Strategy Performance Index

Board Committee

Patient Care and People Committee (PCPC)
Governance Committee (GC)
Finance and Audit Committee (FAC)

2015/16 Strategy Performance Index

Strategic Direction	2016 Outcome	2016 Improvement Priority	Target	Indicator	Indicator Level	Target 2014	Target 2015	Target 2016	Current Performance (FY15 Q3)	Target Justification	Red	Yellow	Green	Board Committee
1 Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety and service improvement initiatives	Partner with patients to improve communication issues identified in patient surveys and feedback	**Inpatients who respond good, very good, excellent to "overall, how would you rate the care you received at the hospital" increases from 94 to 97 percent (QIP) Note: Ont Tch Avg 95%**	**Overall, how would you rate the care and services you received at the hospital (inpatient care)? (add together % of those who responded "Excellent, Very Good and Good") - (QIP)**	**1**	**94%**	**97%**	**97%**	**94% (Q2 F15)**	Match Best Performance Obtained By Other Leading Organizations	<= 85%	85%-96%	>= 97%	PCPC
	All preventable harm to patients is eliminated	Reduce the incidence of hospital acquired infections and unnecessary deaths in hospital	**C-Difficile rate is reduced from 0.34 to 0.24 (QIP)**	**The C-Difficile rate represents the incidence rate of nosocomial CDI per 1000 patient days.(Reported Quarterly) - (QIP)**	**1**	**0.34**	**0.29 (Q3 F15 Prov.)**	**0.25**	**0.34**	Match Best Performance Obtained By Other Leading Organizations (10th percentile for hospitals > 300 beds)	> 0.28	0.26 - 0.28	<= 0.25	PCPC
			Hand hygiene compliance rate improves from 85 to 95 percent (QIP)	**The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data. - (QIP)**	**1**	**95%**	**95%**	**95%**	**85%**	Match Best Performance Obtained By Other Leading Organizations	< 84%	84%-89%	>= 90%	PCPC
			Hospital standardized mortality ratio is at the standard rate of 100 and/or deemed "not significant" (QIP)	**Hospital standardized mortality ratio (HSMR) is the number of observed deaths divided by the number of expected deaths, multiplied by 100 - (QIP)**	**1**	**100**	**100**	**100**	**93 (Q4 F14)**	Match Best Performance Obtained By Other Leading Organizations	Statistically Significant Results	N/A	Statistically Not Significant	PCPC
		Reduce the incidence of specimen collection errors, medication events, falls and skin ulcers	**Every patient receives medication reconciliation at admission (QIP)**	**Medication reconciliation at admission - The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital - (QIP)**	**1**	**N/A**	**100%**	**100%**	**77%**	Internal Stretch Target to Achieve Top Performance	<= 80%	80%-89%	>= 90%	PCPC
			Level 3 and 4 patient falls are reduced from an average of 3 to 1 per quarter (QIP)	**The number patient falls in level 3 and level 4 categories from an average of 3 to 1 per quarter - (QIP)**	**2**	**0**	**0**	**1 (qtr)**	**5**	Internal Stretch Target to Achieve Top Performance	> 3	2 - 3	<=1	PCPC
			The number of incidents associated with with morphine and hydromorphone are reduced to 12 per quarter	Number of incidents associated with morphine and hydromorphone	**2**	**NA**	**12**	**12**	**16**	Internal Stretch Target to Achieve Top Performance	> 20	16 - 20	<= 15	PCPC
			Reduce specimen collection and labelling errors from 76 to 45 per quarter	Number of specimen collection and labelling errors	**2**	**NA**	**45**	**45**	**76**	Internal Stretch Target to Achieve Top Performance	> 55	46 - 55	<= 45	PCPC
			All three phases of the surgical safety checklist are performed for all surgeries (QIP)	**Number of times all three phases of the surgical safety checklist was performed ("briefing", "time out" and "debriefing") divided by the total number of surgeries performed, multiplied by 100 - consistent with publically reportable patient safety data - (QIP)**	**1**	**100%**	**100%**	**100%**	**99%**	Match Best Performance Obtained By Other Leading Organizations	<= 85%	85%-94%	>= 95%	PCPC
			Twenty-five percent fewer patients experience skin ulcers on Kidd 6, Connell 10, and our ICU (QIP)	**Twenty-five per cent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) with the highest prevalence. This will result in 4 less incidents in the ICU, 2 on C10, and 2 on K6. - (QIP)**	**2**	**N/A**	**N/A**	**3 of 3 units achieve 25% reduction**	**0**	Internal Stretch Target to Achieve Top Performance	No units achieve green status	1 or 2 units achieve Green Status	3 of 3 units achieve green status	PCPC
	All preventable delays in the patient journey to, within, and from KGH are eliminated	Reduce wait times, length of stay, avoidable admissions and the number of patients waiting in our hospital for alternate levels of care	**ED wait time for admitted patients improves from 31.6 to 29 hours (QIP)**	**90th percentile ED wait time - all admitted patients (Hrs.) - (QIP)**	**1**	**25**	**25**	**29**	**31.6**	Match Best Performance Obtained By Other Leading Organizations	> 33	30-33	<=29	PCPC
			Percent of ALC days improves from 14.8 to 10 (QIP)	**Total number of ALC days divided by the total number of patient days - (QIP)**	**1**	**7%**	**7%**	**10%**	**14.8**	Match Best Performance Obtained By Other Leading Organizations	> 13%	>10% - 13%	<=10%	PCPC
			Clinical services meeting wait time targets reach 90 percent	Percent of clinical services meeting or exceeding priority 4 wait time targets (excluding cancer surgery)	**2**	**100%**	**100%**	**90%**	**N/A**	Internal Stretch Target to Achieve Top Performance	<= 80%	80%-89%	>= 90%	PCPC
		Manage occupancy rates to optimize patient safety, flow and quality	Overall medical/surgical occupancy rate improves from 102 to 95 percent	Overall medical/surgical occupancy rate (midnight census)	**2**	**N/A**	**95%**	**95%**	**102%**	Internal Stretch Target to Achieve Top Performance	>= 100%	96%-99%	<= 95%	PCPC

