that in terms of physicians the practice is being implemented on a go forward basis and is not retroactive for all current privileged physicians. The discussion around current Board members was referred back to Governance to further discuss

and bring forward a recommendation to the Board. It was also requested that the Governance Committee consider if the process should be undertaken when a Director is up for a term renewal.

It was moved, seconded and carried that the Police Criminal Record Checks for Board Applicants Policy be approved.

6.0 MEETING TERMINATION

It was moved, seconded and carried that the open session be terminated and the Board of Directors proceed into the in-camera session.

Larry Saunders, Chair

Natalie Bubela, Secretary