

Open Meeting

BLUEWATER HEALTH BOARD AGENDA

December 15, 2010
5:30 p.m.
Classrooms – Mitton Site

Please note the start time

Documents: *attached **to be tabled

Topic	Board Responsibility						Presenter
	Establish Strategic Direction	Providing for Excellent Management	Ensuring Program Quality & Effectiveness	Ensuring Financial Viability	Ensuring Board Effectiveness	Fostering Relationships	
1. CALL TO ORDER							
1.1 Welcome/Opening Remarks					✓		B. Davies
1.2 Approval of Agenda							
1.3 Declaration of Conflict of Interest							
2. APPROVAL OF MINUTES							
2.1 November 24, 2010*					✓		B. Davies
3. REPORT FROM IN-CAMERA MEETING					✓		B. Davies
4. ITEMS REQUIRING DECISIONS - none							
5. MONITORING/OVERSIGHT							
5.1 Financial Statement*				✓			S. Anema
5.2 Capital Project/Facilities Planning Report*				✓			M. Lapaine
5.3 Balanced Scorecard - RU&A Indicator Report* - Quality Indicator Report*			✓	✓			S. Thiffeault D. Campbell
6. POLICY FORMATION							
6.1 Policy 4.10 – Resource Planning				✓	✓		S. Thiffeault
6.2 Policy 4.40 – Financial Condition				✓	✓		S. Thiffeault
6.3 Policy 4.50 – Asset Protection				✓	✓		S. Thiffeault
6.4 Policy 4.60 – Investments				✓	✓		S. Thiffeault
7. ITEMS FOR DISCUSSION							
7.1 Board Retreat					✓	✓	R. Newton-Smith
8. ITEMS FOR INFORMATION & ANNOUNCEMENT							
8.1 CEO/Management Reports*			✓			✓	S. Denomy
8.2 Board Chair Report Board Composition – regulatory changes			✓			✓	B. Davies
8.3 Quality Committee Report – December 2*			✓				D. Campbell
8.4 Governance and Nominating Report – December 7			✓				R. Newton-Smith
8.5 Resource Utilization & Audit Committee Report – December 9				✓			S. Thiffeault
8.6 Foundation Report*						✓	L. Kenny

**REGULAR MEETING
BOARD OF BLUEWATER HEALTH
November 24, 2010**

Directors:

Bryan Bouck√	Lorri Kerrigan√	Brent Steeves√
David Campbell(r)	Robert McKinley√	Cindy Thayer√
Bruce Davies√	Richard Newton-Smith√	Stéphane Thiffault√
Sue Denomy√	Wayne Pease√	Dr. Angela Wang(r)
Jim Elliott√	Dr. Alvaro Ramirez(r)	
Dr. Michel Haddad√	Pasquale Rossi√	

Professional Staff: Dr. Brian Hynes(r); Dr. Anil Garach(r)

Staff: Steve Anema√; Kim Bossy√; Connie Courtney√; Mike Lapaine√; Barb O'Neil√

Guests: Jennifer McCullough, Director√
Sue Roger, Director, Medicine

1. EDUCATION SESSION (*attached in the minute record book)

1.1 Releasing Time to Care©

Jennifer McCullough and Sue Roger provided a presentation on the Releasing Time to Care© (RTC©) initiative. J. McCullough provided an overview of the background and the RTC© experience at the hospital. She advised that as of December 2010, the RNs and RPNs on the participating unit will have increased their time providing direct patient care by 30 minutes per 12 hour shift. Sue Roger highlighted the methods of communication and engagement (i.e. flip-chart messages and visual banners), measurement, the literature, the leadership development. J. McCullough reviewed the RTC© connection to the Employee Engagement Survey priorities. They advised that this initiative has received very positive feedback from staff.

2. CALL TO ORDER – 6:25 p.m. (*attached in the minute record book)

2.1 Welcome/Opening Remarks

B. Davies welcomed everyone to the meeting and advised that Dr. Ramirez, D. Campbell and Dr. Wang were not able to attend the meeting.

2.2 Approval of Agenda*

Motion (R. McKinley/B. Bouck) and carried: to approve the agenda as presented.

2.3 Declaration of Conflict of Interest

None was declared.

3. APPROVAL OF MINUTES (*attached in minute record book)

3.1 *Motion (R. Newton-Smith/R. McKinley/) and carried: to approve the minutes of October 27, 2010 as presented.*

4. REPORT FROM IN-CAMERA MEETING

B. Davies reported that the quarterly litigation report and some personnel matters were discussed in the in-camera meeting. In addition, the Board discussed the resignation of Dr. Ramirez as President of the Professional Staff Association (PSA) which comes into effect December 1, 2010. He noted that the PSA will be holding elections for all of the professional staff executive positions in the near future and that the Board looks forward to working with the successful candidates.

5. ITEMS REQUIRING DECISIONS - none

6. MONITORING/OVERSIGHT (*attached in minute record book)

6.1 Financial Statement*

S. Anema presented the Statement of Revenues and Expenses for the period ending September 30, 2010. The current statement shows the hospital's year-to-date revenues are \$82.9 million against expenses of approximately \$84.2 million. He advised that the hospital's operating deficit has decreased significantly from August as a result of the PCOP funding. S. Anema noted that discussions are ongoing with the Ministry regarding transition costs associated with the move (i.e. training/orientation) and that the hospital anticipates to have the first year's costs paid by the end of the year.

Motion (B. Steeves/S. Thiffeault) and carried: to accept the Financial Statement.

6.2 Capital Project/Facilities Planning Report*

M. Lapaine reported that Capital Redevelopment project is 93 percent complete and that EllisDon has been given direction to proceed with the Mental Health consolidation and that the final costs are still being negotiated. He noted that the demolition of the Russell building is underway and that a contemplated change order has been prepared for the demolition of Block X at the north end of the Russell building. He provided the rationale for the decision noting concerns from the Fire Department regarding the sprinkler system. He indicated that the space could be used for parking. He reported that discussions are underway with the Ministry regarding funding the contemplated change order.

Motion (J. Elliott/B. Bouck) and carried: to accept the Capital Project/Facilities Planning Report.

6.3 Balanced Scorecard

Resource Utilization and Audit Committee Report*

S. Thiffeault presented the Resource Utilization and Audit Committee Indicator report. He noted that the Committee had a lengthy discussion regarding performance indicators and how it is difficult to evaluate how the indicators are tracking in terms of efficiencies with the current balanced scorecard. He advised that Jim Elliott will be coming to the December committee meeting to discuss the Performance Indicator Taskforce.

An inquiry was made regarding the Facility Operating Cost per Day, Overtime Expense and the Absenteeism Rate-Unionized Staff indicators. The Board was advised the facility expenses were related to minor equipment purchased made in August and transitional costs and for the new building. S. Anema advised that the increase in overtime expense was due to the training and orientation of staff to the new facility. S. Anema will report back at the December meeting regarding the increase in absenteeism of unionized staff.

Action: S. Anema

Quality Indicator Report*

R. McKinley presented the Quality Committee Indicator report on behalf of D. Campbell. He noted that the majority of the indicators are tracking in green. He noted that the indicators tracking in red, in particular MRI and CT, are for reasons which are of the hospital's control as the hospital needs to receive additional funding to increase the operating hours.

Motion (M. Haddad/L. Kerrigan) and carried: to accept the Resource Utilization and Audit Committee and Quality Indicator Reports.

7. POLICY FORMATION – none

8. ITEMS FOR DISCUSSION - none

9. ITEMS FOR INFORMATION & ANNOUNCEMENT (*attached in minute record book)

The following updates and Committee reports were presented:

9.1 CEO/Management Reports*

- S. Denomy highlighted the events planned for the CEEH 100th anniversary and nursing recruitment in the Critical Care Unit. She advised that Lynda Robinson has been hired as the Vice President Operations and will be joining the organization on January 4th. An inquiry was made regarding the Workplace Violence Prevention training and if this training should be extended to Board members as well. S. Denomy will follow-up and report back.

Action: S. Denomy

9.2 Board Chair Report

- B. Davies noted that the agenda for tonight's Board meeting was lighter than it has been in some time. He acknowledged the work of the Board over the past several months and commended the Directors for their diligence. B. Davies highlighted the November 12th Board mini-Retreat with Dr. Ross Baker regarding the Board's role in driving the quality agenda. He advised that the second part of the retreat will be scheduled in the new year and that details be provided.

B. Davies advised that he will be attending the LHIN Governance Advisory Council meeting on Monday, November 28th on behalf of the Board.

9.3 President of Professional Staff Report

- No report

9.4 Medical Advisory Committee – November 17

- Dr. Haddad reported that the hospital is considering expanding the hospitalist program to cover surgery and mental health and that the programs are preparing business plans to support this initiative.

Dr. Haddad highlighted the Anaesthesia program. He advised anaesthesia will be structured similar to the surgery program and that the program will have a representative on the Medical Advisory Committee. Dr. Haddad reported that the hospital is currently recruiting anaesthetists in order to maintain and expand services in the surgery program. One anaesthetist has resigned effective January 2011 and another may be leaving as well.

Dr. Haddad advised that the hospital is working hard to expand epidural services for expectant mothers by February 1st. The Board was advised that the service will be transitioned in as the hospital does not have the full complement of anaesthetists. It is contemplated that the service will initially be provided from 6:00 a.m. to 11:00 p.m. daily. Discussion ensued regarding risks of not having the service available between 11:00 p.m. to 6:00 a.m. The Board was advised that the long-term plan is to offer the service to expectant mothers 24/7 once the full complement has been achieved. Clarification was sought regarding how many anaesthetists are required to achieve the complement. The Board was advised that two to four more are needed. Dr. Haddad advised that many of the applicants applying for the position are not fully qualified which is making the recruitment difficult.

An inquiry was made regarding the number of women who leave the community to deliver their babies at hospitals where epidural services are available. The Board was advised that approximately 200 women resident in Lambton County deliver babies elsewhere each year and that approximately half of that number are thought to be associated with the lack of availability

of epidurals. In addition, approximately half of the women who do deliver at Bluewater Health would use this service if it were offered.

9.5 Quality Committee Report – November 4*

- R. McKinley reported on behalf of D. Campbell highlighting the litigation claims report and the surgical checklist. He advised that the Committee had a good discussion regarding the *Excellent Care for All Act*, in particular the quality care plan.

9.6 Governance and Nominating Committee – November 9*

- R. Newton-Smith reported that the Committee had a lengthy discussion regarding the *Excellent Care for All Act*. He advised that a compliance tracking chart has been prepared tracking the status of items in accordance with the Act. He highlighted the performance indicator taskforce, the community engagement strategy and operational plan and the December 10th OHA Balanced Governance Scorecard webcast and accreditation. He noted that the Self Assessment survey will be sent out to Directors next week for completion.

R. Newton-Smith thanked Directors for attending the November 12th Board mini-Retreat.

9.7 Resource Utilization and Audit Committee Report – November 18*

- S. Thiffault reported that the Committee received a presentation from the auditors highlighting the schedule and process for the 2010-11 audit which includes a review of PROcure controls. He noted that the Committee received an update regarding the arbitration awards, recruitment and the H-SAA and HAPs process. He advised that the hospital is awaiting direction from the LHIN or Ministry regarding this 2011-12 H-SAA process.

9.8 Foundation Report*

- The Board was informed that Donor Wall ceremony was held on November 18th and that the charity ball was a great success. The ball raised approximately \$40,000 which will be used for medical equipment. The Board was reminded that the 2011 Dream Home is now open from 1:00-4:00 p.m. every weekend until February 10th in the Glenview Estates in Petrolia.

Motion (P. Rossi/B. Steeves) and carried: to receive the above reports as presented.

10. OPEN FORUM

- No items were discussed.

11. NEXT MEETING

December 15, 2010

12. ADJOURNMENT

There being no further items for discussion, the meeting adjourned at 7:33 p.m.

