

Open Meeting

BLUEWATER HEALTH BOARD AGENDA

Note time and location of meeting

August 10, 2011
5:30 p.m.
L-2-666, Norman Site

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. EDUCATION SESSION 1.1 Presentation regarding Home First Program			✓			✓	S. Denomy/G. Switzer/ B. Kuchta
2. CALL TO ORDER 2.1 Welcome/Opening Remarks 2.2 Approval of Agenda 2.3 Declaration of Conflict of Interest					✓		B. Davies
3. APPROVAL OF MINUTES 3.1 June 22, 2011* 3.2 June 22, 2011 – Post Annual General Meeting*					✓		B. Davies
4. REPORT FROM IN-CAMERA MEETING					✓		B. Davies
5. ITEMS FOR DISCUSSION 5.1 Board of Directors Annual Acknowledgement Declaration (Policy 5.25)* 5.2 Broader Public Sector Perquisites Directive* (<i>information purposes only</i>)					✓	✓	B. Davies S. Denomy
6. ITEMS REQUIRING DECISIONS 6.1 ESC LHIN Reference Panel Report on the CEEH Emergency Department* 6.2 2011-12 Board Meeting Schedule*		✓	✓	✓		✓	S. Denomy/L. Robinson B. Davies
7. MONITORING/OVERSIGHT 7.1 Financial Statement* 7.2 PCOP Funding 7.3 Balanced Scorecard - RU&A Indicator Report*				✓	✓		S. Anema M. Lapaine S. Anema
8. POLICY FORMATION –none							

Topic	Board Responsibility					Presenter
	Establish Strategic Direction	Providing for Excellent Management	Ensuring Program Quality & Effectiveness	Ensuring Financial Viability	Ensuring Board Effectiveness	
9. ITEMS FOR INFORMATION & ANNOUNCEMENT 9.1 CEEH – Ambulatory Care*			✓			S. Denomy
10. OPEN FORUM – Opportunity for Directors to reflect on how our patients, families and community were considered in our discussions – Call for future meeting items						All Members
11. NEXT MEETINGS: September 22, 2011						B. Davies
12. ADJOURNMENT						B. Davies

Manual	GOVERNANCE POLICY		POLICY
Section 5.0	Board Effectiveness – Governance Policy Framework		
Title	DIRECTORS ACKNOWLEDGEMENT/ DECLARATION		
Issuing Body/ Prepared By	Governance and Nominating Committee		
Approved by	Board of Directors		Number: GOV 5.25
Effective Date	O. January 2005	Version 4	File Name: "Lhgdata"(J:)/Dept\1/Admin/Chief Executive Officer/Board and Board Committees/Board BWH/Board Policies/5.25 Directors Acknowledgement/Declaration
Revised Date	R: March 2007		
	October 2007 January 2009		
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.			

I, _____, acknowledge and accept the accountabilities as outlined in the appended “*Principles of Governance and Board Accountabilities*” policy and agree to comply with the performance expectations as stated in the appended “*Roles and Responsibilities as an Elected and Ex-officio Director*” policy.

Signature

Date

Chair

Attachments:

- 1) “Principles of Governance and Board Accountability” policy
- 2) “Responsibilities as an Elected and Ex-officio Director” policy

Monitoring:

Method: Board Review

Frequency: Annually

Manual	GOVERNANCE POLICY		POLICY
Section 5.0	Board Effectiveness – Governance Policy Framework		
Title	PRINCIPLES OF GOVERNANCE & BOARD ACCOUNTABILITY		
Issuing Body/ Prepared By	Governance and Nominating Committee		
Approved by	Board of Directors		Number: GOV 5.10
Effective Date Revised Date	O: January 2009	Version 1	File Name: “Lhgdata”(J:)/Dept’1/Admin/Executive Officer/Board and Board Committees/Board BWH/Board Policies/5.10 Principles of Governance & Board Accountability
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.			

1. The Board of Directors governs Bluewater Health through the direction and supervision of the business and affairs of the corporation in accordance with its articles of incorporation, its by-laws, vision, mission and values, governance policies and other laws and regulations.
2. The Board adheres to the *Modified Pointer and Orlikoff Governance Model*, (as referenced in the Roles and Responsibilities of the Board of Directors policy) a model of governance through which it provides strategic leadership and direction.
3. The Board acts at all times in the best interests of Bluewater Health, having regard for its accountabilities to its patients and the communities served, the Ministry of Health and Long-Term Care (Ministry) and the Erie St Clair, Local Health Integration Network (ESC LHIN).
4. The Board maintains a culture of honesty and integrity, open debate, forthright examination of all issues and strives for a consensual approach to decision-making.
5. The Board maintains at all times a clear distinction between Board and management roles, while recognizing the interdependencies between them.
6. The Board is accountable to:
 - its patients and communities served to:
 - engage the communities served when developing plans and setting priorities for the delivery of health care;

- advocate for and seek resources to provide appropriate health care;
- utilize its resources effectively to fulfill Bluewater Health's mission and mandate;
- ensure the quality of the care and treatment of patients
- ensure the appropriate use of community contributions and resources;
- consider the diversity of needs and interests in its policy formulation and decision-making;
- work within its resources, monitoring their efficient and effective use consistent with Bluewater Health's mission and mandate;
- measure Bluewater Health performance against accepted standards and best practices in comparable hospitals;
- inform the Ministry/ LHIN of any gaps between needs of the communities served and scope of services provided, based on resources allocated by the Ministry/LHIN to fulfill the Bluewater Health's mission and mandate; and
- apprise the Ministry/ LHIN and the communities served of Board policies and decisions related to the Bluewater Health's mandate that might be required to operate within its resources.

