

MINUTES OF THE REGULAR PUBLIC FORUM MEETING OF THE NHS BOARD OF TRUSTEES HELD TUESDAY JANUARY 19, 2010 AT 5:30 PM AT THE GREATER NIAGARA SITE, BOARDROOM.

DATE OF MEETING	23-June-09	22-Sept-09	20-Oct-09	15-Dec-09	19-Jan-2010													
ARMITAGE, Jean	X	X	X	X	X													
ARVINTE, Dr. Andrei (appt. 14-10-09)	--	--	X	R	X													
BUTZ, Stephen	X	X	R	R	X													
CAUGHILL, Bruce	X	X	X	X	X													
COOPER, Trevor	X	X	X	X	R													
DIX, Carman	X	X	X	X	X													
EGGLETON, Helen (appt. 17-06-08; 23-06-09)	X	X	X	R	X													
HENRY, Mike	X	X	X	X	X													
HOPE, Dr. S. Joanna (appt. 02-03-09 – Interim Chief of Staff)	X	X	R	X	X													
HUDSON, Steve	X	X	X	X	X													
MATOVIC, Dragan	R	X	R	R	X													
McCOLLUM, Joe	X	X	X	X	X													
PALADINO, Flo	X	X	X	X	X													
PATRICK, Jennifer	X	X	X	X	X													
PILLAR, Steven	R	X	X	X	X													
REDDY, Dr. Ken (appt 08-10-08)	X	X	X	X	X													
SCHRAM, David	X	X	R	X	X													
SEVENPIFER, Debbie	X	X	X	X	X													
SHERK, Mark	X	X	X	X	X													
SIMPSON, Alan	X	X	R	X	X													
SOUTER, Betty Lou	X	X	X	X	X													
TURNER, Mary	R	X	X	R	R													
VEDOVA, Dr. Joseph (appt 28-01-09) (conclude 14- 10-09)	X	R	--	--	--													

STAFF IN ATTENDANCE: Bala Kathiresan, Chief Operating Officer
Angela Zangari, Chief Financial Officer
Christine Clark, Chief Communications Officer

BY INVITATION: Bill Millar, HNHB LHIN Board of Directors
Pat Mandy, Chief Executive Officer, HNHB LHIN
Anne Corbett, Borden Ladner and Gervais LLP

APPROVAL OF THE CONSENT AGENDA

DIX "THAT, the NHS Board of Trustees approves the Consent Agenda
SHERK for the January 19th, 2010 Public Forum Meeting of the Board, as
presented."

CARRIED.

ARMITAGE “THAT, the Minutes of the Public Forum Meeting of the NHS Board
SHERK of Trustees held December 15th, 2009 be approved, as presented.”

CARRIED.

DECLARATIONS OF CONFLICT OF INTEREST

Trustee Joe McCollum declared a conflict of interest with respect to Agenda Item # 8.1 – Greater Niagara General Fire Retrofit Project.

HAMILTON NIAGARA HALDIMAND BRANT LOCAL HEALTH INTEGRATION NETWORK (HNHB LHIN) CLINICAL SERVICES PLAN

HNHB LHIN Board Director Bill Millar and LHIN CEO Pat Mandy provided an overview of the LHIN's Clinical Services Plan for the information of the NHS Board of Trustees.

In her introductory remarks, Pat Mandy explained that Niagara has a higher than average incidence of preventable diseases. Residents smoke more and weigh more compared to other LHINs, both of which impact health. Factors contributing to health and longevity include lifestyle, genetics, social circumstances and environment.

LHIN Board Director Bill Millar call for the commitment and support of the NHS Board of Trustees and emphasized the importance of the support of the LHIN's provider partners in delivering the Clinical Services Plan.

Across the LHIN there are variations in health care, illustrated by readmission rates, alternate level of care (ALC) rates and wait times. For example, only 14% of LHIN residents that are diabetic are having appropriate testing as part of their care. There is a need for best practice guidelines that are used consistently across the LHIN.