Bruce Davies
Chair
Board of Bluewater Health

Sue Denomy
Secretary
Board of Bluewater Health

Jacqueline McGregor
Senior Executive Assistant
Recorder

Statement of Revenue and Expense
Forecast surplus/(deficit) as at March 31, 2011
Based upon the seven (7) months ended October 31, 2010
(000's)

	2011 YTD Budget	2011 YTD Actual	2011 YTD Variance	2011 YTD % Variance	2011 Annual Budget	2011 Forecast Amount	Projected Variance to Budget	2011 Forecast % Variance	Notes
Revenue	\$								
LHIN Revenue	74,529	75,906	1,377	2%	128,128	128,744	616	0%	1
PCOP Expansion Revenue	0	0	0		0	2,673	2,673		1
OHIP Revenue	9,914	11,027	1,112	11%	16,852	18,814	1,962	12%	2
WSIB Revenue	378	236	(141)	-37%	649	426	(222)	-34%	
Revenue	120	126	6	5%	206	206	(0)	0%	
Other Provinces									
Non Residents	68	143	75	110%	116	292	176	151%	
Self Pay	305	241	(65)	-21%	521	456	(65)	-12%	
Room differential	2,067	1,757	(311)	-15%	3,613	3,232	(381)	-11%	3
CC Co-payment	778	556	(221)	-28%	1,330	1,056	(273)	-21%	
Recoveries	1,785	4,848	3,062	172%	3,097	6,190	3,093	100%	4
Parking Revenue	357	390	32	9%	609	703	93	15%	
Other Revenue	140	152	12	8%	154	167	14	9%	
Deferred Equipment Grants	1,199	1,046	(153)	-13%	2,056	2,056	-	0%	
Interest and Donations	56	69	13	24%	95	118	23	24%	
Administered Programs	2,156	2,187	31	1%	3,645	3,725	80	2%	
Total Revenue	\$ 93,852	98,682	4,831	5%	161,070	168,858	7,788	5%	
Expenses	\$								
Salaries and Wages	46,937	46,841	96	0%	80,437	81,502	(1,065)	-1%	5
Medical Staff Remuneration	9,778	11,051	(1,272)	-13%	16,719	19,262	(2,543)	-15%	2, 6
Employee Benefits	13,104	13,870	(766)	-6%	22,263	23,558	(1,295)	-6%	7
Supplies and Expenses	12,953	14,856	(1,903)	-15%	21,861	23,710	(1,849)	-8%	4
Medical/Surgical Supplies	3,851	4,022	(171)	-4%	6,582	6,782	(200)	-3%	
Drug Expense	2,820	3,044	(225)	-8%	4,828	5,250	(422)	-9%	8
Interest Expense	117	155	(39)	-33%	199	238	(39)	-19%	
Amortization	2,699	2,576	123	5%	4,626	4,626	-	0%	
Administered Programs	2,155	2,248	(93)	-4%	3,645	3,825	(180)	-5%	
Total Expenses	\$ 94,412	98,663	(4,250)	-5%	161,161	168,753	(7,592)	-5%	
LHIN Operating Surplus/(Deficit)	\$ (561)	20	580	n/a	(91)	105	196	n/a	
Transition Costs Spent to Date	472	1,599	1,128	239%	805	2,413	1,609	200%	
Deferred Building Grants	585	542	(43)	-7%	1,002	1,002	-	0%	
Building Amortization	1,471	1,490	(19)	-1%	2,521	2,521	-	0%	
Hospital Surplus/(Deficit)	\$ (1,918)	(2,527)	(571)	n/a	(2,414)	(3,827)	(1,413)	n/a	

Balance Sheet
As at October 31, 2010
Comparison to October 31, 2009
(000's)

	<u>2010/11</u>	<u>2009/10</u>	<u>%</u>
	<u>Actual</u>	<u>Actual</u>	<u>Change</u>
	<u>Oct-10</u>	<u>Oct-09</u>	
Assets			
<u>Current Assets</u>			
Operating Cash	\$ 7,586	(4,590)	
Superbuild Cash	7,684	4,204	-83%
Superbuild Fund	16,824	39,554	57%
Investments - CEE Site	1,794	1,762	-2%
Accounts Receivable	5,105	4,811	-6%
Accounts Receivable - MOHLTC	1,410	1,061	-33%
Inventories	1,086	1,183	8%
Prepaid Expenses	1,178	1,165	-1%
Total Current Assets	<u>42,667</u>	<u>49,149</u>	<u>-13%</u>
<u>Fixed Assets</u>			
Land and Land Improvements	5,522	5,650	
Building/Building services Equipment	72,751	72,346	
Furniture and Equipment	96,069	82,797	
Less: Accumulated Amortization	<u>(107,803)</u>	<u>(106,357)</u>	22%
Construction in Progress	227,089	177,378	28%
Other Non Current Assets	338	332	2%
Total Fixed Assets	<u>293,966</u>	<u>232,146</u>	<u>27%</u>
Total Assets	\$ <u>336,633</u>	<u>281,296</u>	<u>20%</u>
<u>Current Liabilities</u>			
Bank Loans Payable	\$ 10,340	3,294	214%
Accounts Payable	3,676	4,301	-15%
Accounts Payable - MOHLTC	8,248	7,860	5%
Accrued Salaries & Vacation Pay	7,860	7,177	10%
Deferred Operating Grant - Trailing Costs	1,587	0	
Other Liabilities	<u>8,549</u>	<u>2,481</u>	<u>245%</u>
Total Current Liabilities	<u>40,261</u>	<u>25,112</u>	<u>60%</u>
<u>Long Term Liabilities</u>			
Long Term Debt	19,969	143,386	-86%
Deferred Revenue	259,236	95,527	171%
Other L/T Liabilities	<u>6,800</u>	<u>5,464</u>	<u>24%</u>
Total Long Term Liabilities	<u>\$ 286,005</u>	<u>244,376</u>	<u>17%</u>
<u>Equity</u>			
Opening Equity	11,295	12,521	
R&E Surplus/(Deficit)	<u>(928)</u>	<u>(714)</u>	
Total equity	<u>10,367</u>	<u>11,807</u>	<u>-12%</u>
Total Liabilities and Equity	\$ <u>336,633</u>	<u>281,296</u>	<u>20%</u>

Hospital Accountability Agreement Indicators:

			<u>Negotiated Target</u>
Current Ratio	0.41	0.14	0.8 - 2.0
Working Capital	(23,897)	(21,482)	

Note: Current ratio excludes Superbuild Cash, Superbuild Investments and CEE Site Investments

Notes to Financial Statements

October 31, 2010 Actual and Full Year Forecast

An overall surplus of \$105K is forecasted for the 2010/11 year end. This is a noted improvement from the September forecast which forecasted a deficit of \$387K. This improvement is mainly due to an improved forecast for supplies and expenses. If minor equipment expenses related to the new building project were removed from the supplies line, there would be a positive variance from budget. The increase to Ministry Funding for PCOP has offsetting increases in expenses.

Note 1

LHIN funding is forecasted to come in over budget by \$616K. This variance consists of additional funding for ALC, Aging at Home, and Pay 4 Results. The budget and forecast have been reduced by \$400K of Palliative Care funding that will be taken back by the LHIN during the year. We are forecasting to recognize \$2.673M of PCOP expansion revenue for various clinical programs. There are offsetting expenses for this PCOP expansion revenue.

Note 2

OHIP Revenue is expected to come in over budget for the year. This is mainly due to Physician billings. There is a corresponding overage in Med Staff Remuneration.

Note 3

Room Differential revenue is forecasted to come in below budget. There has been a continued decline in this revenue over the past couple of years. The decline is a result of a greater need to isolate patients and fewer patients requesting preferred accomodation. The departments contributing to this negative variance are also those departments with lower occupancy levels.

Note 4

Recoveries are forecasted to come in better than budget for the year. This is mainly due to offsetting funding recognized year-to-date for minor equipment purchases related to the new building. The offsetting expense is recorded in supplies.

Note 5

Salaries and Wages are expected to come in over budget for the year. This overage offsets a portion of the forecasted PCOP expansion funding for various clinical areas as indicated in Note 1.

Note 6

Med Staff Remuneration is forecasted to come in over budget for the year. This is mainly a result of physician payments (with offsetting OHIP revenue per Note 2 above). The additional variance is unbudgeted payments related to the new Intensivist model of care in our ICU as well as payments to the Interim Chief of Staff. The budget for the Chief of Staff is included in Salaries.

Note 7

Employee benefits are expected to come in over budget for the year. A portion of this negative variance is a result of In Leiu benefits being over budget ytd. A larger portion of this negative variance is the offsetting expense related to PCOP expansion.

Note 8

Drug Expenses are expected to come in over budget for the year. The model of care has changed for Intensive Care by bringing in an Intensivist. This change is a major contributor to the anticipated overage. The expansion of various clinical programs through PCOP funding is also a contributing factor to the forecasted variance.



Capital Redevelopment Project			
Schedule:		Schedule Status: ■ (Green) On Track	
Construction Start: Oct. 9, 2007			
Phase 1 (Block A & B): Complete		Phase 1 Occupancy: Complete	
Phase 2 Substantial (Block C): Sept. 2011		Final Occupancy: December 2011	
<ul style="list-style-type: none"> • Construction is 93% complete. • Schedule meetings took place with EllisDon, Bluewater Health and the Consultant team to finalize Phase 2 schedule. There are no identified risks to the current schedule, occupancy is on track. • Direction to proceed with the Mental Health Consolidation was given to EllisDon. Final costs are still being negotiated. • Phase 2 renovations underway – EllisDon is working in the following areas: <ul style="list-style-type: none"> ○ Russell Building Levels 2, 3, 4, & 5 – demolition underway ○ Russell Building Levels 6, 7 – mechanical and electrical rough-ins underway • Moves targeted for December: <ul style="list-style-type: none"> ○ London Building Level 2 – Health Records ○ London Building Level 4 – relocating Palliative Medicine to enable renovations to their current unit ○ London Building Level 4 – District Stroke Program 			
Budget:		Budget Status: ■ (Green) On Track	
Final Estimate of Cost (FEC)	MOHLTC Share	Bluewater Health Share	
\$319,491,739	\$243,382,101	\$76,109,638	
<ul style="list-style-type: none"> • To date there have been 204 Change Orders issued. 			
Approved Change Orders	Value	MOH Share	BWH Share
MOHLTC Shareable	6,362,837	5,252,143	1,110,694
Own Funds	762,507	-	762,507
To be Negotiated	-	-	-
<i>Subtotal</i>	7,125,344	5,252,143	1,873,201
Pipeline Change Orders			
MOHLTC Shareable	940,609	846,548	94,061
Own Funds*	1,121,530	-	1,121,530
To be Negotiated	-	-	-
<i>Subtotal</i>	2,062,139	846,548	1,215,591
Total Change Orders / Pipeline	9,187,483	6,098,691	3,088,792
<i>*value includes Contemplated Change Order for Mental Health</i>			

Bluewater Health--Resource, Utilization & Audit Committee (RUA) Balanced Scorecard



Indicator	Recent Performance					Current Period	Period Target	Projected FY 10-11 Year-End	Year-End Target	Interpretation/ Analysis	Action Plan	Next Update (Month of Report)	Updated this Report
Outstanding Performance													
Financial Health (monthly indicators)													
	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Per.Target	Proj. Yr-End	Yr-End Target					
Surplus/(Deficit) YTD	\$ (1,106,424)	\$ (1,385,499)	\$ (1,542,328)	\$ (1,293,293)	\$ 19,766	\$ (560,743)	\$ 105,097	\$ (90,600)	Budget and forecast adjusted for portion of announced PCOP funding.		Jan	Y	
Total Margin	-2.76%	-2.58%	-2.25%	-1.55%	0.02%	-0.06%	0.06%	-0.08%			Jan	Y	
Current Ratio	0.53	0.42	0.41	0.35	0.41	0.8-2.0	0.80	0.8-2.0			Jan	Y	
Working Capital (in 000s)	\$ (12,761)	\$ (17,869)	\$ (21,947)	\$ (26,998)	\$ (23,897)	n/a	\$ (20,000)	\$(13.8M) (5% less than 09-10)	Small forecasted surplus is not enough to eliminate working capital deficits accumulated from prior years.		Jan	Y	
Resource Utilization (monthly indicators)													
	Jun '10	Jul '10	Aug '10	Sep '10	Oct '10	Per.Target	Proj. Yr-End	Yr-End Target					
Facility Operating Cost per Day--YTD	\$ 435,252	\$ 433,339	\$ 431,829	\$ 434,345	\$ 436,609	\$ 427,234	\$ 439,745	\$ 427,419	Sept Actual corrected on this report. Previously stated as \$519,510.		Jan	Y	
Operating Room Utilization: % Block Utilization	87.7%	85.7%	88.6%	89.1%	87.2%	85%=Policy; 86%=Lg Comm Hosp Avg	88.0%	85%=Policy; 86%=Lg Comm Hosp Avg			Jan	Y	
Hospital Service Accountability Agreement (HSAA) Activity													
	Oct '10	Prev. Yr. YTD	% change from Prev. Yr YTD	YTD	YTD Target/Budget	Proj. Yr-End	Yr-End Target	Variances					
Total Weighted Cases (Acute Inpatient & Day Surgery) (CY in 10-11 values with PY restated in 10-11 weights)	1,008 (Sep)	6,001 (Sep)	-9.4%	5,978	6,301	11,923	12,567 (11,813 - 13,321)	(323) YTD (644) Yr-End			Jan	Y	
Acute Inpatient Days (excludes Mental Health, Rehab, & Continuing Care)	4,728	31,111	0.3%	31,197	34,472	53,210	58,797	(5,587) Yr-End			Jan	Y	
Mental Health Inpatient Days	791	5,067	-0.4%	5,046	5,042	8,606	8,600 (7,912 - 9,288)	4 YTD 6 Yr-End			Jan	Y	
Rehab Inpatient Days	665	5,129	-18.8%	4,166	5,511	7,106	9,300 (8,556 - 10,044)	(1,345) YTD (2,194) Yr-End			Jan	Y	
Ambulatory Care Visits	6,408	43,855	-7.2%	40,689	41,041	69,399	70,000 (67,900 - 72,100)	(352) YTD (601) Yr-End			Jan	Y	
Emergency Department (ED) Visits	6,832	52,471	-4.9%	49,901	49,425	85,112	84,300 (81,771 - 86,829)	476 YTD 812 Yr-End			Jan	Y	
Complex Continuing Care (CCC) Resource Utilization Group (RUG) Weighted Patient Days (in 09-10 values)	25,267 (FY 06-07)	25,854 (FY 07-08)	25,810 (FY 08-09)	26,120 (FY 09-10)	23,862	23,862	23,862 (22,908 - 24,816)	2,258 YTD - Yr-End			11/12 fiscal yr		
Incremental Volume Funding--Oct '10													
	Annual Total	Annual Breakout	YTD Volumes	YTD Target/Budget	Proj. Yr-End Volumes	Yr-End Target/Budget	Variances		for Incremental Volumes				
Cataracts	1,385	Base: 720 Incremental: 665	422 722	422 390	720 722	720 665	(0) YTD 57 Yr-End			Have exceeded WT target but still have base volumes to complete for y/e.	Jan	Y	
General Surgery (as of Sep '10)	416	Base: 373 Incremental: 43	180 63	187 22	373 43	656 43	(29) YTD - Yr-End			Although it appears we have achieved target, the breakdown of general surgery indicated haven't achieved base for all types of procedures.	Jan	Y	
Hips/Knees (Primary and Revision)	393	Base: 343 Incremental: 50	202 21	201 29	343 47	343 50	(8) YTD (3) Yr-End			Our revision Knees are exceeding our current WT funding.	Jan	Y	
CT Hours	2,688	Base: 2,340 Incremental: 348	1,372 117	1,372 204	2,340 348	2,340 348	(87) YTD - Yr-End			Under 87 hrs ytd due to slow downs in summer months - hrs will increase to achieve WT target for y/e	Jan	Y	
MRI Hours	3,860	Base: 2,080 Incremental: 1,780	1,220 1,457	1,220 1,044	2,080 1,780	2,080 1,780	413 YTD - Yr-End				Jan	Y	
Colonoscopies	1,102	Base: 742 Incremental: 360	445 156	445 216	742 260	742 360	(60) YTD (100) Yr-End				Jan	Y	
Pacemakers	107	All	107	63	78	107	(17) YTD (29) Yr-End			Uncertainty as to whether we will achieve base volumes for pacemakers.	Jan	Y	