➤ the Ministry of Health and Long-Term Care (Ministry) and/or the Erie St. Clair LHIN to:

- comply with government regulations, policies and directions;
- ensure that Bluewater Health operates within:
 - ✓ the Ministry's provincial strategic plan;
 - ✓ the LHIN's integrated health service plan;
 - ✓ the service accountability agreement with the LHIN
- work within its resources, monitoring their efficient and effective use consistent with Bluewater Health's mission and mandate;
- measure Bluewater Health performance against accepted standards and best practices in comparable hospitals;
- inform the Ministry/ LHIN of any gaps between needs of the communities served and scope of services provided, based on resources allocated by the Ministry/LHIN to fulfill the Bluewater Health's mission and mandate; and
- apprise the Ministry/ LHIN and the communities served of Board policies and decisions related to the Bluewater Health's mandate that might be required to operate within its resources.

7. Consistent with the Board commitment to good governance practices the Board will make available to the public:

➤ the statement of Board and Director roles, responsibilities and accountabilities;

- a list of elected and ex-officio Directors and their participation in Board committees;
- the Board policies designed to allow the Board to function independently of management;
- policies governing Board standing committees; and
- an annual report on Bluewater Health performance.

Monitoring:

Method: Board Review

Frequency: Annually

Manual	GOVERNANCE POLICY		POLICY
Section 5.0	Board Effectiveness - Governance Policy Framework		
Title	ROLES AND RESPONSIBILITIES AS AN ELECTED AND EX-OFFICIO DIRECTOR		
Issuing Body/ Prepared By	Governance and Nominating Committee		
Approved by	Board of Directors		Number: GOV 5.20
Effective Date Revised Date	O: January 2009	Version 1	File Name: "Lhgdata"(J:)/Dept'1/Admin/ Chief Executive Officer/Board and Board Committees/Board BWH/Board Policies /5.20 Roles and Responsibilities as an Elected and Ex-officio Director
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.			

1.0 Accountability and Fiduciary Duties

A Director acts ethically, honestly, in good faith and in the best interests of Bluewater Health and in so doing, supports Bluewater Health in fulfilling its mission and mandate, and discharging its accountabilities. A Director exercises the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances. Directors with special skill and knowledge are expected to apply that skill and knowledge to matters that come before the Board.

A Director does not represent the specific interests of any constituency. A Director acts and makes decisions that are in the best interest of Bluewater Health as a whole. A Director adheres to the vision, mission and values of Bluewater Health and complies with the *Public Hospitals Act*, the *Corporations Act*, by-laws, applicable laws and regulations and Board policies. A Director adheres to the Principles of Governance and Board Accountabilities policy (GOV-5.10)

2.0 Exercise of Authority

A Director carries out the powers of office only when acting as a voting member during a duly constituted meeting of the Board or one of its committees. A Director respects the responsibilities delegated by the Board to the President/Chief Executive Officer and Chief of Professional Staff, avoiding interference with their duties but insisting upon accountability to the Board and reporting mechanisms for assessing organizational performance.

3.0 Conflict of Interest

A Director does not place him/herself in a position where his/her personal interests conflict with those of Bluewater Health. A Director complies with the Conflict of Interest provisions in the by-laws and Board approved policy.

4.0 Team Work

A Director works positively, cooperatively and respectfully with others in the performance of his or her duties while exercising independence in decision-making.

5.0 Participation

A Director reviews pre-circulated material and comes prepared to Board and committee meetings and educational events, asks informed questions, and makes a constructive contribution to discussions. A Director considers the need for independent advice to the Board on major corporate actions.

6.0 Formal Dissent

A Director reviews the minutes of the previous meeting on receipt and insists that they record any Director's disclosure of an actual or potential conflict of interest, abstention or dissent. A Director who is absent from a Board meeting is deemed to have supported the decisions and policies of the Board taken in his or her absence unless he or she formally records a dissenting view with the Board secretary.

7.0 Board Solidarity

The official spokesperson for the Board is the Chair or the Chair's designate. A Director supports the decisions and policies of the Board in discussions with outsiders, even if the Director holds another view or voiced another view during a Board discussion or was absent from the Board meeting. A Director refers requests for statements on behalf of the Board to the Board Chair. The Board Chair may delegate his/her responsibility for representing and acting as spokesperson for the Board to other Directors, as required.

8.0 Confidentiality

A Director respects the confidentiality of *in camera* Board discussions and information and such other Board discussions as deemed to be confidential by the Board. Directors will respect the confidentiality of any Informal Meetings.

9.0 Time and Commitment

A Director is expected to commit the time required to fulfill Board and committee responsibilities. A Director is expected to attend a minimum of 85% of the meetings of the Board and 85% of committee meetings of which he/she is a member. Directors who fail to meet the attendance requirements are subject to review by the Chair and may be asked to step down from the Board. All Directors are expected to serve on at least one Board committee (exceptions to be approved by the Board) and to represent the Board and Bluewater Health in the community when reasonably requested by the Board Chair.

10.0 Competencies

A Director actively contributes specific expertise, skills and other attributes that are needed on the Board.

