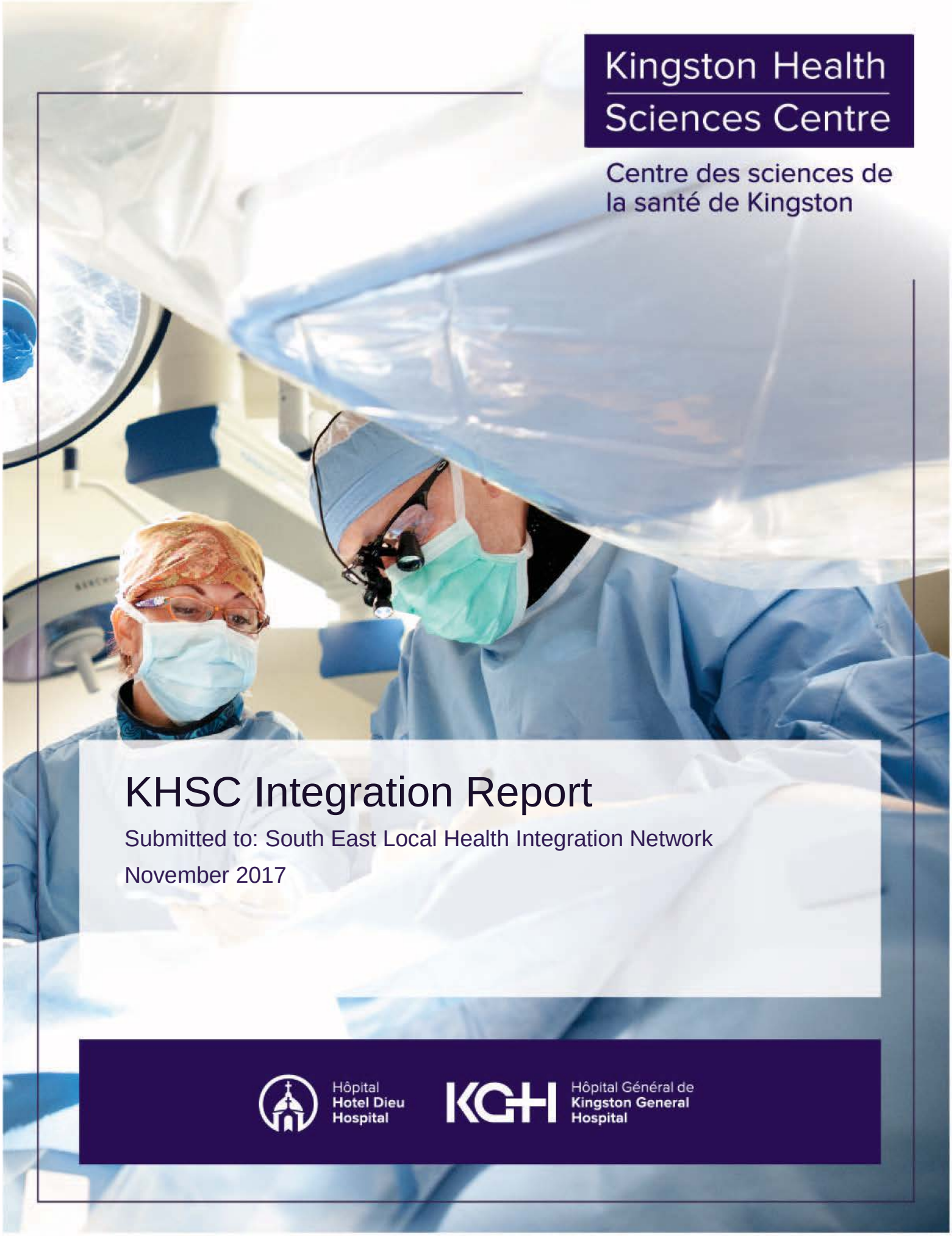

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

KHSC Integration Report

Submitted to: South East Local Health Integration Network

November 2017

Hôpital Hotel Dieu Hospital

Hôpital Général de Kingston General Hospital

Executive Summary

On April 1, 2017, Kingston General Hospital and Hotel Dieu Hospital successfully integrated to form the Kingston Health Sciences Centre (KHSC) following the Minister's approval in January 2017. (Letter attached as Appendix 1).

Before coming together, Kingston General Hospital and Hotel Dieu Hospital were both accredited teaching hospitals funded by the South East LHIN. Combined LHIN/Ministry funding for the two separate corporations was $430 million.

Our voluntary integration is consistent with the MOHLTC's commitment to *Patients First* and will help us make a strong contribution to the SELHIN's objectives of improving access and delivery of healthcare services, enhancing the patient experience, improving quality and creating efficiencies in the healthcare system. This also builds on the excellent work that was undertaken across the region under the banner of Health Care Tomorrow: Hospital Services.

Highlights of our accomplishments

It's been seven months now since our two hospital sites became Kingston Health Sciences Centre (KHSC), and the important behind-the-scenes work to continue to bring us together has continued. Teams across both sites have made significant progress with ensuring that our processes and policies are aligned to help us operate as one organization, and much more is planned over the next 18 months. Here's a quick look at what we've accomplished so far:

- Confirmed our legal and operating name as Kingston Health Sciences Centre. A decision that creates stability for our people as we come together and aligns us with Ontario's other highly specialized academic centres;
- Created our first Annual Corporate Plan, which aligns with regional and provincial strategies to support clear pathways across the entire continuum of care for patients with COPD, hip fractures and those who require palliative care;
- Achieved our first quarter access-to-care targets in both our Emergency Department (length of stay) and Urgent Care Centre (wait times);
- Launched Wi-Fi service at the HDH site and boosted the service at the KGH site to enable clinical practice, improve the patient experience and support new education models;
- Pioneered a new Competency-Based Medical Education model in partnership with Queen's University, which is the first school in North America to implement it across all of its specialty programs all at once;
- Submitted the functional program for our Phase 2 Redevelopment project which will create safe, modern facilities in which to deliver high-quality care;
- Kicked off key Information Technology projects that will help to unify practices across both sites, including the consolidation of core IT infrastructure to enable a single e-mail and log-in for KHSC employees.