Indicator	Recent Performance					Current Period	Period Target	Projected FY 10-11 Year-End	Year-End Target	Interpretation/ Analysis	Action Plan	Next Update (Month of Report)	Updated this Report
Resource Utilization (quarterly indicators)	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11	Q2 10-11	Per.Target	Proj. Yr-End	Yr-End Target					
Average Length of Stay (LOS): Expected LOS Ratio (Acute Care)	1.00	1.02	1.07	1.02	1.02	<=1	1.02	<=1		Improved documentation will adjust ELOS upwards and improve performance further.	Feb		
Potentially Conservable Days (Acute Care--Typical Cases)	25	161	607	218	153	0	180	0					
Acute Inpatient Average Resource Intensity Weight (RIW)	1.04	1.04	0.98	1.03	1.04	1.177 (5% above 08-09)	1.03	1.177 (5% above 08-09)	09/10 RIW regrouped to 10/11	Improved documentation (i.e. capture of comorbidities)	Feb	Y	
Alternate Level of Care (ALC) Patients as a % of Beds	Acute	10.5%	11.4%	10.3%	7.5%	<9%	11.3%	<9%		Weekly t-con with LHIN and CCAC. Aging at Home (GEM nurse) & IHSP2 proposals (Ambulation Team).	Feb		
	Total	23.8%	23.6%	22.6%	16.7%	<22.8% (5% below 08-09)	19.3%	<22.8% (5% below 08-09)					

Resource Utilization (quarterly indicators)	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11	Q2 10-11	Per.Target	Proj. Yr-End	Yr-End Target				
Rehab Case Mix Index (CMI)	1.5348	1.516	1.3283	1.2697	not available	Peer Avg=1.4400; ON avg=1.1204	TBD	Peer Avg=1.4400; ON avg=1.1204			Jan	
Complex Continuing Care (CCC) Case Mix Index (CMI)	CEEH	0.6556	0.6576	0.7742	0.7380	not available	Peer Avg=1.0085; ON avg= 0.9979	TBD	Peer Avg=1.0085; ON avg= 0.9979		Jan	
	Sarnia	0.8937	0.9241	0.9094	0.9115	not available						
Mental Health Case Mix Index (CMI)	1.2440	1.289	1.244	1.242	not available	Peer 1.2723	TBD	Peer 1.2723			Jan	
Mental Health SCIPP Weighted Patient Days	3,518	1,496	2,986	2,545	not available		TBD					

Inspired People

Human Resources (quarterly indicators)	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11	Q2 10-11	Per.Target	Proj. Yr-End	Yr-End Target				
Overtime Expense as % of Total Salary Expense	1.26%	1.50%	1.55%	1.85%	2.37%	1.84%	2.37%	1.84%			Feb	
Sick Time Expense as % of Total Salary Expense	3.07%	3.03%	3.02%	3.18%	3.23%	2.17%	3.20%	2.17%			Feb	
% of Nurses Employed Full-Time	68.32%	69.68%	69.90%	69.34%	68.73%	69.02 (H-SAA); >70% (MOHLTC)	69.02%	69.02 (H-SAA); >70% (MOHLTC)			Feb	
Administration Cost as % of Total Expenses	3.47%	3.61%	3.73%	3.33%	3.42%	3.74%	3.42%	3.74%			Feb	
% Management & Operational Support Hours	16.23%	16.48%	16.44%	16.06%	16.03%	16.20%	16.03%	16.20%			Feb	
Absenteeism Rate--Unionized Staff (avg # 7.5hr sick days)	2.92	3.21	3.04	3.08	3.28	3.27 (OHA avg)	3.04	3.27 (OHA avg)			Feb	
Organization-Wide Turnover Rate	6.32%	5.32%	4.56%	7.80%	10.32%	10.7% (OHA avg); 6.56% (LHIN avg)	7.80%	10.7% (OHA avg); 6.56% (LHIN avg)			Feb	
Vacancy Rate	RN	4.51%	4.53%	5.30%	12.08%	7.93% (OHA avg); 14.3% (LHIN avg)	12.08%	7.93% (OHA avg); 14.3% (LHIN avg)			Feb	
	Total	7.17%	8.41%	9.61%	14.32%	6.08% (OHA avg); 11.1% (LHIN avg)	9.61%	6.08% (OHA avg); 11.1% (LHIN avg)				

Efficiency (OCMD Reporting Period:	FY 06-07	FY 07-08	FY 08-09	FY 09-10	Q2 10-11	Per.Target	Proj. Yr-End	Yr-End Target				
Acute/Newborn Cost per Weighted Case	\$ 4,892	\$ 5,127	\$ 5,792	\$ 5,787	\$ 6,399	\$4919 = Large Community Hospital Mean		\$4919 = Large Community Hospital Mean	Q2 is only an estimate of our weighted cases. Distribution of estimate between IP and Day Surg could be contributing to variance from 09/10	Refer to "Monthly Summary of Significant Recovery Requirements." Prospective Planning efforts directed at addressing efficiency measures.	Feb	Y
Day Surgery Cost per Weighted Case	\$ 6,575	\$ 6,526	\$ 6,103	\$ 5,192	\$ 4,866	\$5423 = Large Community Hospital Mean		\$5423 = Large Community Hospital Mean	Classification of Day Surg changed in 09/10 per OCMD which explains fluctuation between Day Surg & Acute in 09/10 and Q2 10/11		Feb	Y
Acute/Newborn Cost per Diem	\$ 962	\$ 1,009	\$ 1,008	\$ 1,064	\$ 1,206	\$939 = Large Community Hospital Average		\$939 = Large Community Hospital Average	7% greater than Large Community Hospital Average		Feb	Y
Rehab Cost Per Diem	\$ 633	\$ 559	\$ 614	\$ 617	\$ 710	\$563 = Large Community Hospital Average		\$563 = Large Community Hospital Average	9% higher than Large Community Hospital Avg.		Feb	Y
Chronic Cost per Diem	\$ 465	\$ 468	\$ 478	\$ 470	\$ 508	Unknown at this time		Unknown at this time			Feb	Y
Mental Health Cost per Diem	\$ 465	\$ 479	\$ 494	\$ 508	\$ 572	\$613 = Large Community Hospital Average		\$613 = Large Community Hospital Average			Feb	Y

Physical Facilities/Other	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10	Per.Target	Proj. Yr-End	Yr-End Target				
Hotel/Occupancy % (MM, Hskg, Laundry, Plant/Mtce, Security, Biomed, Food)	12.1%	12.3%	11.5%	11.6%	11.5%	11.5%	11.5%	11.5%	% will increase with experience in new building.		Jun	
Project Status Relative to Schedule & Budget	See Supplementary Report											

Legend	All Indicators (except HSAA)	Legend	HSAA Indicators
*	no established target/standard		
	meets/exceeds target		meets/exceeds target (above final 1% of corridor range)
	within 5% of target		within final 1% of corridor range but below target
	worse than target by 5+%		below lower corridor limit

*Only anorectal, cholecystectomy, intestinal, groin hernia, and ventral hernia surgeries count towards incremental volume funding.
 *Only anorectal, cholecystectomy, intestinal, groin hernia, and ventral hernia surgeries count towards incremental volume funding.