11.0 Education

A Director seeks opportunities to be educated and informed about the Board and the key issues in Bluewater Health and broader health care system through review of the Board Orientation Manual, participation in Board orientation and ongoing Board education.

12.0 Self-Evaluation and Continuous Improvement

A Director is committed to a process of continuous self-improvement as a Board member. All Directors participate in evaluation of the Board and elected Directors participate in individual Director peer assessment and act upon results in a positive and constructive manner.

13.0 Fundraising Activity

A Director supports the efforts of the Bluewater Health Foundation and Charlotte Eleanor Englehart Hospital Foundation.

Monitoring:

- Method:
1. Participation in annual assessment of the Board as a whole
 2. Participation in annual performance evaluation based on responsibilities outlined and provisions included in the By-laws.

Frequency: Annually



Broader Public Sector Perquisites Directive

**Issued By
Management Board of Cabinet**

August 2, 2011

Broader Public Sector Perquisites Directive

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1. INTRODUCTION

The Government of Ontario is committed to protecting the interests of taxpayers and strengthening accountability for organizations that receive public funding.

The Management Board of Cabinet has issued this directive under the authority of the *Broader Public Sector Accountability Act, 2010* (Part IV.1: Perquisites), the “Act”.

The Act sets out provisions for perquisites that are allowable and those that are not. A perquisite refers to a privilege that is provided to an individual or to a group of individuals, provides a personal benefit, and is not generally available to others.

The requirements set out in this document raise the level of accountability and transparency for designated broader public sector (BPS) organizations¹, contributing to greater alignment with the high standards expected in ministries and agencies of the Government of Ontario.

2. PURPOSE, APPLICATION AND SCOPE

The purpose of this directive is to set out the requirement for the designated BPS organizations to establish rules on perquisites where these are provided through public funds².

The rules apply to any person in a designated BPS organization, including the following:

- appointees,
- board members,
- elected officials (e.g. school trustees), and
- employees.

This directive does not apply to the following:

- provisions of collective agreements
- insured benefits
- items generally available on a non-discriminatory basis for all or most employees (e.g. an employee assistance program, pension plans)
- health and safety requirements (e.g. provision of work boots)
- employment accommodations made for human rights and/or accessibility considerations (e.g. special workstations, work hours, religious holidays)

¹ “Designated broader public sector organization” as defined under the Act (s.1)

² “Public funds” as defined under the Act (s.1)

- expenses covered under an organization’s rules on travel, meals and hospitality (established in accordance with the BPS Expenses Directive)

Note that in this directive, the term, Chief Executive Officer (CEO), refers to the head of operations in a designated broader public sector organization.

In addition, this directive serves as a guideline to all other publicly funded organizations³. This means that these other organizations can consider this directive in any review or development of their policies and practices related to perquisites.

Designated BPS organizations must comply with this directive.⁴ In addition, every funding agreement between a designated BPS organization and a ministry or agency of the Government of Ontario is deemed to include the requirements of this directive.⁵

Where an agreement addresses the subject matter of this directive, this directive prevails over the relevant terms of the agreement if there is any conflict or inconsistency between them⁶.

This directive does not prevail over a collective agreement between an organization and a bargaining agent representing employees of the organization.

3. PRINCIPLES

This directive is based on three key principles.

A) Accountability

Organizations are accountable for their use of public funds. All expenditures support business objectives.

B) Transparency

Organizations are transparent to all stakeholders. The rules for perquisites are clear and easily understood.

C) Value for Money

Taxpayer dollars are used prudently and responsibly.

³ “Publicly funded organization” as defined under the Act (s. 1)

⁴ As set out in the Act (s. 11.1 (5))

⁵ As set out in the Act (s. 19)

⁶ As set out in the Act (s. 21(1))

4. REQUIREMENTS

Every designated BPS organization must establish rules with respect to perquisites. These rules must cover all individuals in the organization.

The term perquisites, or perks, refers to a privilege that is provided to an individual or to a group of individuals, provides a personal benefit, and is not generally available to others.

A perquisite is not allowable if it is not a business-related requirement. To be allowable, a perquisite must be a business-related requirement for the effective performance of an individual's job.

The following requirements must be included in the perquisite rules for the organization.

4.1 Rules on perquisites must set out that the following perquisites are not allowed under any circumstance:

- club memberships for personal recreation or socializing purposes, such as fitness clubs, golf clubs or social clubs
- seasons tickets to cultural or sporting events
- clothing allowances not related to health and safety or special job requirements
- access to private health clinics – medical services outside those provided by the provincial health care system or by the employer's group insured benefit plans
- professional advisory services for personal matters, such as tax or estate planning

These privileges cannot be provided by any means, including:

- an offer of employment letter, as a promise of a benefit,
- an employment contract, or
- a reimbursement of an expense.

4.2 Rules on perquisites must set out that perquisites that are not related to business requirements are not allowed.

4.3 Rules on perquisites must include an accountability framework to ensure that there is appropriate governance, and that everyone understands who in the organization has the authority for approvals. The approval authority for an allowable perquisite should be at a high level within the organization.

4.4 Rules on perquisites must require that good record-keeping practices be maintained for verification and audit purposes.

4.5 Rules on perquisites must set out that a perquisite is allowable only in limited and exceptional circumstances where it is demonstrated to be a business-related requirement for the effective performance of an individual's job.