The remainder of this report details the full scope of our accomplishments across all dimensions of the organization.

Access to care

Managing capacity remains a priority within our hospital, the SE LHIN and the provincial healthcare system. Sustained increased volumes of emergency department visits and high volumes of patients designated as alternate level of care (ALC) are impacting timely access for patients who need to be admitted into the hospital. In addition and more importantly, long ALC stays in hospital have negative impacts on our patients' quality of life.

Patient flow professionals focus on both internal and external patient flow activities, mandatory provincial reporting and data collection and analysis. Our patient flow management activities include:

- liaising with staff and leaders in the patient care areas and with the bed allocators to ensure continuous movement of patients to the right destination,
- participating in care team and patient and family meetings,
- reviewing and revising patient designation daily to determine appropriate levels of care to facilitate timely transitions and discharges,
- attending weekly team rounds,
- reviewing and monitoring ALC designations continually,
- re-evaluating discharge plans on an ongoing basis, especially if special needs are identified,
- attending complex team and family meetings,
- mentoring and facilitating complex discharge plans and
- working with regional partners on system issues.

An ethicist is now also available to support the clinical team, patient and family with complex ethical issues related to patients who require alternate levels of care.

Following is an analysis of our ALC activity:

In Q1, 13.4 per cent of inpatient days were ALC days. The KHSC target is 13.2 per cent. In the last two quarters, KHSC has met the ALC target for the first time in more than three years.

There is quite a bit of movement with our ALC patients. We started Q1 with 78 patients designated as ALC waiting for different destinations. Twenty-nine, or 37 per cent, of these patients were waiting for beds at a long term care (LTC) home. We ended Q1 with 69 patients designated as ALC with 30 patients, or 43 per cent, waiting for LTC. During the quarter, we discharged 192 ALC patients and five of these patients went to LTC, which clarifies the assumption that it is the same ALC patients waiting at KHSC for beds at other facilities.

	April	May	June
# of cases handled by team	30	31	22
#of requests/suggestions for *Crisis Placement*	8	10	2
# of patients who went directly to LTC as a result of our discharge process	0	2	0
# of patients admitted after discharge planning had begun	4	3	1

The SE LHIN approved a Pay for Results proposal for a refresh of the Home First philosophy to the end of fiscal year 2018. A specialist is focused on working with each patient care area to ensure all opportunities for discharge home are explored rather than designating patients as ALC for long term care (LTC). This work requires support from our internal and external stakeholders as well as education regarding this philosophy, which was delivered to incoming residents at their orientation session at the end of the quarter. The education session was the same one that all care providers received last fiscal year to ensure consistent messaging to our patients, their families and primary care teams.

At this time, we are on track to meet our ALC rate target. This success is based on the provision of SE LHIN funding for the Home First specialist to assist with ensuring patients are returning to the community rather than waiting at KHSC for their next destination.

Emergency Department discharge planning rounds

The patient flow specialist is also focused on discharge planning in the Emergency Department (ED). The specialist leads a team including the social worker, nurse practitioner, physiotherapist and nurses at daily morning rounds to plan complex discharges back to the community to prevent admissions for patients at risk of being designated ALC-LTC.

Between April 1 and July 31, 2017, 105 patient admissions were diverted by focusing on the complex discharge needs required to support patients in the community. Twenty-four patients were deemed to be in crisis and in need of placement in a long term care facility. Three of these patients went to LTC and the remainder went home to await availability at their next care destination.

An abstract outlining the Home First philosophy in the Emergency Department and the work of the ED team has been accepted for presentation at Health Quality Ontario Quality Improvement and Patient Safety Forum in October 2017, at Queen's Healthcare Quality Research Forum in October 2017 and at Ontario Hospital Association HealthAchieve Conference in November 2017.

One of our greatest challenges is patients who present to the Emergency Department with non-acute medical issues who do not meet the criteria for admission to any service and are unable to go home due to dementia and behavioural issues. For many of these patients, once they are assessed and their consultation and discharge plans are complete, they do not have anywhere to go. These patients spend many days in the ED on a stretcher while their behavior is stabilizing. During this time, the team continues to work on a discharge plan and find them a suitable place to return to in the community.

Caring for our youngest patients

In addition to these capacity challenges, there has been pressure within the Neonatal Intensive Care Unit due to increased activity.

KHSC serves as the tertiary care hospital for the region. As such, the Kingston General Hospital site houses the Neonatal Intensive Care Unit (NICU) that is the only facility providing level-three care to neonates within the South East LHIN. Our NICU has historically operated 22 beds which are available for neonates requiring the two and three levels-of-care. There are no restrictions on how many neonates we will accept with a particular care designation. The designation of these beds will fluctuate based on the care needs of the neonates.

Prior to 2015, the planned activity was easily accommodated within this bed complement with minimal need to surge beyond the available beds. However, since 2015 we have experienced a steady increase in utilization of the NICU beds with regular periods of surge.