Quality Committee of the Board -- Balanced Scorecard



Indicator	Quarterly Performance (unless otherwise specified)				Current Period (Q2 10-11 unless otherwise specified)	Target	Interpretation/Analysis	Action Plan	Next Update (Month of Report)	Updated this Report	
	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11							
Quality Care											
Patient Safety Indicators											
Hospital Standardized Mortality Ratio (HSMR)	annual	99 (FY 04-05)	113 (FY 05-06)	115 (FY 06-07)	102 (FY 07-08)	88 (FY 08-09)	<100 (national standard)			Jan	
MRSA Infection Rate (per 1,000 Patient Days)	Milton	0.00	0.10	0.10	0.20	0.00	0.02 (province Jul-Sep 10)			Feb	
	CEEH	0.00	0.00	0.00	0.00	0.00					
	Norman	0.00	0.00	0.00	0.00	0.00					
VRE Infection Rates (per 1,000 Patient Days)	Milton	0.00	0.00	0.00	0.00	0.00	0.00 (province Jul-Sep 10)			Feb	
	CEEH	0.00	0.00	0.00	0.00	0.00					
	Norman	0.00	0.00	0.00	0.00	0.00					
C Difficile Infection Rates (per 1,000 Patient Days)	Milton	0.60 (Jun 10)	0.90 (Jul 10)	0.00 (Aug 10)	0.00 (Sep 10)	0.00 (Oct 10)	0.25 (province Sep 10)	Slight increase at the Norman Site. Cases do not appear to be related and transmission is not being observed.	Infection Control Committee has recommended the creation of a subcommittee for antibiotic stewardship reporting to Medical Quality & Utilization (or MAC).	Jan	◀
	CEEH	0.00 (Jun 10)	0.00 (Jul 10)	0.00 (Aug 10)	0.00 (Sep 10)	0.00 (Oct 10)					
	Norman	0.60 (Jun 10)	0.00 (Jul 10)	0.80 (Aug 10)	0.00 (Sep 10)	0.30 (Oct 10)					
Hand Hygiene Compliance Rate <u>Before</u> Initial Patient/Enviro Contact	Milton	n/a	58% (FY 08-09)	40% (Apr-Sep 09)	45% (Oct-Dec 09)	41% (FY 09-10)	80% (65.73% =province Apr 09-Mar 10)	Mixed results comparing FY 09-10 to FY 08-09. Very close to or better than last year's provincial rate for "after contact". (New comparison data not yet available). CEEH site has made significant strides since the last quarter. The manager has incorporated hand hygiene messaging into the day-to-day rounding on each unit as well as incorporating hand hygiene information into each staff meeting.	Results reported to each program quarterly. Departments are responsible for developing action plans to address identified gaps. All staff are required to complete the hand hygiene e-learning module annually and infection control provides ongoing support and education regarding hand hygiene practice. Revising hand hygiene improvement plan.	May	
	CEEH	n/a	38% (FY 08-09)	64% (Apr-Sep 09)	85% (Oct-Dec 09)	71% (FY 09-10)					
	Norman	n/a	73% (FY 08-09)	28% (Apr-Sep 09)	55% (Oct-Dec 09)	44% (FY 09-10)					
Hand Hygiene Compliance Rate <u>After</u> Patient/Enviro Contact	Milton	n/a	68% (FY 08-09)	65% (Apr-Sep 09)	79% (Oct-Dec 09)	70% (FY 09-10)	80% (78.61% =province Apr 09-Mar 10)			May	
	CEEH	n/a	63% (FY 08-09)	76% (Apr-Sep 09)	97% (Oct-Dec 09)	83% (FY 09-10)					
	Norman	n/a	74% (FY 08-09)	54% (Apr-Sep 09)	84% (Oct-Dec 09)	68% (FY 09-10)					
Patients' Confidence that Caregivers Cleaned Hands (wt. avg of IP, ED, DS, OB)		83.3 (Q1 09-10)	82.4 (Q2 09-10)	85.8 (Q3 09-10)	80.6 (Q4 09-10)	80.5 (Q1 10-11)	83.8% (09-10); 87.95% (10-11) 5% incr. yr-to-yr	OB (76.5), Inpatient (79), and ED (78.6) require improvements to meet target.	Improvements in hand hygiene compliance escalated to corporate priority.	Mar	◀
Ventilator Associated Pneumonia Rate (per 1,000 Ventilator Days)		3.62	0.00	0.00	0.00	0.00	0 (1.70 =province Jul-Sep 10)			Feb	
Central Line Infection Rate (per 1,000 CL Days)		0.00	0.00	0.00	0.00	0.00	0 (0.91 =province Jul-Sep 10)			Feb	
Surgical Site Infection Prevention Rates (antibiotics for hip/knee in right time before surgery)	Milton	84.4%	89.1%	95.6%	90.2%	86.7%	90% (96.62% =province Jul-Sep 10)	13 out of 15--only surgeries up to July (so small n size).		Feb	
	Norman	92.0%	100.0%	94.3%	96.4%	90.9%					
Surgical Safety Checklist Compliance	Milton	n/a	n/a	n/a	n/a	96.3%	100% (92=province; 97=lg comm hosp Apr-Jun 10)	Q1 publicly reported as 96.3% & 94.4% which is above provincial average, but below large community hospital average (97%). Making improvements monthly.	Continue to monitor new indicator and feedback to staff/physicians.	Feb	
	Norman	n/a	n/a	n/a	n/a	94.4%					
Medication Reconciliation (% Complete within 24hr)		60.0%	59.0%	57.1%	57.8%	55.2%	70% (BWH); 90% (CCHSA)	Improvements not being realized despite efforts. Accreditation Canada reported overall compliance with the Med Rec Required Organizational Practice (ROP) within Canadian organizations was 32%.	Charge Nurses leading on Med and Crit Care; changes to nursing documentation screens to make more prominent; incorporating into shift handover messaging; 1:1 education on Mental Health.	Feb	
Medication Reconciliation (% Incomplete after 72hr)		14.0%	15.0%	17.4%	15.4%	18.5%	<10% (BWH)			Feb	
Patient Incidents Category 3 or Higher	med/ fluid error	0 (Jun 10)	0 (Jul 10)	0 (Aug 10)	0 (Sep 10)	0 (Oct 10)	0			Jan	◀
	falls	0 (Jun 10)	1 (Jul 10)	1 (Aug 10)	0 (Sep 10)	0 (Oct 10)					
	adverse drug rxn	0 (Jun 10)	0 (Jul 10)	0 (Aug 10)	0 (Sep 10)	0 (Oct 10)					
Accessibility Indicators											
<i>Reporting Period:</i>		Jun-10	Jul-10	Aug-10	Sep-10	Oct-10					
CEEH: 90th %ile ED LOS	Complex	4	4.1	5.2	5.0	3.6	8hr			Jan	◀
	Minor/Uncomplicated	2.7	2.7	3.1	2.6	2.5	4hr			Jan	◀
Milton: 90th %ile ED LOS	Complex	7.3	7.6	7.8	7.8	7.1	8hr			Jan	◀
	Minor/Uncomplicated	3.3	3.5	3.7	3.4	3.6	4hr			Jan	◀
% Colonoscopies for Pos FOB within 60 days		97%	96%	100%	91%	82%	65% (LHIN 1 target)			Jan	◀
% Colonoscopies for Fam History within 182 days		91%	96%	95%	100%	96%	75% (LHIN 1 target)			Jan	◀

Indicator	Quarterly Performance (unless otherwise specified)				Current Period (Q2 10-11 unless otherwise specified)	Target	Interpretation/Analysis	Action Plan	Next Update (Month of Report)	Updated this Report
	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11						
General Surgery (90% Completed Within:)	119	111	93	104	101	182 days			Feb	
% Completed Within Each Priority Access Target:	81%	85%	90%	89%	95%	>=90%	At Oct 26, 40 cases waiting longer than assigned priority target.		Feb	
Ophthalmic Surgery (incl. Cataracts) (90% Completed Within:)	59	72	85	73	77	182 days			Feb	
% Completed Within Each Priority Access Target:	100%	100%	100%	100%	100%	>=90%	At Oct 26, 14 cases waiting longer than priority target.		Feb	
Orthopedic Surgery (incl. Hips/Knees) (90% Completed Within:)	117	150	97	112	78	182 days			Feb	
% Completed Within Each Priority Access Target:	95%	97%	98%	97%	98%	>=90%	At Oct 26, 32 cases waiting longer than priority target.		Feb	
Cancer Surgery (90% Completed Within:)	72	71	70	70	51	84 days			Feb	
% Completed Within Each Priority Access Target:	59%	76%	68%	78%	76%	>=90%	At Oct 26, 12 cases waiting longer than priority target--all of which are treatment cases. LHIN achieved 77% (yellow) for Q2.	Open O.R. time and extra Same Day Admit offered on a priority basis. Using locum anaesthetists when possible for cases.	Feb	
Gynaecologic Surgery (90% Completed Within)	n/a			62	65	182 days			Feb	
% Completed Within Each Priority Access Target:	n/a			96%	96%	>=90%	At Oct 26, 17 cases waiting longer than priority target.		Feb	
Oral/Dentistry Surgery (90% Completed Within)	n/a			79	111	182 days			Feb	
% Completed Within Each Priority Access Target:	n/a			93%	79%	>=90%	At Oct 26, 9 cases waiting longer than priority target. Limiting open O.R. time may be increasing waits.	Continue to monitor.	Feb	
Otolaryngic Surgery (Ear, Nose, Throat) (90% Completed Within)	n/a			77	97	182 days			Feb	
% Completed Within Each Priority Access Target:	n/a			100%	100%	>=90%	At Oct 26, 1 case waiting longer than priority target.		Feb	
Plastic/Reconstructive Surgery (90% Completed Within)	n/a			268	245	182 days	Surgeon not using available OR dates.		Feb	
% Completed Within Each Priority Access Target:	n/a			52%	83%	>=90%	At Oct 26, 6 cases waiting longer than priority target.	Working to improve data quality.	Feb	
Urologic Surgery (90% Completed Within)	n/a			132	149	182 days			Feb	
% Completed Within Each Priority Access Target:	n/a			88%	90%	>=90%	At Oct 26, 61 cases waiting longer than priority target.	Working on clean-up of data and in-person visit to office.	Feb	
Vascular Surgery (90% Completed Within)	n/a			142	148	182 days			Feb	
% Completed Within Each Priority Access Target:	n/a			100%	93%	>=90%	At Oct 26, 1 case waiting longer than priority target.		Feb	
Paediatric Surgery (90% Completed Within)	n/a			124	141	182 days	Paeds Dental, Plastics, and Urology cases exceeding target.	As above for adult cases.	Feb	
% Completed Within Each Priority Access Target:	n/a			79%	72%	>=90%	At Oct 26, 30 cases waiting longer than priority target.		Feb	
MRI (90% Completed Within:)	48	45	45	43	70	28 days	LHIN Q2 time is 68 days (red). BH is 11th in province (for shortest wait). 10yr-old scanner not as efficient as newer.	Wait times can only be reduced if we receive additional funding to increase operating hours.	Feb	
% Completed Within Each Priority Access Target:	41%	21%	27%	29%	30%	>=90%	94% for highest priority cases. LHIN achieving 44% within target (red). WRH & HDGH operate beyond funded hours (& still yellow/red).	New hire to provide vacation relief (instead of reduced hrs as in summer).	Feb	
CT (90% Completed Within:)	36	33	36	42	53	28 days	LHIN Q2 time is 30 days (yellow).	Wait times can only be reduced if we receive additional funding to increase operating hours.	Feb	
% Completed Within Each Priority Access Target:	73%	68%	61%	57%	53%	>=90%	95% for highest priority cases. LHIN achieving 84% within target (yellow).	Running additional hours to catch up from downtime associated with move.	Feb	

Exceptional Relationships

Patient Experience Indicators

Reporting Period:		Q1 09-10	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11					
Overall Rating of Care	Inpt	94.4	95.5	94.1	89.3	93.4	IP (comm hosp avg=92.4)			Mar	◀
	ED	89.2	91.2	91.0	84.9	83.2	ED (comm hosp avg = 84.2)	Fairly steady decline. Sarnia: 77.2/ CEEH: 92.3	Monitor following move to new facility and implementation of ED Pt Flow Specialist.		
	OB	98.0	94.4	90.2	98.3	97.7	OB (comm hosp avg = 93.5)				
	Day Surg	96.3	95.5	100.0	100.0	97.7	DS (comm hosp avg = 98.4)	Very good score.			

Indicator	Quarterly Performance (unless otherwise specified)				Current Period (Q2 10-11 unless otherwise specified)	Target	Interpretation/Analysis	Action Plan	Next Update (Month of Report)	Updated this Report		
	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11								
<i>Reporting Period:</i>		Q1 09-10	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11						
Would you definitely recommend Bluewater Health?	Inpt	69.9	70.2	71.3	62.4	64.7	IP (comm hosp avg = 69.4) Improvement over past quarter seen in all dimensions and overall. Top reasons: overall condition of hospital (33%) and attitude of staff (12%). CEEH: 84.4; 4E: 67.8; 4N: 57.6; Surg: 61.2					
	ED	63.2	70.0	66.7	59.6	61.7	ED (comm hosp avg = 56.4)					
	OB	54.2	38.9	51.7	63.8	57.1	OB (comm hosp avg = 68.4) Overall condition of hospital and rooms (36%), attitude of staff, time with docs, visiting hrs, noise levels, involvement, understanding of what to do at home (all 9%) were top reasons for not definitely recommending.	Monitor reasons following move to new facility.				
	Day Surg	68.4	58.8	68.8	74.7	70.6	DS (comm hosp avg = 80.8) Stats sig lower than ON commun hosp avg. Parking (27%), overall condition of hospital and rooms (27%), time waiting (13%) and understanding home instructions (13%) top reasons for not definitely recommending.	Continue plans to decrease time patient arrives pre-procedure from 3 hours to 2 hours. Also looking to implement Studor approach to rounding for outcomes to improve nurse-patient communication through the use of scripting.				
Confidence/ Trust in Dr.	Inpt	80.9	85.2	83.5	80.5	85.3	IP (comm hosp avg = 82.6)					
	ED	71.8	77.6	74.9	69.2	71.5	ED (comm hosp avg = 72.0) Very close to target.					
	OB	84.0	78.2	80.0	85.2	95.6	OB (comm hosp avg = 84.1)					
	Day Surg	96.2	93.2	92.6	95.3	93.0	DS (comm hosp avg = 93.6) Very close to target.					
Confidence/ Trust in Nurses	Inpt	76.6	76.1	77.4	75.7	80.9	IP (comm hosp avg = 73.0) Stats sig higher than community hosp avg.					
	ED	76.3	76.2	83.7	69.1	73.6	ED (comm hosp avg = 70.8)					
	OB	69.4	82.1	72.4	86.9	77.3	OB (comm hosp avg = 73.4)					
	Day Surg	79.7	89.8	85.4	94.0	86.0	DS (comm hosp avg = 90.4)					
Overall Rating of Dr. Care	Inpt	95.2	95.1	93.4	92.6	96.2	IP (comm hosp avg = 94.1)					
	OB	100.0	96.4	93.3	98.4	100.0	OB (comm hosp avg = 95.9)					
Complaints												
<i>Reporting Period:</i>		Jun-10	Jul-10	Aug-10	Sep-10	Oct-10						
Complaint Rate (per 1,000 Encounters)		0.39	0.94	1.87	1.25	1.10	TBD	23 complaints total. Top categories of complaints: attitude/courtesy (9), communication (9), and care/treatment (6).		Jan	◀	
Response to Complaints (% Attempted Acknowledgement within 2 bus. days)		70.0%	81.0%	87.8%	92.6%	91.3%	95%	Attempts to resolve were delayed in 2 cases: 1 to allow for investigation and 1 without cause.		Jan	◀	
Resolution of Complaints (% Attempted Resolution within 14 days)		100.0%	95.2%	100.0%	88.9%	100.0%	95%			Jan	◀	
Inspired People												
Worklife Indicators												
Grievance Rates by Union Group	ONA	1.0%	0.2%	1.7%	1.6%	0.6%	3.45% (Healthcare Avg)					
	SEIU	3.6%	2.0%	3.4%	1.8%	2.0%					Feb	
	OPSEU	0.0%	0.3%	1.0%	0.0%	0.7%						
Workplace Safety Indicators												
<i>Calendar Year YTD (Cumulative):</i>		Jun-09	Sep-09	Dec-09	Mar-10	Jun-10						
# of Lost time injuries (LTI)		8	9	11	2	2	<9.9 Jan-Dec '10 (2.5/Q) (10% less than prior year)				Jan	
# of Health Care Claims (No Lost Time Injury)		34	52	72	12	33	<64.8 Jan-Dec '10 (16.2/Q) (10% less than prior year)	Top causes: overexertion/strain (12) and blood & body fluid exposure (6).	Education re: more consistent and reliable use of aids to prevent overexertion (i.e. mechanical lift). Education re: proper procedures and use of PPE to prevent exposure to blood & body fluids.		Jan	
Lost Time Injury Frequency (# of LTIs per 100 Full-Time Workers)		1.16	1.01	0.92	0.68	1.41	<1.66 (2009 healthcare rate)				Jan	
Lost Time Injury Severity (Days Lost per 100 Full-Time Workers)		4.60	4.00	3.67	1.53	7.15	<18.58 (2009 healthcare rate)				Jan	