4.6 Rules on perquisites must set out how summary information about allowable perquisites will be made publicly available. This summary information should be made available on an annual basis. Personal information should not be provided.

APPENDIX A – HOSPITAL REPORT ON CONSULTANT USE

Hospital Report on Consultant Use

Name of Hospital:

LHIN: **Erie St. Clair LHIN**

Reporting Period: April 1, 2011 to March 31, 2012

No.	Consultant Firm Name(s)	Name and Title of Consulting Contract	Contract Term If the contract term has been extended please include the original contract term and the amended contract term	Procurement Value (A) Original value plus (B) Value of amendments and (C) Total procurement value (\$)/ Total Paid	Consultant Selection Process (Open Competitive, Invitational Competitive, Non-competitive) If non-competitive, please provide an explanation	Modifications to Agreement (Yes/No) If Yes, did the procurement documents permit modifications to the term or value of the agreement?
1.	•	•				

Preservation of Solicitor –client privilege:

This legislation maintains the integrity of solicitor client privilege, litigation privilege and settlement privilege, and does not require the disclosure of information subject to any of these privileges.

While hospitals are expected to report on their retention of lawyers and law firms for the provision of consulting services, they are not required to report on instances where they have retained lawyers and law firms to provide legal advice, draft legal documents, conduct litigation on behalf of a hospital, or otherwise for the purpose of providing legal services to a hospital.

Appendix B – Posting of Expenses

Form or Template Form

Name:

Title:

Reporting Period:

Date	Amount	Expense Category	Description

Definitions:

Date(s): - when expense(s) were incurred

Amount: - the value of the approved expense

Expense Category: - the type of expense incurred:

- Travel
 - Vehicle rental or own use (mileage)
 - Train or air travel
 - Taxi or public transportation
 - Accommodation
 - Travel incidentals (insurance, parking, tolls)
- Meal
- Hospitality

Description: Notes explaining the context in which the expenses were incurred, or any other relevant details.

APPENDIX C - ATTESTATION

Attestation Form

Prepared in accordance with section 15 of the *Broader Public Sector Accountability Act, 2010* (BPSAA)

TO: The Board **[insert Name of Hospital]**, (the “Board”)
FROM: **[insert Name]**
Administrator/Superintendent/CEO
[insert Name of Hospital]
Date: **[insert date]**
RE: **[insert dates of reporting period] (“the Applicable Period”)**

On behalf of the **[name of hospital]** (the Hospital) I attest to:

- the completion and accuracy of reports required of the Hospital pursuant to section 6 of the BPSAA on the use of consultants;
- the Hospital’s compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;
- the Hospital’s compliance with any applicable expense claims directives issued under section 10 of the BPSAA by the Management Board of Cabinet;
- [to be added once ss. 15(1)(c.1) of the Act is proclaimed into force] the Hospital’s compliance with any applicable perquisite directives issued under section 11.1 of the BPSAA by the Management Board of Cabinet; and
- the Hospital’s compliance with any applicable procurement directives issued under section 12 of the BPSAA by the Management Board of Cabinet,

during the Applicable Period.

In making this attestation, I have exercised care and diligence that would reasonably be expected of a **[select applicable title: hospital administrator/superintendent/CEO]** in these circumstances, including making due inquiries of Hospital staff that have knowledge of these matters.

I further certify that any material exceptions to this attestation are documented in the attached Schedule A.

Dated at **[insert city]**, Ontario this **[insert date]**, 20xx.

[insert name of [select applicable title: Administrator/Superintendent/CEO]]

[insert title: Administrator/Superintendent/CEO]

[insert: Name of Hospital]

I certify that this attestation has been approved by the board of the **[insert Name of Hospital]**
on **[insert date]**.

[insert: Name of Board Chair]

Chair of the Board

[insert: Name of Hospital]

SCHEDULE A to Attestation

Instructions [please delete instructions once you have completed the Schedule]:

If, on behalf of your Hospital, you have no material exceptions to declare, please include a “no known exceptions” statement in each section to this schedule.

If, on behalf of your Hospital, you have material exceptions to declare with respect to any of the matters set out below, please:

- a) list them accordingly
 - b) provide a rationale for each exception in respect of why the Hospital did not comply with the requirement, and
 - c) describe what actions have been, or will be taken, to address each exception.
1. Exceptions to the completion and accuracy of reports required in section 6 of the BPSAA on the use of consultants;
 2. Exceptions to the Hospital's compliance with the prohibition in section 4 of the BPSAA on engaging lobbyist services using public funds;
 3. Exceptions to the Hospital's compliance with the expense claims directive issued under section 10 of the BPSAA by the Management Board of Cabinet;
 4. [to be added once ss. 15(1)(c.1) of the Act is proclaimed into force] Exceptions to the Hospital's compliance with the perquisites directive issued under section 11.1 of the BPSAA by the Management Board of Cabinet; and
 5. Exceptions to the Hospital's compliance with the procurement directive issued under section 12 of the BPSAA by the Management Board of Cabinet.