For the past two fiscal years, KHSC has experienced an increase in patient days in the NICU with 5,954 days in 2016 and 5,723 in 2017 respectively. In the first four months of fiscal 2018, we have already had 2,114 patient days. Should this trend continue, we will end the year with over 6,000 patient days in the NICU. It is noteworthy that the increase of neonates born outside of Kingston that are transferred to our NICU has increased by 53 per cent over the past two fiscal years. KHSC is delighted to receive funding for two additional NICU beds, which was recently announced by the MOHLTC.

KHSC is also reviewing surges in activity that may be associated with a number of factors including regional capacity challenges. This may be related to physical capacity challenges, as well as human resource challenges within other sites. Discussions are occurring from a LHIN perspective and through the KHSC Medical Advisory Committee. Discussions are underway to consider adopting a "one number" approach for all patients requiring transfer to KHSC from the region when care is not available through the home hospital. This would provide better data to help us understand the care needs of our patients from a system perspective.

Other capacity pressures

KHSC is experiencing volume pressure in our Cardiac Program, mainly due to higher than targeted TAVI cases and EVT procedures as these have provided very significant benefits to patients.

In summary, our work to improve patient flow overall is aligned to the SE LHIN patient flow action plan to ensure consistent practices exist across the region. These include collaborations with community partners, Health Links, primary care providers and the SE LHIN Home and Community Care Team. As a result of our collective efforts, although we are experiencing increased patient activity, we are seeing better movement of patients through the system as a result of the strategies that are in place. We continue to monitor relevant data and patient experience feedback so that we are able to continuously identify and act on opportunities for improvement.

Progress on service levels compared to baseline

As part of our commitment to improving access to high-quality health care while sustaining the financial health of our organization, we are aiming to complete the full volume of services that we are funded to deliver this year. This includes all available cardiac and cancer surgeries, diagnostic imaging services, and Quality Based Procedures that we offer. When we meet our funded service volumes, we retain the full amount of funding that has been allocated to our health sciences centre, which enables us to maximize access to high-quality health care for patients in southeastern Ontario. This model of activity-based funding is part of the Ministry of Health and Long-Term Care's Health System Funding Reform that aims to improve hospital efficiency and access to care while ensuring transparency and accountability of healthcare spending. To help us deliver on this target, we will undertake work to identify and act on opportunities for improvement across all clinical areas where we are not currently completing all our funded service volumes.

This is a new metric that we have implemented as a measure of KHSC's ability to provide stewardship of funded procedures. Resources have been realigned to support and optimize from an integration perspective:

As of Q1 and Q2 we are achieving 97 per cent of funded activity. Measuring and monitoring processes are in place to evaluate on a regular basis

Impact on patient experience and patient & staff satisfaction

Patient Experience Advisors & Patient Councils

Prior to integration, each of the hospitals had created Patient Experience Advisor programs, recruiting patients and family members to partner with the hospitals on all decisions that have a material impact on the patient experience in our hospital. Each hospital also established Patient Councils. At the HDH site, a Patient & Family Council (PFAC) was established and met monthly approximately ten times per year. At the KGH site, a PFAC met monthly (10-12 times per year). In addition, there is a Patient & Family Advisory Council for the Renal Program and the Regional Cancer Centre.

A small task team of advisors came together with administrative leads over the summer to consider how to move forward in the context of integration. This group suggested – and advisors agreed – to move forward with the following effective immediately:

- All patient advisors will be considered KHSC advisors (not site-specific);
- The two existing Councils will merge into one KHSC PFAC. The two site Council Chairs will co-Chair the new Council.

The first meeting of the newly integrated Council took place in October. All advisors are now working on projects and issues regardless of their "site of origin" and are invited to participate in partnership at either hospital site. Furthermore, as a first joint initiative, the Exceptional Healer Award created and launched last spring by the Patient & Family Council of HDH is now extended across KHSC. Physicians from either site can be nominated by patients, families or staff as exceptional healers for how they exemplify the principles of patient- and family-centred care.

Quality & quality improvement

- The patient safety, risk management and patient relations portfolios from HDH and KGH have been brought together into one integrated portfolio. Patient Relations Specialists and Patient Safety & Quality Specialists no longer have site-specific roles. They are aligned to support patient care portfolios across both sites.
- The process of policy harmonization/standardization continues, e.g. patient feedback policies and incident reporting policies are being standardized.
- The PSQR portfolio was committed to bringing the best practices of the legacy organizations together and has taken the necessary time required to start to harmonize these processes and practices.
- Patient safety and quality improvement priorities are being viewed from an integrated perspective. For instance, medication reconciliation, a patient safety priority with unique challenges in the ambulatory care setting, is being overseen by a single steering committee with the same subject matter experts at both sites.

Research

A decades-long vision of an in-hospital, patient-oriented clinical research centre was realized earlier this year with the official opening of the W. J. Henderson Centre for Patient-Oriented Research on September 11, 2017. The $4.3 million, 10,000 square-foot collaborative research hub located within the KGH site, enhances the collective research and innovation potential of KHSC, Queen's University and the KGH Research Institute. The opening event attracted visitors from the research community, industry and the local community, and more than a dozen clinician-scientists and researchers were on hand to demonstrate their patient-oriented research.