Indicator	Quarterly Performance (unless otherwise specified)				Current Period (Q2 10-11 unless otherwise specified)	Target	Interpretation/Analysis	Action Plan	Next Update (Month of Report)	Updated this Report
	Q2 09-10	Q3 09-10	Q4 09-10	Q1 10-11						
WSIB Neer Index Rating (3 yr Window)	<i>Report Quarter:</i>	Sep-09	Dec-09	Mar-10	Jun-10	<1	June 30, 2010 NEER statement supports a health rebate from WSIB.		Jan	
	2010				0.04					
	2009	0.20	0.34	0.79	0.24					
	2008	0.22	0.22	0.21	0.25					
	2007	0.70	0.68	0.67	0.66					

Outstanding Performance

Risk Management Indicators

<i>Calendar Year:</i>	2005	2006	2007	2008	2009					
HIROC Claims Ratio (includes reserves for reported claims; no property claims)	3%	153%	50%	30%	38%	51.8% (peers-- 5 yr)			Jul	
HIROC Average Cost Per Claim	\$ 2,131	\$ 98,998	\$ 16,514	\$ 12,239	\$ 10,498	\$38,427 (peers-- 5 yr)			Jul	
HIROC Claim Frequency (# of claims)	5	7	16	15	23	6.3 (peers--CY 2009)	# of claims is higher, but lower claims ratio and cost/claim (above)		Jul	

Resource Utilization

Alternate Level of Care (ALC) Patients as a % of Beds	Acute	10.5%	11.4%	10.3%	7.5%	11.3%	<9%	Upward trend as available CCC beds were decreased in this period.	Continue weekly t-con with LHIN and CCAC and optimize idle bed use in community.	Feb	
	Total	23.8%	23.6%	22.6%	16.7%	19.3%	★				

Legend	All Indicators (Except Wait Times)	Wait Time Indicators
	Meets/Exceeds Target	>= 90% Completed within Priority Target
	Within 5% of Target	51%-89% Completed within Priority Target
	Worse than Target by 5+%	<=50% Completed within Priority Target
★	no established target/standard	

Manual	GOVERNANCE POLICY		POLICY
Section 4.0	Ensuring Financial Viability		
Title	RESOURCE PLANNING		
Issuing Body/ Prepared By	Resource Utilization and Audit Committee		
Approved by	Board of Directors		Number: GOV 4.10
Effective Date	O: June 2005	Version 2	File Name: "Lhgdata"(J:)/Dept'1/Admin/ CorpDev/Corp&Board Planning/ Governance Policy/ 4.10 Financial Planning
Revised Date	R: December 2010		
Controlled document. Any documents appearing in paper form must be used for reference purposes only. The on-line copy on the file server above must be considered the current documentation.			

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health wishes to ensure that the organization undertakes appropriate financial planning, optimizes the use of and operates within its resources and adheres to its Hospital Service Accountability Agreement (H-SAA). This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

As set out in the Principles of Governance & Board Accountability policy (GOV 5.10), Bluewater Health is accountable to work within its resources and according to legislative and other binding directives of the Ministry of Health and Long-Term Care (Ministry) and the Erie St. Clair Local Health Integration Network (ESC LHIN).

The Hospital’s funding and service obligations are set out in the H-SAA which is based on the Hospital Accountability Planning Submission (HAPS). In particular, the Hospital is required to achieve a balanced budget in each fiscal year.

The Board hereby delegates responsibility and authority to the President & CEO (CEO) to develop an annual operating plan which:

1. is consistent with the Board’s strategic priorities in the allocation of resources among competing program and service needs;
2. contains sufficient information to support projections of revenues, expenditures, cash flow, and service levels with clear distinction of capital and operational items, and disclosure of planning assumptions and restrictions related to program/service volumes, borrowing requirements, cash flow, significant changes in financial position and material changes to accounting procedures;
3. is consistent with the HAPS and is premised on achieving or surpassing the patient service targets established in the H-SAA;
4. incorporates the following at a minimum:
 - a. program and service plans;

- b. a financial plan, including operating and capital budgets; and
- c. human resource plans for hospital employees and Professional Staff.

The CEO shall ensure that:

- 1. reasonable opportunities exist for stakeholder engagement in the development of the operating plan; and
- 2. any material deviation(s) between actual revenues, expenses, staffing and service volumes from the operating plan approved by the Board and any significant reallocations of resources between programs are promptly brought to the Board's attention.

Monitoring

Method & Frequency: 1. Review of the Policy (every three years)

Manual	GOVERNANCE POLICY		POLICY
Section 4.0	Ensuring Financial Viability		
Title	FINANCIAL CONDITION		
Issuing Body/ Prepared By	Resource Utilization and Audit Committee		
Approved by	Board of Directors		Number: GOV 4.40
Effective Date	O: December 2010	Version 1	File Name: "Lhgdata"(J:)/Dept'1/Admin/ CorpDev/Corp&Board Planning/ Governance Policy/ 440 Financial Condition
Controlled document. Any documents appearing in paper form must be used for reference purposes only. The on-line copy on the file server above must be considered the current documentation.			

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health wishes to ensure that the financial condition and operations of the Hospital are consistent with the Board-approved Operating Plan and Budget. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The CEO shall ensure that appropriate and effective processes exist to manage the operating and capital expenses within the Board-approved operating and capital budgets.

These processes exist to minimize the opportunity for expenditures to occur which may jeopardize the Hospital's financial standing.

The CEO shall ensure that any material reallocation of funds between programs and projects will be promptly brought to the Board's attention.

Accordingly, the CEO is responsible for ensuring that sufficient internal controls and reporting structures are in place and are followed so that:

- Revenue is only expended for its intended purpose
- More funds are not expended than have been budgeted or reasonably forecast to be received
- Reserves are used only as approved by the Board
- Debt, whether capital or operating, is only incurred in accordance with the Board's direction

- The Hospital's cash balance is maintained at a sufficient level to meet the Hospital's obligations in a timely manner
- Governmental, regulatory and agency filings and payments thereon are made in a timely and accurate manner

Monitoring

Method & Frequency: 1. Review of the Policy (every three years)
2. Review of regular monitoring reports (per workplan)

Manual	GOVERNANCE POLICY		POLICY
Section 4.0	Ensuring Financial Viability		
Title	ASSET PROTECTION		
Issuing Body/ Prepared By	Resource Utilization and Audit Committee		
Approved by	Board of Directors		Number: GOV 4.50
Effective Date	O: May 2005	Version 2	File Name: "Lhgdata"(J:)/Dept'1/Admin/ CorpDev/Corp&Board Planning/ Governance Policy/ 4.50 Asset Protection
Revised Date	R: December 2010		
Controlled document. Any documents appearing in paper form must be used for reference purposes only. The on-line copy on the file server above must be considered the current documentation.			

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health wishes to ensure that the assets of the Hospital are reasonably protected, adequately maintained and not placed at unnecessary risk. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

The Board hereby delegates responsibility and authority to the CEO to implement appropriate and effective processes to safeguard Hospital assets and not unnecessarily expose the Hospital or its Board, staff or volunteers to claims of liability. Accordingly, the CEO shall ensure that:

1. appropriate liability, property and fidelity insurance coverage is obtained and maintained in force for the protection of Bluewater Health, its Directors, Officers, non-Director Committee members, employees, volunteers and such other persons whom the CEO deems appropriate;
2. adequate control processes are in place, both internally and through Hospital agents, for the receipt, processing and disbursement of funds in compliance with Canadian generally accepted accounting standards and applicable internal control practices;
3. financial reporting is consistent with Canadian generally accepted accounting standards;
4. Hospital funds are invested in accordance with the Hospital's Investment Policy (GOV 4.60);
5. real property is not acquired, disposed of or encumbered without the prior approval of the Board;

6. plant and equipment are adequately maintained and not subjected to unreasonable wear and tear.

Monitoring

Method & Frequency: 1. Review of the Policy (every three years)
2. Annual External Review of Financial Processes and Internal Controls

Manual	GOVERNANCE POLICY		POLICY
Section 4.0	Ensuring Financial Viability		
Title	INVESTMENTS		
Issuing Body/ Prepared By	Resource Utilization and Audit Committee		
Approved by	Board of Directors		Number: GOV 4.60
Effective Date	O: May 2005	Version 3	File Name: "Lhgdata"(J:)/Dept'1/Admin/ CorpDev/Corp&Board Planning/ Governance Policy/ 4.50 Asset Protection
Revised Date	R: January 2007 December 2010		
Controlled document. Any documents appearing in paper form must be used for reference purposes only. The on-line copy on the file server above must be considered the current documentation.			

Purpose

As part of its responsibility for ensuring financial viability, the Board of Bluewater Health wishes to ensure that investment activities are undertaken in a manner designed primarily to preserve and safeguard capital, and secondarily to optimize investment return. This policy sets out processes to support the Board in fulfilling this responsibility.

Policy

Preservation of both the operating and capital funds are of paramount importance in the administration of the investment policy. The mix of investments must adhere with current legislated requirements and be within the powers of the Hospital Board as set out in the By-Laws.

The investment mix should generate a steady, dependable and predictable flow of revenue from year to year. In all cases, maturity dates of investments shall recognize the forecasted cash flow requirements for operating and capital expenses.

The Board hereby delegates responsibility and authority to the CEO to invest surplus-to-need funds in order to optimize investment return while minimizing the risk of loss.

Investments may take two forms:

1. Long term (greater than 12 months) investments shall be limited to:
 - a) Debt obligations issued or guaranteed by the Government of Canada;
 - b) Debt obligations issued or guaranteed by a Province of Canada provided the instruments are rated, and continue to be rated, at least AA or equivalent, by a recognized rating agency;

- c) Debt obligations issued or guaranteed by a Canadian municipal government provided the instruments are rated, and continue to be rated, at least AA or equivalent, by a recognized rating agency;
 - d) Debt obligations issued or guaranteed by a corporation, incorporated under the laws of Canada or a province thereof, provided the instruments are rated, and continue to be rated, at least A-1 or equivalent, by a recognized rating agency;
 - e) Bankers' acceptances, bonds or term deposit receipts of a Canadian chartered bank which are rated, and continue to be rated at least A-1 or equivalent, by a recognized rating agency; and
 - f) Equity-based instruments of a corporation, incorporated under the laws of Canada or a province thereof, with the approval of the Board.
2. Short term (12 months or less) investments shall be limited to:
- a) Cash or cash equivalents held on deposit at the Hospital's chartered bank, other Canadian chartered bank or regulated investment agency;
 - b) Short term instruments such as Treasury Bills or Guaranteed Investment Certificates when the rate of return is superior to cash or cash equivalents.

Monitoring

Method & Frequency: 1. Review of the Policy (every three years)
2. Investment Review (quarterly)



Vision: Exceptional Care - Exceptional People - Exceptional Relationships
Values: Compassion, Accountability, Respect, Excellence (CARE)

President / CEO Report to the Board

Quality Care

Palliative Medicine

On December 7, Palliative Medicine was temporarily relocated to the renovated nursing unit on 4 London South. Palliative Medicine will return to 5 London in late January following painting, new flooring and upgrades to the nurse call and phone systems. During the renovations, a new nursing station and medication room will be installed. This work has been much anticipated by our nursing staff and patients.

Critical Care Unit

On January 7, 2011, we will formally change the names of Critical Care and Level 2 to Intensive Care Unit and Coronary Care Unit, to more accurately reflect the more common naming, familiar to patients and families. We are changing due to patient and community partners feedback and to ensure timely and helpful way-finding for staff, families and physicians.