Reference Panel Report on Charlotte Eleanor Englehart Hospital Emergency Department

June 28, 2011

Presented by:

Dr. David Ng,

Mary-Pat Gleeson,

Rosanne Orcutt,

Shannon Sasseville,

and Ralph Ganter



Agenda

- Overview of Erie St. Clair Local Health Integration Network (ESC LHIN) Emergency Departments (ED)
- Original Physician Proposal
- From then to now
- Final submission of recommendations

Overview of Emergency Departments in ESC LHIN

- Shortage of ED physicians across the province
- ED physicians short across ESC LHIN
- Two ESC LHIN hospitals currently using HealthForceOntario (Chatham-Kent Health Alliance and Charlotte Eleanor Englehart [CEEH])

Original Physician Proposal

8 a.m. – 8 p.m. Coverage Period

- Reduced ED hours
- Close from 8 p.m. to 8 a.m.
- Physician to remain on-site until 10 p.m. to complete patient care requirements

Physician Proposal Rationale

- Physician burn out due to covering an understaffed ED, family practices and long-term care homes
- Anticipated shortage of CEEH ED physicians
- Increased lower severity ED visits increased workload for physicians
- Negative impact of 24-hour shifts on office and home life

Current Situation

- Significant recruitment effort by the Petrolia community achieving short-term success
- Risk remains in sustainability of physician staffing and the reliability of temporary physician resources
- Intermittent unplanned closures and planned closures remain a possibility
- Detailed contingency plans are finalized and in place by CEEH and Emergency Medical Services (EMS) in event of a planned or unplanned closure

Reference Panel

The Reference Panel was convened by the ESC LHIN to:

- Review and evaluate the proposal to reduce hours of operation at the CEEH ED
- Explore all options to keep the CEEH ED open 24/7
- Provide recommendations to the ESC LHIN Board

Reference Panel Process

- Evaluation of original CEEH Physician Proposal
- Completion of community engagement activities
- Submission of report - short, medium and long-term options to ESC LHIN Board to maintain the CEEH ED 24/7
- Completion of process

Community Engagement

Online Communications

- Input collected through options suggestion form
- Email updates
- Dedicated webpage

Engagement Sessions

- Health service provider and stakeholder engagement session
- Bluewater Health (BWH) staff engagement sessions
- Community meeting with approximately 400 participants
- Feedback suggestion box placed in Petrolia Town Hall

Community Engagement

Print Communications

- Paid advertisements in local newspaper
- Four press releases and Public Service Announcements
- Information on CEEH distributed to 15,000 households

**All community and stakeholder feedback
was considered by the Reference Panel**

Community Engagement

Key Themes of Public Input

- Options suggested were captured in report
- Community passion to keep CEEH open at all costs
- Importance of having access to emergency and resuscitation services in Petrolia 24/7
- The community expressed they would rather have an unplanned closure rather than a planned closure
- Some of the community expressed the need for the ESC LHIN to provide additional funding

Medium-Term Options to Maintain 24/7 ED Coverage

7 to 18 months

Medium-Term Option

United States based physicians

- Opportunity to explore interest by Michigan-based physicians to work in ESC

Medium-Term Option

Off-site Model “Virtual Doc in a box”

- Pilot a project using health care professional teams for onsite ED services
- Onsite team would be supported by an off-site ED physician by phone or video link
- Offsite ED physician could support several rural EDs at the same time

Medium-Term Option

24/7 Recovery Strategy

- Develop a plan to quickly return to 24/7 ED operation, in the event of a temporary reduction in ED hours

Long-Term Options to Maintain 24/7 ED

19 months and beyond

Long-Term Option

Medical Schools and Training Initiatives

- Provide physicians/residents opportunities to practice medicine in rural communities
- Physicians will better understand the value of a rural setting and may choose to stay in the community

Long-Term Option

Centre of Excellence

- Develop CEEH as a 'Rural Health Centre of Excellence' for residency training

Marketing and Recruitment Initiatives

- Improve strategic marketing efforts and exposure to rural communities through BWH, Petrolia community, and HFO MRA

Summary

ESC LHIN

- Action immediately those items in scope
Example:
Common credentialing

BWH

- Action immediately those items in scope
Example:
Focused marketing and recruitment initiatives
such as employ full-time ED physician at CEEH

MOHLTC

- Action immediately those items in scope
Example:
Policy initiatives such as medical
school and training initiatives

Questions & Discussion

Reference Panel Report on Charlotte Eleanor Englehart Hospital Emergency Department

June 28, 2011

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Confidential/Embargoed until Wed. June 29, 2011

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**BLUEWATER
HEALTH**

TO BWH BOARD OF DIRECTORS

AGENDA
ITEM # 6.1

Name of Committee/Report: CEEH RURAL REFERENCE PANEL REPORT		
Committee Meeting Date: August. 10, 2011		
Purpose of Report:	<input checked="" type="checkbox"/> Info	<input type="checkbox"/> Input
		<input checked="" type="checkbox"/> Approval
Board Meeting Date: August 10, 2011	Time: 17:30	Location: Mitton Classroom A & B

Situation

In 2010, the Charlotte Eleanor Englehart Hospital (CEEH) of Bluewater Health (BWH) physicians proposed reducing the Emergency Department (ED) hours of operation from 24 hours/day to 12 hours/day.

In response to extreme community concern, the ESC LHIN placed the proposal on hold, convened and chaired a panel, CEEH Rural Reference Panel. The mandate of the reference panel was to review the decision to reduce ED hours, identify strategies/options and provide recommendations to keep the CEEH ED open 24/7. While the reference panel was completing the work, the CEEH ED maintained 24/7 hours of operation through significant effort and with the financial support from the MOHLTC for HFO physician coverage. The Panel has now completed the work and the report was received and approved by the ESC LHIN, June 28, 2011.