Communications

The Strategy Management and Communications department was blended in the spring of 2017 and is now working as one team that spans both sites. Over the summer months, the team developed and launched a survey to gather information from internal users about their information needs and preferences to inform a plan to bring together communications strategies, tools and vehicles. In response, a new weekly newsletter called "KHSC now" was launched for all staff across KHSC in September of 2017. This replaces the previous weekly email called "What's Up at HDH" and weekly email/newspaper called "KGH Today". The new electronic newsletter provides information, stories, links and highlights of key information relevant to staff across Kingston Health Sciences Centre and has been positively received to date. Looking ahead, the team will move ahead with an integrated Intranet for KHSC as a key tool for staff and is now working with the project management office to map out the project plan, timeline and resources required for this work. Once implemented, the new KHSC intranet will generate considerable efficiencies by reducing duplication of effort and maintenance costs.

The communications department is also facilitating regular forum for leaders to come together. For example, Club Change is offered to leaders throughout KHSC to come together to talk about change management. This well-received "fireside chat" style meeting is intended to create an easy opportunity for people to come together in the context of all of the change underway and to reflect on successes and identify ongoing needs which can then be incorporated into the operational work of the hospital as necessary. Leaders' Connection is another forum offered monthly to help keep leaders informed and engaged with developments at the hospital and system level.

Performance Reporting

A new performance reporting process and schedule has been developed for KHSC and endorsed by leadership and the board. This process replicates neither the KGH nor the HDH way of reporting performance, but rather, attempts to adopt the best of both systems to promote rigour, accountability and ease of public reporting. While some metrics will be internally reported to focus teams, the board and community will receive three bundles of quarterly reports:

- A performance report that measures and describes performance against targets set in the annual corporate plan;
- A performance report that measures and describes performance against the Quality Improvement Plans (QIPs) for both the HDH and KGH sites (note: Health Quality Ontario had requested last fiscal year that each site continue to submit separately as the QIPs were due prior to the legal integration. Every effort was made to align the two plans leading into integration.);
- A Service Accountability Agreement (SAA) report that measures and describes performance on metrics reported through various LHIN-KHSC service accountability agreements and through the LHIN reporting tool(s).

Each board committee has included in its work plan for the year a schedule for reports to come forward for review and discussion prior to public release.

To prepare first quarter results, education was provided by the Decision Support team to all those with data and reporting accountability. This education oriented leaders to the data and the tool, and also facilitated coaching and a decision support "buddy" to help support those new to the process.

Extensive work was undertaken to verify data integrity and facilitate clarity of performance descriptions prior to presentation of Q1 results to the Board. Following board discussion and input at the end of September, performance results were released publicly through the KHSC website. Performance results were also discussed with leaders and we sought their feedback on the process following Q1 to help us identify opportunities for improvement that we can build into the reporting cycle. This communication is facilitating ownership over improvement initiatives and the performance results themselves.

Risk Management

Risk management frameworks and plans from the legacy hospital sites are being integrated into a single framework. A harmonized KHSC policy guiding policy approval/review/deletion processes has been approved. A Patient Safety and Quality intake process and form have been developed and are being piloted to ensure that PSQR resources are prioritized in a consistent manner in alignment with KHSC priorities.

Administration

KHSC has successfully integrated the management reporting structure (Appendix 3) of the legacy hospitals and the clinical and administrative operations now report through an integrated management structure with one executive team, reporting to a single board. The back-office functions of IT, Finance, and Human Resources now operate as single departments. Their accomplishments are detailed in the next sections of this document.

Human Resources

The People Services (Human Resources) departments of the KGH and HDH sites came together in the spring of 2017. In October of 2017, the department staff expanded their roles and accountabilities to include Providence Care. This re-design leverages the synergies that were identified during the Health Care Tomorrow conversations. This new structure provides opportunities to create consistent human resources practices across each organization while implementing leading practices and quality improvement initiatives, increasing access to internal expertise, reducing duplication and improving efficiencies.

Leading up to and post integration, it has been consistently communicated to the HDH and KGH site non-union employees that the pre-integration compensation, benefits and vacation practices at each of the respective sites will remain in effect until such time that there is an approved KHSC non-union total compensation structure. This work is anticipated to be finalized by March 31, 2018. In addition to evaluating all of the non-union positions for placement within the new KHSC non-union wage structure, work is currently underway to align the benefit plan design, vacation plans and the non-union terms and conditions of employment between the two previous site practices.

The Executive Compensation Framework for the inaugural KHSC executive team was submitted to the Ministry of Health and Long-Term Care on September 28, 2017 in compliance with *Ontario's Broader Public Sector Executive Compensation Act.*

KHSC has embarked on the creation of an integrated engagement strategy focused on enhancing the workplace experience of our employees, physicians and volunteers. The aim of this strategy is to put practices and measures in place that support a safe, healthy and caring work environment that brings out the best in our people, inspires excellence and fosters a sense of pride in being part of the KHSC community. The integrated engagement strategy has been incorporated into the KHSC Annual Corporate Plan for 2017-18 and is aligned with accreditation standards. KHSC will undertake an employee engagement survey and a physician engagement survey on or before the spring of 2019, in accordance with the *Excellent Care for All Act* (ECFAA, 2010).

Since April 2017, KHSC leadership has created opportunities to recognize and thank staff for their contributions. Examples include staff appreciation events at both sites such as the Strawberry Social, Executive Rounds, and a join Leadership Celebration event. This Leadership event provided a venue to thank leaders for their exceptional work to prepare for integration, to give leaders an opportunity to get to know each other, to strengthen relationships, and learn and be inspired through a keynote speech on facilitating change, building resiliency and team building.