In terms of creating sustainability into the future, NHS is ahead of most organizations in the LHIN. Challenges with health human resources are expected within the workforce, particularly for Registered Nurses. The LHIN has fewer Family Physicians compared to the provincial average, and the highest number of seniors who account for about 40% of acute hospital stays. If the status quo continues, a 30% increase in hospital utilization may be seen. The LHIN and its provider partners must look at how to live within available resources, being mindful of provincial financial challenges. The provincial government has committed to ensuring appropriate access to health practitioners and services, accountability for public expenditures and evidence-based decision making.

Stakeholder groups working on development of the Clinical Services Plan identified three (3) major themes:

- Interprofessional Care
- Clinical Program Integration
- Community-based Service Capacity.

Foundational to delivery of the Clinical Services Plan is the Electronic Health Record.

Clinical Program Integration will link services across organizations and settings, on a program basis so that all aspects of care delivery are connected and coordinated. Coordinated LHIN-wide programs will eliminate duplication, provide clear roles, responsibilities and accountabilities; and ensure best practice and common standards. Clinical program integration will be a multi-year, phased implementation achieved through LHIN-wide planning across all parts of the continuum of care. Year one of the coordinated integration will move forward with approval, with year two and

three approved in principle. Implementation in Year one will depend on the readiness of the system.

A LHIN-wide charter will formalize the commitment of all LHIN provider partners to work together. The LHIN hospitals are already working together to share common issues and, as the Clinical Services Plan moves forward, discussion will focus more on siting and sizing of programs. For example, NHS has entered into Memorandums of Understanding (MOUs) to define its role with tertiary care centres on a LHIN-wide basis in the areas of Thoracic and Vascular surgery. NHS also works with academic partners to ensure that best practice is implemented and that best use is made of available health human resources.

Capacity to provide care in the community must be available. To plan for implementation of the CSP, providers with similar resources will need to work together to provide services. Across the health care continuum, there must be linked service, access to primary care and improved client matching services to ensure that people get the right care, at the right place at the right time. Organizations beyond the mandate of the LHIN will be part of the planning process.

Interprofessional care links the broader team of health professionals along the continuum of care. Family Health Teams (FHT) are good models for interprofessional care in the community. In future, teams may be colocated, or could be virtual and connected electronically, with all team members working to their full scope of practice or expertise. Providing an interprofessional team approach to care would ensure consistent service provision and communication to health providers, better patient outcomes, improved work satisfaction for health professionals, and make effective use of academic partnerships. Through changes in scope of practice, there is greater opportunity for health professionals like pharmacists to participate in care and provide patient advice in the community.

E-health is a critical enabler to delivery of the Clinical Services Plan. Initiatives such as “Clinical Connect”, a provider portal that gives providers real time access to information about patients, will be expanded across the HNHB LHIN.

The expected benefits of E-health include:

- Reduction in repeat diagnostic tests
- Reduction in medical errors
- Improved patient safety and outcomes
- Patient, physician and staff time savings
- Improved workflows with less manual processing
- Reduced phone calls to obtain patient results

Integrated decision support will enhance evidence based planning for decision-making. For example, hospitals will receive patient discharge data much sooner than previously available through the Canadian Institute for Health Information (CIHI). That data can help to highlight any gaps in the health care system as well as opportunities for better case management.

There may be opportunities for laboratory integration across the HNHB LHIN to better coordinate service provision. Cancer planning is well underway between NHS and Cancer Care Ontario for the Walker Family Cancer Centre, a regional component of the St. Catharines Healthcare facility.

The Clinical Services Plan is strongly based on expert opinion and best practice. While the plan will allow sustainability of the health system, it is about quality and the experience of the individual through the health system. There must be strong commitment and continued support from government; internal collaboration with staff and physicians; and commitment to work with other Boards for health system integration. B. Millar urged the NHS Board of Trustees to support senior staff to work in partnership with a broad range of providers, to focus on the needs of the community and to collaborate with partners. NHS must commit to the notion of aligning service

delivery across the health system, not just for the hospital but across the entire continuum of health and wellness. That may mean that treasured program areas will need to be modified to make best use of limited resources. The role of the Board of Trustees will be instrumental in the successful implementation of the LHIN's Clinical Services Plan.