It should be noted, the risk of inadequate numbers of physicians to ensure continuous ED operation in the long term remains. This is related to a current and future shortage of ED physicians across the province. BWH acknowledges and appreciates the Petrolia physicians for their extra efforts and patience during this period of review, and the ongoing staffing challenges.

Background

The CEEH ED physician proposal originated from an imminent shortage of CEEH ED physicians to provide continuous coverage, as well as physician burn out related to the increasing number of lower acuity ED visits and the negative impact of 24 hour shifts on their office practice and home life.

The BWH Board of Directors accepted the physician proposal and planning to implement reduced ED hours of coverage, was undertaken. Vocal members of the community opposed the reduction in ED hours and initiated an aggressive campaign to maintain 24/7 hours of operation. This resulted in the ESC LHIN implementing a moratorium on the decision to reduce hours. The moratorium was to allow the convening of a LHIN led, multidisciplinary CEEH Reference Panel

to review and evaluate the physician proposal, explore all options to keep the CEEH ED open 24/7 and provide recommendations to the ESC LHIN Board.

The Reference Panel met regularly from Fall 2010 through March 2011 and evaluated the original proposal, completed fulsome community engagement and identified short, medium and long-term strategies to maintain the CEEH ED 24/7. The short term actions were implemented immediately to ensure continuous physician coverage and 24/7 ED operations.

The report with Medium and Long-Term Options, outlined to maintain 24/7 ED coverage strategies was received and approved by the LHIN June 28, 2011. The recommended actions are broad and vary in scope with some requiring action or intervention by the University of Western Ontario (UWO), the ESC LHIN, MOHLTC or the Province while some actions are within the scope and authority of BWH.

Medium-Term options focused on:

- a) recruitment strategies;
- b) alternate models of ED coverage; and
- c) 24/7 Recovery Strategy.

Long-Term options focused on:

- a) increased physician training opportunities
- b) becoming a Centre of Excellence for residency training; and
- c) marketing and recruitment initiatives

Recommendations

BWH received and reviewed the report and proposed developing a committee to evaluate and implement the strategies within scope of BWHs authority and capability.

It is suggested that BWH steering committee would be comprised of:

- Dr. F. Riedl, Connie Courtney, CEEH Site & Business Director-Rural Health, Lynda Robinson, VP Operations, Alison Mahon, Director, Professional Staff Programs, and Dr. M. Taylor, VP President Medical Affairs & Chief Quality/Patient Safety/risk Management
- An additional CEEH family physician (to be determined)
- Additional ad hoc members would be invited

The steering committee will conduct a feasibility and risk assessment, develop business and project plans, and implement strategies for panel recommendations within BWH jurisdiction/mandate.

BWH Medium-term Considerations (7-18 months) or recommendations include:

- a) Recruitment of physicians;
- b) Alternate Coverage Options (ED coverage by Residents, N.Ps., Physician Assistants);
- c) 24/7 Recovery Strategy

BWH Long-term considerations (>19 months) include:

- a) Marketing and Recruitment Initiatives (utilizing marketing strategies)

Other Options & Considerations:

- a) Recommend that local physicians develop strategies to reward colleague physicians who do extra shifts and;

- b) Employ a full-time ED physician with no other responsibility

For strategies outside of BWH scope, the following strategies are recommended:

- 1) Actively partner with ESC LHIN to support development of LHIN project plan to address initiatives within LHIN jurisdiction/mandate;
- 2) Support initiatives within MOHLTC and Provincial jurisdiction/mandate; and
- 3) Actively partner with UWO in assessment and planning for the Center of Excellence for Residency Training.

Attachments:
Result of Board's Review:



BLUEWATER HEALTH

Life, health and renewal.

BOARD MEETING SCHEDULE

Date	Time	Location
August 10, 2011	4:30 p.m.	Norman Site, Rm L-2-666
September 28, 2011	5:00 p.m.	Mitton Site - Classrooms A&B
October 26, 2011	5:00 p.m.	Mitton Site - Classrooms A&B
November 30, 2011 ¹	5:00 p.m.	TBD, Petrolia
December TBD, 2011 ²	TBD	Sarnia Site, Rm R-4-810
January 25, 2012	5:00 p.m.	Sarnia Site, Rm R-4-810
February 22, 2012	5:00 p.m.	Sarnia Site, Rm R-4-810
March 28, 2012	5:00 p.m.	Sarnia Site, Rm R-4-810
April 25, 2012	5:00 p.m.	TBD, Petrolia
May 23, 2012	5:00 p.m.	Sarnia Site, Rm R-4-810
June 27, 2012 & AGM	5:00 p.m.	Sarnia Site, Rm R-4-810

¹ Meeting would normally be November 23 (4th Wednesday), but that is the week of management move from Mitton Site to new facility.

² December meeting to be discussed, as possible meeting dates potentially conflict with Christmas holiday.