On the unionized labour side, KHSC unionized employees are represented by five bargaining agents: Ontario Nurses Association (ONA); Canadian Union of Public Employees (CUPE); Ontario Public Service Employees Union (OPSEU); Professional Institute of the Public Service of Canada (PIPSC); and Professional Association of Residents of Ontario (PARO). These bargaining agents in turn represent employees in 14 bargaining units. Five of the 14 KHSC collective agreements will expire in the latter part of this year. Negotiations have or will commence at either the central table or the local level in the next few months.

On May 1, 2017, CUPE, representing the service and clerical bargaining unit members at the KGH site, made an application to the Ontario Labour Relations Board (OLRB) under the *Public Sector Labour Relations Transition Act* (PSLRTA). This application started a process that will result in a determination of the following;

- The number and description of bargaining units representing unionized employees at KHSC; and
- The union which will represent each of the bargaining units.

PIPSC and PARO are not involved in this rationalization of bargaining units, OPSEU and ONA have responded to the application, as has KHSC.

The parties (KHSC, OPSEU, CUPE and ONA) participated on August 30, 2017 in a day of mediation with a representative of the OLRB. The purpose of the mediation was to finalize the number and description of the bargaining units. As the parties were unable to reach an agreement, a further conference call was held on October 16, 2017. Issues still remain unresolved between the parties, including the configuration of the bargaining unit(s) for the service, clerical and IT group; positions at both sites that are currently represented by different bargaining agents; and one classification that is non-union at one site and unionized at the other site.

The parties have agreed on the following timetable for the CUPE/OPSEU issues. A timetable for the ONA issue has not yet been determined.

November 3, 2017	CUPE files its submissions on any outstanding issues;
November 24, 2017	OPSEU and KHSC file replies to CUPE's submissions;
December 1, 2017	All parties reply to the other parties' submissions;
December 13, 2017	A "consultation" on outstanding matters will occur. A consultation is a less-formal version of a hearing, but may result in decisions by the OLRB on outstanding matters. A hearing may follow if matters remain outstanding.

It is anticipated that a vote will occur sometime in the first half of 2018. It is expected that the PSLRTA application will have an impact on negotiations that are taking place locally at KHSC. As an interim measure, OPSEU and KHSC have an agreed upon Memorandum of Agreement with OPSEU which provides the Hospital and OPSEU some structure around the movement of OPSEU professional staff between the two sites. The Hospital is also in discussions of a similar nature with ONA.

IT Infrastructure & Business Systems

IT infrastructure

Our primary objectives with respect to infrastructure are to implement the updated corporate logins and e-mail addresses, implement security best practices, consolidate the downstream infrastructure components, apply the appropriate change and communication strategy, update dependent applications, and support the necessary IT and organizational changes. As of the time of this report, the project initiation phase is complete and the Project Charter is approved. As per the Charter, the project team resource assignments have been allocated, and initial scope and timelines have been determined. The project team is engaged in the Planning phase through comprehensive current state analysis of dependent applications, development and validation of future design, engagement of stakeholders to develop the change management plan, and refinement of the scope and timelines.

Business systems

The business systems project is focused on identifying and planning the Stage 2 KHSC Business Systems integration priorities for Finance, HR and Strategy Management & Communications. As of the time of this report, up to 16 business systems integration projects have been identified. Project intake requests have been drafted or submitted. A prioritization process and capacity planning are underway.

Finance

Q2 financial results for KHSC indicate a surplus position of $24.4 M, about $3.8M favourable to budget. Please see Appendix 2 for a detailed variance explanation and financial statements.

With regards to the integration, KHSC has targeted efficiencies of $1.25M in 2017/18, an additional $1.5M in 2018/19, and another $1.0M in 2019/20, for a total of $3.7M over three fiscal years. For the first six months in 2017/18, KHSC has achieved annualized savings of $1.1M, and is on track to achieve the targeted savings for 2017/18.

Efficiencies have been made in the areas of compensation ($854.8K), membership and other fees ($188.4K), and increase in interest revenues ($15K).

The next six months

Strategic Planning

The Board of KHSC has endorsed a work plan to develop the inaugural strategy for KHSC with a target launch of September 2018. A strategic planning steering committee has been formed and is comprised of all members of the executive committee, the Vice-Dean of the Faculty of Health Sciences at Queen's University and two patient experience advisors. This group meets bi-weekly to oversee the implementation of the work plan and will report regularly through the Governance Committee to the Board. The board has also scheduled its first all day strategic planning session for Saturday December 9, 2017.

Accreditation

The PSQR portfolio is coordinating preparations for a KHSC accreditation survey in April 2018. The accreditation process provides an opportunity for leaders, staff and physicians from the HDH and KGH sites to come together to achieve the common goals of learning, improving, and modeling excellence.

Appendices

- Appendix 1 – Minister's Approval Letter & Designations
- Appendix 2 – Fiscal 2018, Quarter 2 Internal Financial Results (period ending 2017 September 30)
- Appendix 3 – KHSC Organization Chart

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Ontario

HLTC5965MC-2016-74

JAN 17 2017

Mr. George Thompson
Chair, Board of Directors
Kingston General Hospital
76 Stuart Street
Kingston ON K7L 2V7

Mr. J. Michael Hickey
Chair, Board of Directors
Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston
166 Brock Street
Kingston ON K7L 5G2

Dear Mr. Thompson and Mr. Hickey:

Re: Integration of Kingston General Hospital (KGH) and the Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston (HDH) – approvals under the *Public Hospitals Act* and amended designations under the *Mental Health Act*

I am pleased to grant to KGH and HDH (the "Hospitals") the following approvals under the *Public Hospitals Act* (PHA):

(1) Pursuant to subsection 4(1) of the PHA, approval to proceed with an application to incorporate a new hospital under the *Corporations Act* (Ontario), to be known as the KINGSTON HEALTH SCIENCES CENTRE (KHSC); and

(2) Pursuant to subsection 4(4) of the PHA, approval for:

(a) HDH to lease to KHSC the real property of HDH in accordance with the terms of the form of ground lease that was submitted to the South East Local Health Integration Network (the "SE LHIN") and the ministry for review (draft dated November 1, 2016); and

(b) KGH to transfer its real property to KHSC pursuant to the terms of the asset transfer agreement between KGH and KHSC that was submitted to the SE LHIN and the ministry for review (draft dated October 25, 2016).