P. Mandy explained that the HNHB LHIN Clinical Services Plan was approved by the LHIN Board in November 2009. NHS has been part of the change occurring in the LHIN, evidenced by the development and implementation of the Hospital Improvement Plan (HIP). The Clinical Services Plan is not only about integration; it is more about linking services and sharing resources.

It is acknowledged that moving forward with change and integration can create anxiety; however, there is already evidence of improvements to quality and access to care across the LHIN. For example, NHS and Hamilton Health Sciences Corporation (HHSC) are working collaboratively in the areas of vascular and thoracic surgery. Clinicians are working together to ensure that changes proposed are appropriate. Working groups which include tertiary partners are in place to implement HIP changes. An integrated Director and integrated clinical rounds have already been introduced for the NHS Oncology Program.

Dr. K. Reddy questioned whether surgical wait times could be reduced as a result of progress with alternative level of care and improved utilization. Mrs. Sevenpifer explained that, at their January meeting, the Resources and Audit Committee discussed the unusual pressures experienced across NHS sites and the HNHB LHIN over the past few weeks. Data must be further analyzed to better understand the increased patient activity. A scorecard that will include ALC days, surgical cancellations, Emergency Department Wait Times, Emergency Department offloads and other factors will be developed to determine if there is something NHS could do differently to alleviate system pressures. The matter is also being discussed at meetings of the LHIN 4 CEOs.

J. Armitage noted that the efforts underway to improve utilization and decrease Emergency Department wait times may be hindered by factors such as a lack of long term care beds and impact on CCAC capacity.

P. Mandy indicated that while improvements have been seen in many areas, the LHIN is aware of the challenges facing staff in the St. Catharines General Emergency Department and the requirements for a new building. With respect to complex continuing care, the LHIN recognizes that there is limited supportive housing available and continues to work with municipalities, other Ministries and other providers to seek options to improve supportive housing in the community. There may be opportunities to avoid hospital admissions through introduction of Nurse Practitioner led nursing homes, and by providing night supports in supportive housing and assisted living residences. The LHIN Board will make the third year investments for Aging at Home initiatives, and will look at where the greatest value for investment can be realized.

On behalf of the Board, Chair Betty Lou Souter extended appreciation and encouraged the HNHB LHIN to continue their efforts. The NHS Board of Trustees is committed to supporting implementation of the Clinical Services Plan.

QUALITY COMMITTEE

Synoptic Report

Committee Chair Mark Sherk presented the Synoptic Report of the Quality Committee for January 2010. On a quarterly basis going forward, the Board will receive the Physician Chart Completion Status report regarding any physician suspended on three or more occasions during the reporting quarter. The Quality Committee has asked that monitoring physician chart completion be a priority for the Board to ensure that the Medical By-laws and Rules and Regulations are being applied consistently across the NHS.

The Committee received an overview of Ethical Decision-Making. The NHS has continued its progress in the area of ethics, and has access to a Clinical Ethicist in Hamilton in the absence of a dedicated ethicist on NHS staff.

The Adverse Events Report is presented to the Quality Committee on a quarterly basis. The highest volume of incident reports continues to be attributed to in-patient activity. An increase in the number of reported incidents is being seen, indicating that staff are becoming more comfortable to report and understand the importance of reporting for statistical and quality improvement purposes. The NHS “Just and Fair Philosophy” is well received and understood by staff.

The Committee received and discussed the Sentinel Event Case Review for fiscal 2008 - -2009, and requested that all learnings and trending data be reviewed by the Board.