Balance Sheet
As at June 30, 2011
Comparison to June 30, 2010
(000's)

	<u>2011/12</u>	<u>2010/11</u>	
	<u>Actual</u>	<u>Actual</u>	<u>%</u>
	<u>Jun-11</u>	<u>Jun-10</u>	<u>Change</u>
Assets			
<u>Current Assets</u>			
Operating Cash	\$ 1,853	(2,115)	
Superbuild Cash	14,417	9,860	-46%
Superbuild Fund	19,718	16,385	-20%
Investments - CEE Site	1,802	1,775	-2%
Accounts Receivable	5,616	11,339	50%
Accounts Receivable - MOHLTC	19,654	1,166	-1586%
Inventories	481	1,068	55%
Prepaid Expenses	962	648	-49%
Total Current Assets	<u>64,504</u>	<u>40,126</u>	<u>61%</u>
<u>Fixed Assets</u>			
Land and Land Improvements	5,522	5,522	
Building/Building services Equipment	271,392	72,519	
Furniture and Equipment	91,368	88,708	
Less: Accumulated Amortization	(111,849)	(109,943)	351%
Construction in Progress	34,699	219,548	-84%
Other Non Current Assets	322	338	-4%
Total Fixed Assets	<u>291,455</u>	<u>276,691</u>	<u>5%</u>
Total Assets	\$ <u>355,959</u>	<u>316,817</u>	<u>12%</u>
<u>Current Liabilities</u>			
Bank Loans Payable	\$ 0	2,461	-100%
Accounts Payable	920	3,513	-74%
Accounts Payable - MOHLTC	11,067	8,409	32%
Accrued Salaries & Vacation Pay	5,975	5,656	6%
Deferred Operating Grant - Trailing Costs	1,294	0	n/a
Current Portion - Long Term Debt	32,865	0	n/a
Other Liabilities	10,145	5,836	n/a
Total Current Liabilities	<u>62,265</u>	<u>25,875</u>	<u>141%</u>
<u>Long Term Liabilities</u>			
Long Term Bank Loans Payable	8,495	1,259	n/a
Long Term Debt	0	16,822	-100%
Deferred Revenue	270,524	256,769	5%
Other L/T Liabilities	7,341	6,341	16%
Total Long Term Liabilities	<u>286,359</u>	<u>281,192</u>	<u>2%</u>
<u>Equity</u>			
Opening Equity	9,120	11,295	
R&E Surplus/(Deficit)	(1,786)	(1,545)	
Total equity	<u>7,334</u>	<u>9,750</u>	<u>-25%</u>
Total Liabilities and Equity	\$ <u>355,959</u>	<u>316,817</u>	<u>12%</u>

Hospital Accountability Agreement Indicators:

Negotiated Target

Current Ratio	0.46	0.47	0.30 - 0.36
Working Capital	(19,038)	(18,431)	

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

Working Capital excludes all current assets and current liabilities related to the new building project

Statement of Revenue and Expense

Forecast surplus/(deficit) as at March 31, 2012

Based upon the three (3) months ended June 30, 2011

(000's)

	2012 YTD Budget	2012 YTD Actual	2012 YTD Variance	2012 YTD % Variance	2012 Annual Budget	2012 Forecast Amount	Projected Variance to Budget	2012 Forecast % Variance	Notes
Revenue	\$								
LHIN Revenue	31,350	31,536	186	1%	126,086	126,079	(7)	0%	
PCOP Revenue (includes Facility & Amort. Funding)	2,010	1,540	(470)	-23%	8,086	9,054	968		1
OHIP Revenue	4,328	5,104	776	18%	17,557	19,954	2,396	14%	2
WSIB Revenue	143	95	(48)	-34%	574	378	(196)	-34%	3
Revenue									
Other Provinces	47	45	(2)	-4%	188	186	(2)	-1%	
Non Residents	29	34	5	17%	116	121	5	4%	
Self Pay	106	103	(3)	-3%	426	423	(3)	-1%	
Room differential	894	801	(93)	-10%	3,595	3,186	(409)	-11%	4
CC Co-payment	315	234	(81)	-26%	1,268	936	(332)	-26%	5
Recoveries	848	960	112	13%	3,307	3,419	112	3%	6
Parking Revenue	195	306	111	57%	782	981	198	25%	7
Other Revenue	12	20	8	64%	170	178	8	5%	
Deferred Equipment Grants	1,152	1,047	(106)	-9%	5,083	5,083	-	0%	
Interest and Donations	25	26	1	6%	99	101	1	1%	
Administered Programs	906	1,026	120	13%	3,689	3,809	120	3%	
Total Revenue	\$ 42,360	42,876	516	1%	171,027	173,888	2,861	2%	
Expenses	\$								
Salaries and Wages	21,833	21,558	275	1%	86,590	86,314	275	0%	8
Medical Staff Remuneration	4,332	4,847	(516)	-12%	17,572	19,382	(1,810)	-10%	2
Employee Benefits	5,835	5,792	43	1%	21,691	21,691	-	0%	
Supplies and Expenses	6,012	5,585	427	7%	24,107	24,200	(93)	0%	
Medical/Surgical Supplies	1,645	2,032	(387)	-24%	6,615	7,612	(997)	-15%	9
Drug Expense	1,258	1,458	(199)	-16%	5,061	5,778	(717)	-14%	10
Interest Expense	32	40	(9)	-27%	127	136	(9)	-7%	
Amortization	1,811	1,708	103	6%	7,244	7,244	-	0%	
Administered Programs	921	1,063	(142)	-15%	3,672	3,814	(142)	-4%	
Total Expenses	\$ 43,679	44,083	(404)	-1%	172,680	176,172	(3,491)	-2%	
LHIN Operating Surplus/(Deficit)	\$ (1,319)	(1,207)	112	n/a	(1,653)	(2,284)	(631)	n/a	
Deferred Building Grants	1,751	1,378	(372)	-21%	7,005	7,005	-	0%	
Building Amortization	2,278	1,874	404	18%	9,112	9,112	-	0%	
Interest on L/T Liabilities	92	83	9	10%	371	371	-	0%	
Hospital Surplus/(Deficit)	\$ (1,938)	(1,786)	152	n/a	(4,131)	(4,761)	(631)	n/a	

Notes to Financial Statements

June 30, 2011 Actual and Full Year Forecast

An overall deficit of \$2.284K is forecasted for the 2011/12 year end. The main contributor to this deficit is the lack of announced increased base funding. Unionized salaries have increased and ongoing inflation make it next to impossible to stay balanced with no increase to base funding.