Releasing Time to Care

I am pleased to report that 4 London (Acute Medicine) has experienced a milestone in their Releasing Time to Care journey. The continued work of the front-line staff on aspects of patient safety, has demonstrated another significant improvement in November. The staff report a reduction of patient falls that is double their pre-determined target.

Privacy Breach

The hospital sent out over 100 letters to community members whose personal information was inappropriately accessed by a North Lambton Community Staff member. The Privacy Office of Bluewater Health received 39 calls from community members who had further questions in regards to the breach of their personal health information. We responded to each call. From the 39 individuals who called 6 requested to meet with us. We met with each individual in November. We have also received official notification from the Information Privacy Commission that we have met their expectations from a privacy perspective and they have closed our breach file.

We take our responsibility to protect the privacy of our patients and clients personal health information very seriously. We have made and will continue to make improvements in this area under the leadership of our Privacy Officer to ensure we are in total compliance with the requirements of the *Personal Health Information Protection Act*.

Workplace Safety and Insurance Board

Bluewater Health has demonstrated improvements in providing a safe workplace for our employees, and volunteers. The September 30, 2010, Workplace Safety and Insurance Board, New Experimental Rating (NEER) program statement has recently been received, and indicates a rebate of \$76,949.98 to Bluewater Health. Through the WSIB NEER program, we can earn rebates on our WSIB premiums by maintaining a good health and safety record. NEER compares us to other companies doing similar work e.g. other hospitals in the province.

We have numerous health and safety prevention programs in our workplace to protect our workplace from injury and illness.

Inspired People

Western Ontario Health Knowledge Network

Bluewater Health supports the ongoing knowledge acquisition and development of our employees and Professional Staff through a partnership with the University of Western Ontario.

The Western Ontario Health Knowledge Network (WOHKN www.wohkn.ca) has redesigned its website in order to provide improved access to the suite of electronic resources. The new web design features subject guides that highlight key books, journals, and web resources on different healthcare topics. WOHKN has also purchased a new medical reference electronic library: Access Medicine, which contains over 60 full text online reference books. This key clinical resource provides current, accurate and authoritative reference material for clinicians in support of safe and quality patient care.

The WOHKN portal gives healthcare and administrative professionals from the participating [WOHKN Partners](#), (Bluewater Health, Chatham Kent Health Alliance Grey Bruce Health Services, Share Library Services, St Joseph's Health Care, London Health Science Centre and University of Western Ontario) access to electronic health resources from their desktop or networked workstation in whichever hospital they are working in, within the region.

A Culture of Innovation

Health Records

On December 6th, the Health Records team moved to into their new location. All Health Records staff will be centralized to one location. Health Records staff currently working at CEEH will remain at CEEH.

Exceptional Relationships

CEEH 100th Anniversary Planning

Great planning continues for the recognition and celebration of the Charlotte Eleanor Englehart Hospital of Bluewater Health. An enthusiastic planning team of community members, volunteers and staff members have planned a number of exciting functions. Mark Your Calendars!

(see attached)



CEEH 100th Anniversary Planning

“CEEH – Celebrating our First Century of Health, Heritage and Community”

Update – December 2010

Main dates of Functions:

1. **Saturday, January 29, 2011**, 2 – 4 pm – kick off of the 100th anniversary at VPP – music and several venues planned for this function.
2. **Saturday, May 14, 2011** – Unveiling of plaque and statues in commemorative Englehart Garden – will have formal invitation for dignitaries for this.
3. **Sunday, June 12, 2011** – Strawberry Social (lead by Auxiliary and IODE)
4. **Saturday, November 12, 2011** - Banquet, Dance and Auction at Wyoming Fair Building.

Other Community Involvement/Planning:

1. **Heritage committee** – Organized compilation of **Cook book** – expecting delivery of cook book to CEEH in November, 2010. CEE Auxiliary to manage distribution and funds.
2. **LCCVI** - Local Secondary school – all grade 12 art classes, one grade 9 class and one grade 11 class will be doing the **art for CEEH 100th anniversary**. Any medium in art and photography that is connected to history for medicine or the CEE Hospital was thought to be acceptable. All are to be completed by end of December 2010. We are encouraging them to be displayed around the town in various businesses/community centres - starting Jan10, 2011. We are asking if some would be donated and then become part of the auction in November, 2011.
3. **CEEH Auxiliary** –
 - Application for grant, plus other applications/requests for donation
 - Strawberry social (assistance from IODE)
 - Planning of celebration for the January function, unveiling ceremony and strawberry social – will be utilizing assistance of those below:
 - Town of Petrolia
 - IODE
 - Rotary – Petrolia branch
 - Town crier
 - Lambton Youth Choir
 - Petrolia Community Theatre

Lambton Mainstreet Players
Petrolia Music makers (brass quartet)
Norm Sutherland and Bluewater Connection
LCCVI – art class/ competition
Local business Association
Petrolia in Bloom
Charlottes Task Force
Bluewater Health staff
Community volunteers

4. **Bluewater Health Foundation - Dream Home 2010/2011** – located in Petrolia and giving a donation of \$100,000 in honour of the 100th anniversary. Our 100th Anniversary committee has set up a “heritage room” in the basement of the Dream Home commemorating the anniversary. Also, our committee is hosting a weekend open house in January, 2011.
5. **Parades** – Charlottes Task Force organized a float for the Santa Claus parade on December 4 – promoting the 100th anniversary.

Submitted by Connie Courtney

Minutes/ Report



QUALITY COMMITTEE

Thursday, December 2, 2010

4:30 PM

Mitton Site Board Room

Members:

(Attendance indicated with ✓ mark, R = regrets)

DRAFT

Elected Directors:

David Campbell(C)✓; Bruce Davies(R); Jim Elliott✓; Lorri Kerrigan✓; Bob McKinley✓; Richard Newton-Smith✓; Cindy Thayer✓

President/CEO:

Sue Denomy✓

Acting Chief of Professional Staff:

Dr. Michel Haddad(R)

Interim VP, Medical Affairs, Chief Of Quality, Patient Safety, & Risk Management/Administrative Lead:

Dr. Renato Pasqualucci✓

Non-Director Committee Members:

Victoria Hawksworth✓; Joan Korpan✓; Arvind Phadnis✓; Janet Raiger✓

Medical Staff Member:

Dr. Anil Garach✓

Staff Members:

Mike Lapine✓; Barb O'Neil(R)

1.0 CALL TO ORDER – 4:30 p.m.

2.0 APPROVAL OF AGENDA

- *Motion (B. McKinley/C. Thayer) and carried: to approve the agenda.*

3.0 CONFLICT OF INTEREST

- None declared.

4.0 APPROVAL OF MINUTES

- *Motion (B. McKinley/C. Thayer) and carried: to approve the minutes of November 4, 2010.*

5.0 NEW BUSINESS

5.1 *Clinical Nutrition Annual Report* - (attached in minute record book)*

Liz Dunlop, Director of Nutrition and Food Services, attended the meeting with Kathy Sterling, Manager of Clinical Nutrition. Liz referred the Committee to her report. There were no questions raised with respect to the report as it was presented. Kathy then explained to the Committee that e-mail consent forms had been introduced to improve quality of patient care for diabetic patients. Kathy discussed the steps involved in implementing the forms and noted that they are now able to communicate blood sugar readings to patients via e-mail. This has resulted in more effective communication with patients, time savings, etc. It is expected this method of communication will likely prevent hospital admissions, however, such data is not currently captured. Kathy reported that both the staff and patients are very pleased with the outcome. This should result in

improved patient and staff satisfaction. Lastly, questions with respect to insulin pumps were raised and answered.

5.2 MIC Annual Report* – (attached in minute record book)

Connie Courtney attended the meeting on Kelly Ross' behalf. Connie referred the group to the overview provided within the report. She advised that patient satisfaction had improved, noted the projects they are working on with external partners, and reported that the MORE OB Program was coming to an end in December. Next, Connie discussed three areas of upcoming change within the program including: cross training of Paediatric/Special Care nursing staff with a goal to be completed within 6 months, epidural services being offered effective February 1, 2011, and a closed model unit for C/Sections to be implemented within 18-24 months. Connie discussed the epidural training being provided and also reviewed the module they will be using to train nurses to circulate for C/Sections. The transition of the OB unit to a closed model will be three-phased: 1. Circulation; 2. Scrubbing; 3. Recovery. The program is currently in the planning stages for the Scrubbing and Recovery phases of the transition. Questions were raised and answered. Connie indicated that costs savings will not be realized with the changes, however, patient satisfaction is expected to improve with having the same nurse involved throughout the patient's hospital experience. Connie then confirmed that the training being provided is paid, and that the number of births this year is currently tracking on target. Next, she discussed the three areas where patient satisfaction could be improved and explained the steps being taken to improve these areas. Finally, there was discussion with respect to using nurse anaesthetists in the future and the recruiting currently taking place to address the shortage of anaesthetists at the hospital.

6.0 FOLLOW UP FROM PREVIOUS MINUTES

6.1 Surgical Safety Checklist

Dr. Pasqualucci confirmed that compliance with the Surgical Safety Checklist will be reviewed at monthly OR staff meetings, Surgery Program Council, Quality Performance Council, and lastly by this Committee. He further noted that the checklist has been amended to require that a nurse sign off on each of the three sections, however, there continues to be reluctance from the surgeons to take responsibility for the entire process. Discussion ensued. Dr. Pasqualucci indicated that he was not aware if surgeons in other hospitals were being held accountable for completion of the checklist. Lengthy discussion of the various hospital councils and the reporting structure followed. It was requested that the Committee be provided with an organizational chart illustrating the reporting relationships amongst the various councils.

Action: *Dr. Pasqualucci*

6.2 Terms of Reference* - (attached in minute record book)

6.3 ECFAA Compliance Tracking Document* - (attached in minute record book)

D. Campbell suggested that items 6.2 and 6.3 be discussed together. The Committee reviewed the Terms of Reference and the ECFAA Compliance Tracking Document. It was determined that until the OHA had provided additional information regarding the ECFAA, the Terms of Reference would remain the same.

6.4 Litigation Claims Review* - (attached in minute record book)

Dr. Pasqualucci presented the Risk Management Claims Analysis Reporting Policy to the Committee for review. Amendments suggested included removing the word "Interim" from the title of Interim Vice-President Medical Affairs and Chief of Quality, Patient Safety and Risk Management noted under numbers 2 and 3, removing the graph specification under number 5, and changing the language of number 6 to read "The report will also include a précis of litigation files that may be of current concern or result in a higher than the HIROC average settlement."

- **Motion (J. Elliott/B. McKinley) and carried: to approve the policy with the changes noted above.**

Action: *Dr. Pasqualucci*

7.0 WORK PLAN/STANDING ITEMS

7.1 Indicator Report* - (attached in minute record book)

Dr. Pasqualucci reviewed the updated areas of the Balanced Scorecard. The *C Difficile Infection Rate* increased slightly at the Norman site however, the cases do not appear to be related. Dr. Pasqualucci noted that the Infection Control Committee has recommended the creation of an Antibiotic Stewardship Subcommittee which will report to MAC. This Subcommittee is expected to improve the use of antibiotics which will result in cost savings. The proposed make up and reporting schedule of the Subcommittee was discussed. Next, the *Patient's Confidence that Caregivers Clean Hands* indicator was discussed. Dr. Pasqualucci noted that the lead staff member overseeing this program is currently facing health issues, however the issue is a corporate priority and is being addressed as part of the RTC© program. The *Overall Rating of Care* indicator has dropped for the Emergency Department. Dr. Pasqualucci noted that wait times have increased since the move and the drop in the indicator may be a reflection of this. An ED patient flow specialist will be implemented to improve the situation. Dr. Pasqualucci also noted that lack of beds in the hospital affects the wait times in Emergency. The indicator *Would you definitely recommend Bluewater Health* was also reviewed. It was noted that these numbers are from Q1 and reflect patient complaints from the old facility. The action plan to improve the indicator was discussed. Dr. Pasqualucci had nothing further to add in regards to the *Complaints* indicators. Lastly, Dr. Pasqualucci noted that the Directors are being held more responsible for the results of the Balanced Scorecard at the Quality Performance Council and the Medical Quality & Utilization Council meetings.

7.2 Concerns/Compliments* - (attached in minute record book)

Barb O'Neil was not present. D. Campbell mentioned that there was nothing to note in the report.

7.3 Patient Safety/Accreditation* - (attached in minute record book)

Dr. Pasqualucci noted that the Patient Safety/Accreditation lead staff member is facing health issues, therefore, the report was prepared by Margaret Mai. He confirmed that the RMSAM review had been completed for HIROC, the draft Fire Safety Plan had been completed for the CEEH site for approval by the Fire Department, and that lock down procedures for the CEEH site will be implemented the second week of December. The difference between adverse and critical events was clarified. An inquiry was also made with respect to the discretion made in reporting adverse events. Dr. Pasqualucci explained that the reporting of adverse events depends on the culture of Patient Safety within the hospital. The hospital's goal is to encourage people to report adverse events. Recent survey results suggest that staff don't feel they won't be punished if they report an error, therefore the hospital is working to improve this. Dr. Pasqualucci added that the culture shift will depend largely on the physicians and how they react to nurse errors. Last, there was discussion regarding the levels at which adverse events are investigated and surgical site infections. D. Campbell added that a patient safety video would be shown to the Committee at the January meeting.