Highlights of the Patient and Visitor Complaints and Compliments report were reviewed. Complaints are analyzed according to site, department, as well as by category or type. Because the data contained in the report is an example of the type of information that the Accreditation Survey Team will want to know, a copy of the Complaints and Compliments report was provided for the interest of the Board.

A quarterly update regarding the work of the Patient Safety Committee, struck in June 2009, was received and reviewed. Matters concerning the Greater Niagara General Emergency Department will be a standing item on the Quality Committee Agenda for the next several meetings. With the Emergency Department conversions now in place at the Port Colborne and Douglas Memorial sites, and with the significant changes implemented at the GNG ED with respect to physicians, there is an expectation for performance improvement, particularly in the areas of patient volumes, Admit No Beds (ANB), wait times, physician throughput, and patient satisfaction. A scorecard will be developed and implemented to effectively track and highlight these performance improvement indicators, as well as other indicators of success and opportunities for improvement. Emergency Department and bed flow will continue be a priority for NHS.

RESOURCES AND AUDIT

Synoptic Report

Committee Chair Steve Hudson reported that the members had received a recommendation regarding the retention of Auditors. The proposed base audit fees for the year ending March 31st 2010 are \$54,850 which remains unchanged from the previous year.

HUDSON **“THAT, on the recommendation of the Resources and Audit Committee,**
SIMPSON **the NHS Board of Trustees approves the audit fees for the year ending**
March 31st 2010 as submitted by Durward Jones Barkwell & Company LLP.”

CARRIED.

CFO Report

Chief Financial Officer Angela Zangari reported that for the eight months ending November 2009, NHS had a deficit from operations before HIP one time items of \$8,142,219 versus a forecasted deficit of \$7,983,055, resulting in a negative variance of \$159,164. The forecast deficit was revised from \$11.8 million to \$16.8 million as the \$5 million funding assumption for annual interest carrying costs and one-time restructuring costs which has not been received. The deficit after “one time costs” is \$11,405,538 versus a forecast deficit of \$10,983,055, a negative variance \$422,483, due to an additional \$135,646 variance for unforeseen H1N1 pandemic supplies and an additional \$127,673 in HIP one time costs. It is expected that costs related to H1N1 pandemic supplies will be slightly higher for December. NHS is trending positively for overtime and sick time, but overtime did increase in November due to H1N1 and pandemic response.

The NHS cash position at the end of November was negative \$116.8 million, and was bridged through cash advance from the HNHB LHIN. Meetings with the LHIN continue on a monthly basis to review daily cash flow projections and pressures. NHS continues to base its forecast on a 2% funding increase; however the final planning targets for 2010/11 remain unknown. If funding is less than 2%, additional service reductions will need to be considered.

A 20% or 29-bed decrease in Alternate Level of Care (ALC) patients in acute beds was reported for the 2009 year to day. This is well below 2008 rates and the improvements are due to patient flow initiatives, community investments and re-designation of beds from acute to chronic.

While NHS expects to meet or exceed wait list targets, reallocation of up to 300 cases for cataracts may be required. NHS is reviewing current volumes and capacity to add additional cases. The expected cataract shortage is due to cancellations due to H1N1 and available resource issues. Cases that were not completed within the allocation concluding at March 31st 2010 would be transferred to another hospital within the LHIN.

With the exception of total margin and weighted cases, NHS continues to track positively against the Hospital Services Accountability Agreement (H-SAA).

Through discussion, it was noted the economic increase to funding may not be known until May 2010. Multi-year funding for the two year period 2008/2009 and 2009/2010 was previously announced in January.

Human Resources Report

Chief Operating Officer Bala Kathiresan presented highlights of the Human Resources Report for the period ending November 30, 2009. Significant improvements have been made to OPSEIU and SEIU vacancy rates. The overall vacancy rate has been reduced to 4.37 percent, as compared to as compared to 5.33% at the end of October and 4.67% at this same time last year.

Outstanding grievances have been closed through positive collaboration with the bargaining units. There had been approximately 216 grievances dating back to 2006/07.