- Note 1** PCOP Revenue is forecasted to come in better than budget by \$968K. The majority of the variance pertains to Amortization Funding and Facility Cost Funding. Bluewater Health just recently received confirmation from the Ministry for these funding amounts for 2011/12.
- 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** WSIB Revenue is expected to be under budget for the year. There is a steady decline in WSIB patients being seen at the hospital.
- Note 4** Room Differential revenue is forecasted to come in below budget. Part of this decline can be attributed to the number of isolation patients within the hospital.
- Note 5** Co-payment revenue is forecasted to come in below budget for the year. Alternative Level of Care (ALC) patients generate co-payment revenue. The number of ALC patients occupying hospital beds is a determining factor in our co-payment revenue.
- Note 6** Recoveries are forecasted to come in better than budget for the year. Contributing factors are an increase in drug recoveries and an increase in building rental income.
- Note 7** Parking Revenue is forecasted to be better than budget for the year. Staff parking rates were increased to subsidize the cost of a shuttle to allow for staff to park at the Mitton Site. The expenses of the shuttle are included in the Supplies & Expenses line.
- Note 8** Salaries & Wages are expected to come in under budget for the year. Some PCOP growth was built into the budget for 11/12. There were also new positions that were budgeted for that will be vacant for a portion of the year as recruitment occurs, etc.
- Note 9** Medical & Surgical Supplies are expected to be over budget for the year. Bluewater Health is still working through the transition of having PROcure serve as our procurement specialist. As of the end of June, our Med/Surg supplies were over budget by \$387K.
- Note 10** Drug Expenses are expected to be over budget for the year. Part of this overage relates to Oncology which has offsetting funding (included in OHIP Revenue). At the end of June, Drug expenses were over budget by \$199K.



Name of Committee/Report: CEEH Ambulatory Care Update			
Purpose of Report:	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Info	Input	Approval
Board Meeting Date:	August 2011	Time: 6:00 pm	Location: Sarnia

SBAR Report for CEEH Ambulatory Care

July 2011

Situation:

There are 5 doctors leaving Bluewater Health by the end of 2011 who all provide services and Ambulatory Clinic visits at the CEEH ambulatory clinic. This will have a negative impact of approximately 1200 of the current 4352 visits (27%). This leaves a gap in the services for our community.

The rural program is conducive to primary care and ambulatory care can support that need for the community.

Background:

The following changes have been identified to the current Ambulatory Care program at CEEH:

- Retirement of GYN specialist (Gyn) – although there was one specialist that indicated interest in replacing – he has not sought extension of privileges
- Departure of Intensivist, Respirologist at the end of summer (internal medicine - respiratory specialty)
- Three other doctors have announced their upcoming retirements – Ortho, urology and dermatology by this fall/end of year. Some are staying on until replacements are found – so no definite retirement date in place.
- One doctor has requested an extra day a month (internal medicine – arthritis)

We currently staff the program with one part time clerical and one part time RN. With the reduction in services there will be potential of loss of hours and notice of lay off.

Assessment / Analysis:

A Healthy Sarnia-Lambton Community Picture report dated March 2011 and prepared for the Ministry of Health Promotion and Sport by the County of Lambton Community Health Services Department identifies prevalence of chronic conditions. Lambton County is higher than provincial rates for osteoarthritis, asthma, COPD, arrhythmia and ischemic heart disease. Osteoarthritis and asthma are the highest chronic conditions. According to the same report lung and colorectal cancers are priority health concerns.

BWH is actively recruiting specialists to the community to fill the identified gaps in the Physician human resource plan. CEEH is identified as part of BWH and included in opportunities for work.

From review for needs of crisis intervention for mental health related to OTN in the ED and the pressures on the mental health beds for BWH, it is evident that there is a need for mental health services/support at CEEH.

The Ambulatory Care services provide a vital service to the community and support the health care needs. This is a program that should grow for the rural community. Every attempt is being made to increase the program to full capacity. The following meetings and actions have been taken to date:

1. The request for additional time granted to Dr Hamideh, Internal medicine/rheumatology - Dr Riedl has approved this increase to 1 day a month
2. Offer of ambulatory care time to new cardiologist. (Dr K Shetty)
3. Offers of work currently include availability of ambulatory care time at CEEH to all new BWH specialty recruits. Discussions with recruits to include service to CEEH as a condition of offer are under way.
4. Consideration of new clinic time to support mental health - social work, psychologist or psychiatrist.
5. Our family doctors could schedule "Removals of lumps and bumps" in Ambulatory care instead of the current practice in the ED (would reduce number in ED)
6. Additional time to be offered to existing physicians/specialists – especially those with longer wait times.

Recommendation:

This briefing note services to provide information only at this time. No action is required.