7.4 Releasing Time to Care ©

D. Campbell noted that he had attended the RTC© pilot celebration. He was pleased to report the staff members were very excited about RTC© and the differences being made.

7.5 Pandemic Plan

Deferred to the next meeting.

Dr. Pasqualucci noted that the Pandemic Plan lead staff member is facing health issues but that the plan would be reviewed.

7.6 Monitor Effective Coordination of Patient Care and Positive Relationships with Community Health Service Providers via ALC Indicator Reporting and Other Sources* - (attached in minute record book)

Dr. Pasqualucci referred the Committee to the OHA Bulletin included within the meeting package. He noted that he had also spoken with Nadine Krasinkiewicz with respect to the hospital's relationships with community health service providers. Nadine had reported that:

1. The hospital is currently working with CCAC, LTC and the LHIN to identify the current needs for LTC in both the community and hospital with regard to specialty units;
2. They continue to work with LTC home operators in an effort to maximize use of idle beds in Long Term Care;
3. The CCAC recently attended a Clinical Leadership meeting to promote their Geriatric Rapid Response Team;
4. There are weekly teleconferences with CCAC, the LHIN and the Chatham Kent Health Alliance focusing on ALC management strategies and knowledge between agencies and hospitals; and
5. Regional implementation of new software will work to streamline ALC reporting throughout the LHIN.

The affect of ALC patients on increased wait times in the ER was discussed as were the benefits of the GEM nurses introduced at the hospital in January. Clarification was provided with respect to the service offered by CCAC and the care provided by the GEM nurses.

7.7 Support the Implementation of the Community Engagement Strategy Development Committee Recommendations

Deferred to the next meeting.

Dr. Pasqualucci noted that Christine Murphy had recommended that the Committee defer this item until January and rephrase it as "Support the Implementation of the Community Engagement Strategy and Operational Plan."

7.8 Establish Committee Goals and Develop Work Plan

Deferred to the next meeting.

It was suggested that the Committee continue using the current Work Plan until further clarification regarding the ECFAA was provided by the OHA.

8.0 OPEN DISCUSSION FORUM

Mike Lapaine and Sue Denomy briefly discussed the Health Based Allocation Model (HBAM) Simulation Conference they had attended that day. The ECFAA Webinar scheduled for December 15, 2010 was mentioned as was the Webinar scheduled on December 10, 2010, regarding the Balanced Scorecard. The group also briefly discussed recent news articles related to healthcare.

9.0 NEXT MEETING – January 6, 2011

10.0 ADJOURNMENT – 6:21 p.m.

D. Campbell, Chair

Melissa Rondinelli, Recorder



**Minutes/
Report**

Governance & Nominating Committee

**Tuesday, December 7, 2010
Board Room
Mitton Site**

Members: (Attendance indicated with a√)

Board Members: Richard Newton-Smith(C)√; Bruce Davies√; Sue Denomy(r); Jim Elliott√;
Lorri Kerrigan√; Stéphane Thiffeault√

Staff: Christine Murphy√

1.0 Call to Order – 4:38 p.m.

2.0 Approval of the Agenda

Motion (J. Elliott/L. Kerrigan) and carried: to approve the agenda as presented.

3.0 Conflict of Interest

None declared.

4.0 Approval of the Minutes – November 9, 2010

Motion (S. Thiffeault/J. Elliott) and carried: to approve the minutes of November 9, 2010 as presented.

5.0 Follow Up From the Previous Minutes (*attached in minute record book)

5.1 Performance Indicator Working Group

J. Elliott provided an update on the Performance Indicator Working Group activities. He advised that Jennifer McCullough, Director of Performance Management, will be preparing a draft of the proposed corporate balanced scorecard which will be presented at the next meeting. He noted that the indicators selected may need to be modified in accordance with the requirements of Quality Improvement Plans prescribed under the *Excellent Care for All Act (ECFAA)*.

5.2 Excellent Care for All Act and the Public Hospitals Act – Regulation 965 Amendments*

B. Davies reported that the Ontario Hospital Association had responded to the Ministry of Health and Long-Term Care's (MOHLTC) request for commentary on the *Excellent Care for All Act (ECFAA)* proposed regulations and the *Public Hospitals Act (PHA)* - Reg. 965 proposed amendments. The OHA's comments were based on a survey of all Ontario hospitals. He noted that the MOHLTC has not finalized the regulations to either statute.

B. Davies reported that he attended the Professional Staff Association (PSA) Annual General Meeting on December 1st. Much of the discussion at the AGM related to the resignations of Dr. Ramirez, Dr. Garach and Dr. Hynes from their PSA executive positions. These positions remain vacant and the PSA will be holding elections in the near future. Dr. Wang will continue as Vice President but is currently on maternity leave. Discussion ensued

about various matters pertaining to the lack of PSA representation at the Board meetings and methods of engaging physicians in the hospital's governance.

5.3 Community Engagement Strategy/Operational Plan Review and Draft Community Engagement Policy*

C. Murphy presented the revised Community Engagement Strategy and Operation Plan 2009-2012 and the amended draft Community Engagement policy for review and approval. She advised that the policy was revised to focus on the governance roles and responsibilities for Community Engagement with operational elements of the policy moved to the operational plan.

The Committee discussed the plan and policy and decided that the endorsement of the CE Strategy and Operational Plan and recommendation of the draft Community Engagement Policy be deferred to the January Board meeting in conjunction with an educational session.

Motion (J. Elliott/L. Kerrigan) and carried: to recommend the adoption of the draft Community Engagement Policy 6.10 to the Board, for approval at the January meeting.

5.4 Financial Viability Policies from RUAC – Gov. 4.10-4.60*

The Committee reviewed the amended draft financial viability policies (Gov. 4.10, 4.40-4.60). C. Murphy suggested that Policy 4.10 – Resource Planning and Policy 4.30 – Annual Operating Plan could be combined into one policy as they overlapped considerably. She sought the Committee's feedback regarding Policy 4.20 - Performance Monitoring: Financial and Activity Indicators and whether this policy should be expanded to include quality performance monitoring in addition to financial performance monitoring. The committee agreed with these suggestions.

The following amendments were proposed:

Policy 4.10 – Resource Planning

- add “wishes to” before “ensure” in the first sentence of the Purpose section, and
- delete Item 2 under the Policy section.

Motion (B. Davies/J. Elliott) and carried: to recommend that Policy 4.10 – Resource Planning be referred back to the Resource Utilization and Audit Committee as amended.

Policy 4.40 – Financial Condition

- amend the Purpose section to delete the word “will” and add “wishes to” before ensure and add “that” after the word ensure in the first sentence;
- add “and operations” after “financial condition” and change “is” to “are” in the same sentence;
- delete the second sentence in the first paragraph under the Policy section, and
- add “The CEO shall ensure that any material reallocation of funds between programs and projects will be promptly brought to the Board's attention” as the third paragraph under the Policy section.

Motion (J. Elliott/L. Kerrigan) and carried: to recommend that Policy 4.40 – Financial Condition be referred back to the Resource Utilization and Audit Committee as amended.

Policy 4.50 – Asset Protection

- amend the Purpose section to delete the word “will” and add “wishes to” before ensure and add “that” after the word ensure in the first sentence;
- add “and operations” after “financial condition” and change “is” to “are” in the same sentence, and
- add the word “whom” before “the CEO deems” in Item 1 of the Policy section.

Motion (L. Kerrigan/J. Elliott) and carried: to recommend that Policy 4.50 – Asset Protection be referred back to the Resource Utilization and Audit Committee as amended.

Policy 4.60 - Investments

- amend the Purpose section to delete the word “will” and add “wishes to” before ensure and add “that” after ensure in the first sentence;
- delete “to implement appropriate and effective processes” in the third paragraph of the Policy section;
- amend the third paragraph by deleting the word “which” in Item 1 and 2 of the Policy section, and
- delete the words “such instruments” and add “which” in Item 1e of the Policy section.

Motion (J. Elliott/L. Kerrigan) and carried: to recommend that Policy 4.60 – Investment be referred back to the Resource Utilization and Audit Committee as amended.

5.5 Strategic Planning Retreat - Review and Next Steps

C. Murphy presented the proposed format for the Board retreat. She advised that the tentative dates for the retreat are Friday, February 11th and Saturday, February 12th with a facilitator leading the session. The retreat will build on the work of the November 12th Board mini-retreat with Dr. Ross Baker regarding Quality and Patient Safety.

The committee agreed that the purpose of the retreat should be to:

1. provide an opportunity for management to report to the Board on the status of the implementation of the 2009-12 strategic plan;
2. review the multi-year goals and determine where the hospital's focus should be for the remainder of the term of the strategic plan; and
3. provide the Board and leadership with an opportunity to discuss the Quality Improvement Plan as required by ECFAA.

The Committee discussed the proposed format and agreed that the proposed session is broader than a Board retreat and should include Directors, non-Director Committee members, business directors and Medical Directors. A detailed agenda will be developed based on these discussions for review at the next meeting.

C. Murphy sought a volunteer from the Committee to assist with the developing the agenda for the session. B. Davies volunteered to provide assistance.

5.6 Accreditation Update

C. Murphy provided a brief update on the upcoming accreditation process noting that all Directors will be asked to complete the self assessment survey and Governance Functioning Tool, similar to the 2008/09 process, in next couple of weeks.

5.7 Governance and Nominating Committee Work Plan – Monthly Review/Monitoring*

The Committee discussed the work plan and no changes were proposed.

6.0 New Business (*attached in minute record book)

6.1 Board Meeting Process (Item 5.11)

C. Murphy sought feedback from the Committee regarding Item 5.11 – Continue to strengthen Board meeting processes on the work plan and if there were any changes they would like to have made. No concerns were raised. It was agreed that the Committee would continue to monitor this item through Board meeting evaluations.

6.2 HIROC Risk Management Self Appraisal*

The Committee discussed the response details for the HIROC - Board and Governance Module. C. Murphy advised that hospital receives a discount on its insurance premiums by participating in the self- appraisal process.

6.3 OHA 2010 Prototype Board-Appointed Professional Staff by-laws*

C. Murphy advised that OHA and OMA had issued a joint letter on November 24th that stated that both organizations agreed that joint professional staff prototype by-laws would be preferable and that they had resumed discussions to that end.

6.4 Upcoming Release of the Auditor General's 2010 Annual Report*

The Committee was advised the Auditor General's 2010 Annual Report has been released and that it included a number of chapters related to hospitals: (1) a review on the discharge of hospital patients; (2) a review of hospital emergency departments and whether they had adequate systems and procedures to meet patient needs in a cost-effective manner; (3) Organ and Tissue Donation and Transplantation, and (4) a follow up on the 2008 report on hospital governance. Once the information is reviewed any governance concerns will be brought to the Committee's attention.

6.5 Board Education – Upcoming OHA webcast

The Committee was reminded that there is an OHA webcast scheduled for December 10th on the Balanced Governance Scorecard and an OHA webcast and videoconference scheduled for December 15th on the *Excellent Care for all Act* – an Update on Implementation Including the Quality Improvement Plan.

7.0 Next Meeting Date

The next meeting is scheduled for January 11, 2011.

8.0 Adjournment – 6:26 p.m.

Chair
Richard Newton-Smith

Recorder
Jacqueline McGregor

DRAFT



Minutes/ Report

Resource Utilization and Audit Committee

Thursday, December 9, 2010
3:30 p.m.
Boardroom – Mitton Site

Members: (Attendance indicated with a ✓)

Board Members: Bryan Bouck✓; Sue Denomy(r); Dr. Michel Haddad(r); Robert McKinley✓;
Wayne Pease✓; Pasquale Rossi✓; Brent Steeves✓; Cindy Thayer✓;
Stéphane Thiffault✓
Non-Director Committee Members: Terry McNally✓; Kathryn Poole✓
Staff: Steve Anema✓; Colleen Cook✓; Mike Lapaine✓
Guest: Jim Elliott, Director Bluewater Health✓

1.0 Call to Order - 3:30 p.m.

2.0 Chairman's Remarks

- S. Thiffault welcomed everyone to the meeting.

3.0 Approval of the Agenda

- *Motion (R. McKinley/B. Bouck) and carried: to approve the revised agenda as presented.*

4.0 Call for Declaration of Interest

- None declared.

5.0 Approval of the Minutes

- *Motion (K. Poole/B. Bouck) and carried: to approve the minutes of November 18, 2010 as presented.*

6.0 Follow-Up from Previous Minutes (*attached in the minute record book)

6.1 Indicator Taskforce

J. Elliott provided an overview of the Performance Indicator Taskforce. He advised that there are a number of indicators that the hospital is required to publish some of which are already published on other central sites. He noted that one of the immediate goals of the taskforce is to determine which Board indicators should be published as part of the corporate balanced scorecard on the hospital website.