ONA has joined NHS in requesting consideration from WSIB with regard to payment of the finalized NEER surcharge. NHS has requested that a portion of the surcharge be re-invested at NHS for occupational health and safety related activities, and is awaiting response.

It was suggested that the Human Resources Report be presented to the Board on a quarterly basis. The Resources and Audit Committee would continue to receive a more detailed report on a monthly basis. The request was referred back to the Resources and Audit Committee for a recommendation to the Board.

The Board acknowledged the tremendous decrease in the number of grievances, and asked that their appreciation be extended to Human Resources staff.

GOVERNANCE

Presentation of the Professional Staff Bylaw, Rules and Regulations

Introducing the presentation of the Professional Staff Bylaw, Rules and Regulations, Board Chair Betty Lou Souter acknowledged the tremendous commitment of the Bylaw Sub-committee as well as Dr. Chris Carruthers who provided consultation for the Sub-committee. Committee Co-chair Bruce Caughill also expressed appreciation to Anne Corbett of Borden Ladner Gervais LLP for legal counsel provided to the Sub-committee in review of the Bylaw, Rules and Regulations.

At the December 15th 2009 meeting of the NHS Board of Trustees, a draft of the Bylaw, Rules and Regulations was presented for the information of the Board. To ensure that all feedback

received from the medical staff was considered, the Sub-committee held a further meeting on January 5^h 2010.

The Medical Advisory Committee (MAC) received and endorsed the Professional Staff Bylaw at their January 14th, 2010 meeting.

A Special Meeting of the Medical Staff Association (MSA) was held January 18 2010, the Minutes of which were circulated to the table for the information of the Board.

Interim Chief of Staff Dr. Joanna Hope explained that in the present Bylaw, there is a 21-day window to seek input from individual medical staff members and from MAC and MSA. All comments received were circulated to the By-Law Sub-committee members and all members of the Professional Staff. The Minutes of the January 5th Bylaw Sub-committee meeting were included in the Board's agenda binder and reflect the extent of review and deliberation undertaken in preparing the final Professional Staff By-Law and Rules and Regulations for recommendation to the Board.. The By-Laws Sub Committee is unanimous in recommending the By-laws and the Rules and Regulations in the form presented to the Trustees.

Following discussion at the Special MSA meeting of January 18th, an amendment to item 2 (a) of the Resolution was proposed.

Bylaw Sub-committee Co-chair Bruce Caughill presented the Resolution with one amendment as noted to item 2 (a) of the Resolution as noted.

**CAUGHILL BE IT RESOLVED THAT:
PALADINO**

1. The Professional Staff By-law ("By-law No. 2") in the form presented to the Directors be and the same is hereby approved to take effect as herein provided.
2. Despite Section 13.2 (a) of By-law No. 2, which repeals and restates in its entirety the Medical, Dental and Midwifery By-laws of the Corporation previously enacted (the "Previous By-law"), By-law No. 2 shall take effect and the Previous By-law shall continue as follows:
 - (a) Provisions of By-law No. 2 with respect to Medical Leadership positions (Article 9) "***and composition of the Medical Advisory Committee (MAC)***" shall take effect in whole or in part on a date or dates to be determined by the Board and the provisions in the Previous By-law related to the same matter shall continue in effect until such date or dates.
 - (b) Reference to actions or responsibilities to be taken by the Chief of Department in By-law No. 2 or in the Rules and Regulations shall be actions and responsibilities to be taken by the Chief of Staff or delegate until all provisions of Article 9 of By-law No. 2 have taken effect.
 - (c) Any proceeding with respect to a restriction, suspension, revocation or termination of an appointment or privilege that was commended under the Previous By-law shall continue under that By-law, if appropriate, as determined by the Chief of Staff and Chief Executive Officer on the advice of legal counsel.
 - (d) Members of the Professional Staff (as defined in By-law No. 2) shall continue in the category to which they were appointed under the Previous By-law and shall apply for reappointment under and pursuant to the processes and categories in By-law No. 2.