. . . /2

Mr. George Thompson and Mr. J. Michael Hickey

You have advised that the planned effective date for the integration transactions will be April 1, 2017 (the "Integration Date"). It is my expectation that, following the integration, KGH and HDH will each amend their corporate objects to reflect that they are no longer operating hospitals, and KGH will remove the word 'hospital' from its legal name. To effect these changes, the Hospitals should file for supplementary letters patent as soon as possible following the Integration Date, but no later than March 31, 2018. I request that KGH and HDH submit to the ministry a copy of their supplementary letters patent following their approval by the Ontario Public Guardian and Trustee and the Ministry of Government and Consumer Services (MGCS).

In addition to the foregoing approvals under the PHA, I am pleased to advise that the designations of psychiatric facilities under the *Mental Health Act* will be amended to reflect the name change resulting from the integration, provided that MGCS approves the application for letters patent for KHSC and a copy of same is submitted to the ministry. The KGH and HDH sites of KHSC will be designated as psychiatric facilities under the *Mental Health Act* in accordance with the enclosed designation. These designations will be effective as of the Integration Date and will be posted on the ministry's website.

You have also confirmed that the *Public Hospital Act* classifications for each of the KGH and HDH sites of KHSC will not be changing. The ministry will update the PHA classifications for each of the sites to reflect the new corporate name as set out in the appendix to this letter.

I congratulate the Boards of KGH and HDH for achieving this significant milestone. This voluntary integration demonstrates the hard work and commitment of both organizations and advances the vision of integrated patient care for Kingston and the broader southeastern communities which you serve.

Once again, thank you for your leadership and contribution to health system integration and transformation.

Yours sincerely,

Dr. Eric Hoskins
Minister

Attachment

c: Mr. Jim Flett, Interim President and Chief Executive Officer, KGH
Dr. David Pichora, Chief Executive Officer, HDH
Mr. Paul Huras, Chief Executive Officer, South East Local Health Integration Network
Ms. Donna Segal, Board Chair, South East Local Health Integration Network

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DESIGNATION

Pursuant to subsection 80.2 (1) of the *Mental Health Act*, R.S.O. 1990, c. M.7 (the "Act"), the designations of psychiatric facilities under the Act are amended as follows.

1. The designation of Kingston General Hospital in Kingston Ontario is revoked.

2. The designation of Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston in Kingston, Ontario is revoked.

3. The Kingston Health Sciences Centre – Kingston General Hospital site in Kingston, Ontario, is designated as a psychiatric facility for the observation, care and treatment of persons suffering from mental disorder, and shall offer a program that includes the following essential services:

    1. In-patient services.
    2. Out-patient services.
    3. Emergency services.
    4. Consultative and educational services to local agencies.

4. The Kingston Health Sciences Centre – Hotel Dieu Hospital site in Kingston, Ontario, is designated as a psychiatric facility for the observation, care and treatment of persons suffering from mental disorder, and shall offer a program that includes the following essential services:

    1. Out-patient services.
    2. Day care services.
    3. Consultative and educational services to local agencies.

Dr. Eric Hoskins
Minister of Health and Long-Term Care

Effective from December 1, 2016.

Appendix

Classification of Hospitals

***Section 32.1 of the Public Hospitals Act,* R.S.O. 1990, c. P. 40**
Regulation 964, R.R.O. 1990

Kingston Health Sciences Centre

Hospital	Sites	*Classification
KHSC	• KGH Site • HDH Site	Group A Hospitals – General / Teaching
KHSC	• KGH Site	Group D Hospitals – Cancer Care
	• HDH Site	Group K Hospitals (Diagnostic/treatment for disabled persons)
	• KGH Site • HDH Site	Group M Hospitals - Computerized Axial Tomography (CTs)
	• KGH Site	Group N Hospitals (Magnetic Resonance Imaging - MRI scan)
	• KGH Site	Group O Hospitals (Transplantation)
	• HDH Site	Group T Hospitals - Cystic Fibrosis

*The post integration classifications reflect the classifications currently in effect at each existing hospital. There are no changes.

Kingston Health Sciences Centre

Briefing Note

TOPIC OF REPORT: Summary Financial Results – September 2017

Submitted to: KHSC Executive

Submitted by: J'Neene Coghlan, Vice President & Chief Financial Officer

Date submitted: October 16, 2017

For Decision	
For Discussion	✓
For Information	✓

The summary financial results through the first half of Fiscal 2018 represent an overall surplus position of $24.4 million; approximately $3.8 million favourable to budget.