J. Elliott advised that one of the long-term goals for the taskforce is to seek the Quality Committee and Resource Utilization and Audit Committee's input regarding which indicators the committees would like to see published from the balanced scorecard beyond what is required. He reported that these indicators should be in accordance with the strategic plan. J. Elliott sought the Committee's feedback regarding the balanced scorecard regarding current indicators.

Clarification was sought regarding which indicators are required and which ones were optimal. The Committee was advised that Jennifer McCullough has the information categorizing the indicators which can be shared with the Committee. Discussion ensued.

An inquiry was made regarding the timeframe for feedback. He advised that the taskforce will meet once before and once after Christmas.

The Committee sought feedback regarding the balanced scorecard in terms of tracking efficiencies. J. Elliott advised that it was not the Committee's role to measure the efficiency but rather to monitor the indicators. He advised that the trend analysis is an operational role. The Committee advised that the measure and understanding the trend is important in order to know what is working well and what is not and what is being done to correct inefficiencies. The Committee advised that they are not able to tell how the indicators are doing on a month to month basis with the current scorecard. A lengthy discussion ensued regarding the number of indicators, frequency of reporting and cost per weighted case.

The Committee was asked to select four to six indicators that align with the strategic plan for discussion at the Board retreat. There was agreement that the monitoring needs to be consistent with the hospital goals.

The Committee reviewed the next steps to: provide feedback of which indicators should and should not be published on the hospital website for the upcoming meeting; administration to report back on seminal indicators (what they are and how many) at the January meeting i.e. cost per weighted case, and determine what the key indicators are and how indicators should be tracked (i.e. monthly or highlight the red indicators only).

6.2 ***Policy 4.10 – Resource Planning****

6.3 ***Policy 4.40 – Financial Condition****

6.4 ***Policy 4.50 – Asset Protection****

6.5 ***Policy 4.60 – Investments****

The Committee reviewed the above-mentioned policies together. The Committee was advised that the Governance and Nominating Committee revised the policies and forwarded them back to the Committee for review and consideration. The Committee agreed to recommend the policies to the Board for approval.

Motion (B. Bouck/R. McKinley) and carried: to recommend Policy 4.10 – Resource Planning to the Board for approval.

Motion (B. Steeves/W. Pease) and carried: to recommend Policy 4.40 – Financial Condition to the Board for approval.

Motion (R. McKinley/B. Steeves) and carried: to recommend Policy 4.50 – Asset Protection to the Board for approval.

Motion (C. Thayer/T. McNally) and carried: to recommend Policy 4.60 – Investments to the Board for approval.

The Committee was advised that Policy 4.20 – Performance Monitoring: Financial and Activity indicators requires further consideration as the policy may be broadened to include quality performance monitoring in addition to financial performance monitoring.

7.0 New Business (*attached in the minute record book)

7.1 ***Unpaid Loans***

S. Thiffeault reported that the Governance and Nominating Committee discussed the Committee's concerns regarding unpaid physician loans and agreed that revisions to the by-laws are not required due

to the new banking arrangements. However, the Committee may want to consider implementing a new policy to enforce the repayment of the physician loans.

The Committee held an in-camera discussion regarding the status of outstanding loans. The Committee was advised that the hospital is only the guarantor for the first five years of the loan after that the loan is considered a personal loan between the physician and the bank.

The Committee agreed that a policy is required in order to retrieve the bad debt as the loans were granted in good faith, and that the policy must outline all the necessary steps required before the suspension of privileges is considered. Discussion ensued and concerns were raised regarding privileges and due diligence. A request was made that at the time of renewing privileges, physicians with outstanding debt be identified with an asterisk so the Board is aware, and that notification be provided to physicians regarding the policy once approved.

Motion (B. McKinley/T. McNally) and carried: to recommend that management prepare a policy for the collection of unpaid loans for physicians.

7.2 ***Orientation***

S. Thiffault sought the Committee's feedback regarding orientation. Discussion ensued regarding the logistics and topics to be covered (i.e. terminology, funding processes, HAPs/H-SAA submissions, cost per weighted case and *Excellent Care for All Act*).

S. Anema sought clarification regarding the approach – a brief training session before the monthly meeting or a separate meeting specifically focusing on orientation. M. Lapaine proposed a one hour session before or after the monthly meeting with the option of opening it up to other Directors and non-Directors in order to be respectful of the volunteer's time. He also proposed that the August meeting be scheduled solely for the purposes of orientation. The Committee agreed an orientation session should be offered at least once a year after the committees are formed in order to bring new Directors and non-Directors up to speed and refresh existing Directors. There was consensus that the session should be mandatory and that it should be no more than an hour with the purpose of providing an overview of the Committee reports and an understanding of why and how the reports are used and linked.

The Committee requested that a training session be scheduled for the February meeting providing an overview of the budget, funding model and performance indicators.

Action: S. Anema/M. Lapaine

Motion (B. Steeves/T. McNally) and carried: to recommend that the Board consider re-formalizing formal orientation sessions every August.

7.3 ***Letter from the Minister regarding 2010-11 Funding for Diabetes Education****

The Committee was advised that the hospital has received additional base funding from the Ministry for diabetes education for the 2010-11 fiscal year and that this item was for information purposes only.

8.0 Work Plan Reports/Minutes (*attached in the minute record book)
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8.1 ***Facilities and Planning/Honeywell Projects****

M. Lapaine provided an update regarding the Facilities, Planning and Development report. He informed the Committee that the Ministry has acknowledged receipt of the mental health change order and is considering funding the change order within the total project cost.

M. Lapaine reported that there was a miscommunication between the architect and the City of Sarnia regarding the demolition of the Mitton Site in particular removal of trees, curbs and lights in January. He reported that the City's concerns have been resolved and that any future communications regarding the decommissioning of the Mitton Site will be between himself and Mr. Fennell at the City. He noted

that the Heritage Society is considering preserving the southwest corner of the Mitton Site and the Nursing building as heritage buildings.

M. Lapaine advised that the architect is preparing the tender documents for the costing of the decommissioning of the Mitton site in order to commence dialogue with City Council. He reviewed the timing and noted that the documents will not be ready until February-March; however, it is anticipated that it will be approximately a year before the hospital and City will be ready to go to tender. He noted that the hospital would like to have the tender documents to City Council by April-May so that the costing of the decommissioning is budgeted for in the City's 2012 budget. He reported that there are substantial savings for the demolition to occur during the spring-summer as opposed to the winter as premium fees are applied to winter demolitions.

S. Anema provided an update regarding the Honeywell project. He noted that the documentation for the Mitton site has been sent to Natural Resources Canada and that he has not received any feedback. He noted that there will be a minor credit for the CEEH and Norman sites and that he will report back next month with the final details. He noted that an outside consultant has been hired to verify the savings guaranteed by Honeywell.

Any inquiry was made regarding the status of the deficiencies identified in the new building. M. Lapaine provided an update regarding the steamers for the SPD Sterilizing Unit. He advised that a third person has been brought in to help identify the issue as the vendor and engineers have been unable to identify the problem.

Action: S. Anema

8.2 **Human Resources – December 2010***

C. Cook provided an update on the Human Resources report. She reported that OPSEU was recently awarded language in their contract regarding "home site". She advised that language pertains to where employees work and if they work at more than one site then mileage may have to be provided. She advised that this should have minimal impact on the hospital as the number of OPSEU employees that work on both sites is low. She noted that it is anticipated the other unions will seek the same language in their contracts.

C. Cook reported that OPSEU central negotiations are scheduled for February with mediation scheduled for March, and that the dates for the ONA negotiations have not been determined. She noted that an arbitration date has not been determined for the SEIU local to resolve the outstanding issues. C. Cook reported that the SEIU local has elected a new union president.

8.3 **Cash Balance Analysis***

The Committee reviewed the weekly cash flows for the period covering August 28, 2010 to April 2, 2011. S. Anema highlighted the \$5.7 million of PCOP funding received in November and advised that the hospital's cash position should return to a net positive position as a result of the funding. S. Anema reported that the cash position should remain the same until February-March when the ESC LHIN will recover the \$7.5 million cash advance over the last three payments of the 2010-11 fiscal year. He noted that discussions are ongoing with the LHIN concerning preparation for the 2011-12 operating year.

An inquiry was made regarding the ESC LHIN recovery of funds and if this recovery has been accounted for in the operating balance. S. Anema advised that \$4 million has been maintained in the Superbuild capital fund. S. Anema advised that as a result of the PCOP funding, the hospital will not have to borrow as much to bridge funding until the end of March. He will report back on how much has been withdrawn from the line of credit to date as well as reflect the status of the line of credit and loans of the capital redevelopment project on next month's report.

Action: S. Anema

8.4 **Financial Forecast – October 2010***

S. Anema presented the Statement of Revenues and Expenses for the period ending October 31, 2010. The statement shows the hospital's year-to-date revenues as \$98.6M and expenses are \$98.6M. He noted that the hospital has an operating surplus of \$20,000. S. Anema reported that there were improvements with room differentials and acknowledged the work of Nadine Krasinkiewicz. He highlighted co-payment, salary and wages, supplies and expenses. He reported that discussions are underway with the Ministry regarding outstanding transition costs.

B. Steeves requested the capital amount be added below the LHIN Operating Surplus on the Statement of Revenues and Expenses.

Action: S. Anema

8.5. **Work Plan (Item 4.14)***

The Committee discussed the work plan, in particular Item 3.14 – Monitor cost per weighted case and Item 4.14 - Review the financial stewardship principles and identify financial risk management indicators. S. Anema advised that he will report back regarding who assesses the financial risk management indicators. The Committee agreed that Item 3.14 will be monitored on a regular basis and that orientation should be added as an item to the work plan and track for August-September.

Action: S. Anema/J. McGregor

8.6 **Balanced Scorecard***

S. Anema provided an update regarding the balance scorecard and reported that there was an error with the Facility Operating Cost per Day indicator last month. The indicator should have read 434,345 not 519,510. He noted that the hospital is projecting a small surplus at year end as a result of the PCOP funding; however, this surplus is not enough to eliminate working capital deficits accumulated from prior years.

S. Anema highlighted the following indicators: CT hours, pacemakers, overtime expense and sick time expense. He noted that the CT hours target should be achieved by year-end as there was a slow down over the summer and that it is anticipated that funding for pacemakers may be clawed back due to the shortfall in completed procedures. He reported that overtime hours are up due to issues with the sterilizing equipment in SPD and the lab accreditation. He advised that the hospital has looked into the increase in sick time and advised there is no specific explanation for the increase. Discussion ensued regarding attendance management.

P. Rossi inquired if would be possible to be provided with an explanation for why indicators are tracking poorly in terms of determining how the bottom line is affected, for example, the Acute/Newborn indicator in the Efficiency section and cost per weighted cases. Discussion ensued regarding direct and fixed costs and incremental funding. S. Anema advised that it is difficult to measure some of the indicators as it is not easy to determine why they fluctuate as there could be many factors.

An inquiry was made regarding colonoscopies and the vacancies.

8.7 **Building Project Local Share Cash Flows Facilities and Planning Reports**

M. Lapaine highlighted the \$1,121,530 of own funds under the Pipeline Change Orders to be used for an elevator shaft in the Russell building. The Committee requested the Project Local Share Cash Flows chart be brought to next month's meeting.

9.0 Next Meeting Date – January 13, 2011

10.0 Adjournment

The meeting adjourned at 6:08 p.m.

Chair
S. Thiffeault

Recorder
Jacqueline McGregor

DRAFT

Bluewater Health Foundation
Report From the Executive Director
November 2010

Barry Hogan has resigned from the board in order to assist another local charity with a capital campaign (as per our conflict of interest policy). He is staying on our Investment Management Committee.

The Dream Home ribbon cutting and donor reception were held at the home in Petrolia. Open houses are attracting good crowds and great reviews.

I attended the OHA convention and confirmed a new donor and several leads for the golf tournament. The literature is ready to be released for the CEOs to “save the date” and for the solicitation of prospective sponsors.

The Muslim Association ethnic dinner was a great success and they have presented a cheque for \$10,000 to the Foundation.

I attended a presentation on new innovation available in MRI. The current MRI is approaching 10 years and may need replacing in the near future. This may be a fundraising opportunity for the Foundation.

The donor wall unveiling was held on November 18th in the Atrium. Over 170 donors attended and were thanked for their generosity. We sent a note of thanks to our guest speakers, Sue Denomy and Sheila Groombridge a nurse from Ambulatory Care, who spoke on behalf of the staff and patients of BWH.

We have received our first rent cheques from the atrium businesses. A separate account has been set up to delineate these funds in our banking and will be accounted for through the Business Centre in the financial reports.

Our Heart to Heart newsletter was sent out to over 6000 donors and Pulse was distributed to over 40,000 homes.

Respectfully submitted,

Liz Kenny