- (e) Members of the Associate Staff appointed under the Previous By-law shall be subject to the limits with respect to term of appointment and reappointment as set out in the Previous By-law.

Except as provided above, By-law No. 2 takes effective immediately and the Previous By-law is repealed.

3. Pursuant to sections 8.1 and 8.2 of By-law No. 2 the Department and Services are approved as presented to the Directors.
4. The Rules and Regulations in the form presented to the meeting are approved and previous Rules and Regulations relating to the same subject matter are repealed.

Dr. Reddy highlighted MSA membership concerns related to proposed changes to the Rules and Regulations pertaining to:

- **On call issues related to the fact that there are no site specific privileges (particularly for Anaesthesia)**
- **The use of the word “performance” in describing the Annual Performance Review of Members of the Professional Staff as part of the re-appointment process**

In response to a question about the position of Deputy Chief of Staff in the By-Laws, Dr. Hope also explained that the Deputy Chief of Staff is an optional position. A. Corbett noted that the reference is typical of how a Bylaw is written, and provides the greatest amount of flexibility in managing Medical Staff leadership positions. Dr. Hope also noted that issues brought forward concerning on-call obligations and site-specific privileges will be dealt with as part of the implementation of the Bylaw.

Dr. Reddy indicated that he had no issues with respect to the By-Laws but requested that the Rules be revisited with respect to the two issues raised by the members of the MSA at their Special Meeting on January 18th, 2010.

It was discussed that the most appropriate way to move forward would be to pass both the Bylaw and the Rules and Regulations and to refer the two areas of concern back to the By-law Sub-Committee, tasked by the Board, for further review.

The Board requested that the Committee further consider the two issues raised at the meeting, and the Board will consider those issues when brought forward.

MOTION TO APPROVE CARRIED UNANIMOUSLY

Dr. Reddy expressed gratitude to the members of the Bylaw Sub-committee and to the Board for hearing the concerns raised.

Chair Betty Lou Souter expressed appreciation to the Sub-committee membership. Mrs. Souter also commended Dr. K. Reddy for continuing to voice the opinions and concerns of physicians.

CAPITAL

Trustee Joe McCollum declared a conflict of interest with the agenda item pertaining to the Greater Niagara General Fire Retrofit Project.

Chair Steven Pillar advised the Board that at their January meeting, the Committee had toured parts of the Greater Niagara General facility including the endoscopy suite, receiving docks, patient room and washroom facilities in the former chronic care unit, and the Operating Room where spatial and operational deficiencies were highlighted. Following the tour, the Committee had received a presentation and reviewed a proposal for redevelopment of the facility. Additional

information related to costing was requested by the Committee. A more comprehensive proposal including costs, impact and comparison to new build options will be prepared for presentation to the Board at their February meeting.

The Capital Revitalization Committee will rotate its meetings across NHS sites to allow members to become more familiar with NHS facilities, and will hold meetings at the St. Catharines Healthcare Complex site on alternating months. An invitation to tour the construction site will also be extended to members of the Board. Trustees were encouraged to visit the project website where webcam images capture real-time construction progress on the St. Catharines facility.

The Executive Summary of the Project Monthly Status Report for the new hospital complex will be regularly provided to the Board of Trustees.

COMMUNICATION AND RELATIONSHIPS COMMITTEE

Committee Chair Stephen Butz provided an update on the Committee's work to date to examine and underpin NHS' approach to communication and relationship-building. The theme of trust in both the work of the Board and the work of the hospital continues to emerge. Once a baseline of trust in the Board and the organization is established, the Board will need to understand what that baseline means in terms of the work of the NHS and its relationships with its community in order to create a strategy for making community connections that will build common understanding. The Committee's work will provide a foundation for the Board's next Retreat.

ADJOURNMENT

There being no further business, the Public Forum Meeting of the Board of Trustees was adjourned at 7:05 p.m.

Chair, Betty Lou Souter

Recording Secretary, J. Upper