After offsetting corresponding revenue and expense variances, major category results varying from budget can be attributed mainly to the following ($ millions):

Ministry/LHIN/CCO revenue	1.9	Reconciliation of prior year activity - CCO
Patient revenue	0.6	Higher Federal Government and non-resident revenue offsets lower OHIP technical fees, WSIB and preferred accommodation revenue
Miscellaneous revenue	0.6	Interest income and grants revenue
Compensation	0.5	Turnover allowance (non front-line position vacancies) has offset significant cost overruns mainly in the Medicine and Paediatric in-patient programs, and the KGH site Emergency Department
Patient care supplies	(0.2)	Higher medical/surgical supplies costs (e.g. joints, instruments)
Drugs and medical gases	0.5	Higher than planned costs mainly in the Renal and Medicine programs offset by lower utilization in other patient care services
Supplies and other expenses	(0.1)	Unplanned Integration legal costs, insurance claim deductible, and fiscal support to HDHkRI
Variance to budget	**3.8**	

Setting aside the one-time revenue from the reconciliation of prior years' activity for Cancer Care Ontario managed programs (i.e. funding for activity undertaken last year in excess of funded levels), the hospital maintained its surplus position from the prior month.

The hospital's capacity for capital spending remains at approximately $24 million. The hospital Board approved the provision of $3 million per year from the patient care equipment provision within the annual capital budget related to future equipment investment for the Redevelopment Phase 2 project – KGH site. Including this provision, there remains only $2.5 million of this year's capital budget currently unallocated. Remaining capital spending will be addressed only within the STATCAP policy until Q4. A review will be undertaken at that time based on the hospital's overall financial position and capital requirements to support Integration activities. An amount of $20 million of accumulated working capital has also been provisioned aligned to the local share requirement for the Redevelopment Phase 2 project (held in "Restricted cash").

The current ratio (current assets divided by current liabilities) has increased slightly from the prior year ending position as reflected in the increase in Working Capital (current assets divided by current liabilities). An increase in amounts due to the organization from Government (e.g. HIRF and priority programs funding for the current and prior year) and the reallocation of investments to Restricted Cash on maturity (awaiting reinvestment activity) aligned to the future replacement of the Health Information System (HIS) account for the majority of this change.

KINGSTON HEALTH SCIENCES CENTRE
Statement of Financial Position

as at September 30, 2017
(in thousands of dollars)

	September 2017 $	March 2017 $
Assets		
Current assets		
Cash	47,707	68,495
Restricted cash	92,920	48,414
Accounts receivable	15,684	20,304
Due from MOHLTC/LHIN/CCO	14,521	3,102
Inventories	7,708	6,720
Other current assets	8,371	7,223
	186,911	154,259
Other Investments	6,492	14,849
Investments in Joint Ventures	3,512	3,512
Capital assets, net	272,770	279,093
	469,685	451,713
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued liabilities	49,807	43,615
Accrued compensation	24,424	33,285
Note payable - KGH Auxiliary	700	475
Agency obligations	3,640	3,606
Current portion of long-term debt	1,591	1,814
	80,163	82,795
Long-term debt	7,876	8,336
Employee future benefits	33,081	32,595
Interest rate swaps	395	395
Deferred contributions	251,997	255,769
Net assets		
Invested in capital assets	17,252	20,439
Unrestricted	78,687	51,135
	95,939	71,573
Accumulated remeasurement gain (losses)	234	249
	469,685	451,713
Current Ratio	2.33	1.86
Working Capital	106,748	71,464

KINGSTON HEALTH SCIENCES CENTRE
Statement of Cash Flows

for the period ended September 30, 2017
(in thousands of dollars)

	August 2017 $	March 2017 $
Operating activities		
Surplus of revenues over expenses	$ 24,383	$ 14,023
Add (deduct) non-cash items		
Amortization of capital assets	17,022	34,679
Amortization of deferred capital contributions	(12,435)	(25,245)
Change in fair value of other investments	(33)	(106)
Change in non-cash working capital balances	(11,570)	(908)
Increase in employee future benefits	486	1,184
Decrease in deferred contributions	967	(621)
	18,821	23,006
Capital activities:		
Purchase of capital assets	(10,699)	(27,591)
Receipt of deferred capital contributions	7,696	25,023
	(3,003)	(2,568)
Financing activities		
Repayment of long-term debt	(683)	(1,952)
Note payable - KGH Auxiliary	225	75
	(458)	(1,877)
Investing activities		
Decrease of investments (net)	8,357	29
Increase in investment in Joint Ventures	-	(442)
	8,357	(414)
Increase in cash during the year	23,717	18,147
Cash, beginning of year	116,909	98,762
Cash, end of year	$ 140,626	$ 116,909
Cash, end of year is represented by:		
Cash	$ 47,707	$ 68,495
Restricted cash	92,920	48,414
	$ 140,626	$ 116,909

KINGSTON HEALTH SCIENCES CENTRE
Statement of Revenues and Expenses

for the period ended September 30, 2017
(in thousands of dollars)

	YTD Actual $	YTD Budget $	YTD Variance $	Full Year Budget $	Variance Comments
Revenues					
MOHLTC/LHIN/CCO	216,641	214,422	2,219	430,190	Mainly prior year reconciliation activity
Patient revenue from other payers	15,781	14,932	849	29,159	Higher revenue from Federal Government and non-resident payors, offsets lower OHIP technical fees and WSIB revenue
Differential and co-payment	1,807	1,911	(104)	3,823	Lower than planned semi and private accommodation revenue
Recoveries and miscellaneous revenue	11,360	10,382	979	21,803	Higher than planned interest income and miscellaneous recoveries; expense offsets
Amortization of deferred capital contributions	3,290	3,288	2	6,514	
Total revenues	248,879	244,935	3,944	491,489	
Expenses					
Salaries and benefits	151,614	152,189	575	331,960	Favourability from vacancies (non-front line care) offset cost overruns mainly in the Medicine and Paediatric programs and the Emergency Department
Medical and surgical	21,643	21,233	(410)	41,343	Higher utilization of joints (non hip/knee) and surgical instruments; rebate offsets
Drugs and medical gases	13,179	13,012	(167)	26,424	Cost overruns mainly in the Renal, Medicine and Oncology programs, offset by lower utilization in other patient care services
Supplies and other	28,431	28,187	(245)	57,807	Mainly unplanned costs related to insurance claims (flooding), Integration legal costs and support of HDHkRI. Also higher than planned cost for referred out laundry and chemistry testing
Amortization of major equipment	6,927	6,927	-	30,029	
Rental lease of equipment	1,595	1,689	94	3,452	Favourable variance mainly in Information Management
Bad Debts	-	-	-	375	
Total expenses	223,389	223,237	(152)	491,390	
Surplus/(deficit) from hospital operations	25,490	21,698	3,792	99	
Fund 2 surplus/(deficit)	-	-	-	-	
Fund 3 surplus/(deficit)	-	-	-	-	
Surplus (deficit) before building amortization, net	25,490	21,698	3,792	99	
Building amortization, net	(1,107)	(1,088)	(19)	(2,242)	
Total surplus (deficit)	24,383	20,610	3,773	(2,143)	
Total margin consolidated - all fund types	9.12%	7.88%			
Total margin - hospital sector only	10.24%	8.86%			

Executive Portfolio Update

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Kingston Health Sciences Centre
Board of Directors

David Pichora, President & CEO

Dr. Mike Fitzpatrick, Chief of Staff

- Medical Advisory Committee

Silvie Crawford, Exec VP & CNE
- Surgical Program, Laurie Thomas (interim)
- Cardiac Program, Reg Hart (interim)
- Women & Children's Program, Stacey Wolfrom (interim)
- KidsInclusive, Margaret van Beers
- Critical Care Program, Leanne Wakelin (interim)
- Professional Practice, Jane Warner, Leanne Wakelin, Cynthia Phillips

Mike McDonald, Exec VP, Regional Partnerships & Ambulatory
- Emergency/Urgent Care & Ambulatory Services, Carol McIntosh
- Medicine Program, Cynthia Phillips (interim)
- Addictions & Mental Health, Michelle Matthews (interim)
- Regional Partnerships & Transitions in Care, Cindy Bolton
- Ventilator Equipment Pool, Cynthia Phillips
- Ininew Patient Services, Midge Rouse
- CACC, Mark Halliday
- Regional Paramedical Program for Easter Ontario (RPPEO) , Jason Lewis

Troy Jones, Exec VP & CIO
- Performance Management & Decision Support, TBD
- Information Management, Valerie Gamache-O'Leary
- Clinical Engineering, Chris Scott
- Registration & Health Information Services, Deborah Sapp
- Privacy Officer, Karen Hanewich
- Project Management Office, Dino Loricchio
- Clinical Lab Services, Joyce deVette-McPhail
- Imaging Services, Karen Pearson
- Pharmacy Services, Veronique Briggs

J'Neene Coghlan, VP & CFO
- Financial Services, Caroline Reid
- Nutrition Services, Sheri Campbell
- Procurement & Supply Chain, Ann Van Herpt *
- Business Development
- Protection Services, Rocky Prosser *

Sandra Carlton, VP & CHRO *
- Employee & Labour Relations,* Clarence Willms
- Leadership & Talent Development, * Micki Mulima
- Occupational Health, Kelly Monaghan, Joanna Noonan
- Infection Control, Kelly Monaghan, Darlene Campbell
- Volunteer Services, Jill Holland-Reilly
- Labour & Employment Adjudication, Scott MacInnes
- Workplace Planning & Utilization, TBD
- HR Planning & Performance, * Indira Naraine

Brenda Carter, VP Quality & Regional VP
- Cancer Centre of Southeastern Ontario (CCSEO) & SE Regional Cancer Program, Tyler Hands (interim)
- Palliative Care, TBD
- Haematology, TBD
- Renal Services, Wilma Cohrs (interim)
- Quality, Patient Safety and Risk Management, Janine Schweitzer (interim)
- Facilities Maintenance (FM), Infrastructure Planning (IP): Allan McLuskie (FM & IP, KGH) Larry Erwin, (FM, HDH/BGH) Krista Wells Pearce, (IP, HDH)

Elizabeth Bardon, VP Missions, Strategy & Communications
- Mission
- Patient & Family Centred Care, Daryl Bell (lead)
- Spiritual Health, Mission, Ethics (HDH/PC)- Neil Elford; Ethics (KGH) - David Campbell; Spiritual Services (KGH)-Daryl Bell
- Auxiliaries
- Environmental & Portering Services, Brian Harvey
- Strategy Management & Communications, Theresa MacBeth

Dr. Roger Deeley, VP Research
- Research Institute(s) Veronica Harris-McAllister Smita Sengupta (KGHRI) Vic Sahai (HDHkRI)

Physician Advisory Council

Dr. Mike Fitzpatrick VP Medical Affairs
- Medical Affairs, Chris Gillies
- Queen's Liaison
- Program Medical Leads **

Denise Cumming, President & CEO, UHKF

Steve Miller Corporate Development & Transition Lead

* City-wide position (PC & KHSC)
** Jointly overseen by VP

Revised – August 16, 2017

Hôpital Hotel Dieu Hospital
Hôpital Général de Kingston General Hospital