Strategic Direction	2016 Outcome	2016 Improvement Priority	Target	Indicator	Indicator Level	Target 2014	Target 2015	Target 2016	Current Performance (FY15 Q3)	Target Justification	Red	Yellow	Green	Board Committee
2 Bring to life new models of interprofessional care and education	Our Interprofessional Collaborative Practice Model (ICPM) is implemented in every clinical area with high ratings from patients, staff and learners KGH is recognized as a centre of excellence in interprofessional education	Increase adoption of patient- and family-centered care standards in every clinical area	Adoption of patient- and family- centred care standards improves from 93 to 98 Percent	Percent compliance within each of the 5 standards across clinical areas	**2**	**N/A**	**100%**	**98%**	**93%**	Internal Stretch Target to Achieve Top Performance	<80%	80-89%	>= 90%	PCPC
3 Cultivate patient oriented research	Externally funded research at KGH has increased by 50%	Advance the plan for a Kingston-wide health research enterprise	Open the William J. Henderson Centre for Patient-Oriented Research	William J. Henderson Centre for Patient-Oriented Research implementation plan is meeting all quarterly milestones	2	**N/A**	**As per stated project milestones**	**As per stated project milestones**	**Yes**	Match Best Performance Obtained By Other Leading Organizations	No	N/A	Yes	GC
4 Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	Reduce 30-day readmission rates	**30-day readmission rate outperforms its expected MOH rate (QIP)**	**30-day readmission rate outperforms its expected MOH rate (QIP)**	**2**	**12.9%**	**12.9%**	**Quarterly expected MOH rate**	**15.8% (FY15 Q1)**	Match Best Performance Obtained By Other Leading Organizations	> 10% of expected	plus 10% expected	At or below expected	PCPC
		Engage the KGH community of people to help us shape the future of KGH	Deliver a long-term KGH strategy in the context of Health Care Tomorrow	KGH Strategy Development Process deliverables are met	**2**	**N/A**	**N/A**	**As per quarterly plan deliverables**	**Yes**	Internal Stretch Target to Achieve Top Performance	No	N/A	Yes	GC
5 Enable high performance	Staff are engaged in all aspects of our quality, safety and service improvement initiatives	Address priorities identified in our employee and physician and volunteer engagement surveys	Staff who respond "yes" to "does the organization provide opportunities for employee education, learning and development" improves by 20%	Does the organization provide opportunities for employee education, learning and development? (add together % of those who responded "yes")	**2**	**N/A**	**N/A**	**20% increase**	**50%**	Internal Stretch Target to Achieve Top Performance	<10% increase	10-20% increase	20% increase	PCPC
		Align organization and individual accountability	1500 additional staff participate in performance reviews and agreements are completed (phase 2 of 2)	Number of staff with performance reviews and agreements on file	**2**	**N/A**	**1500**	**1500**	**886**	Internal Stretch Target to Achieve Top Performance	< 1000	1000 - 1199	>= 1200	PCPC
	All preventable harm to staff is eliminated	Reduce the incidence of musculoskeletal injuries and incidents of workplace violence	Musculoskeletal (MSI) injury recorded incidents from staff are reduced from 53 to less than or equal to 42 per year (reduced 20%)	MSI injury recorded incidents that occur in staff as a result of inpatient mobilization are reduced by 20%	**2**	**N/A**	**N/A**	**42**	**49 YTD**	Internal Stretch Target to Achieve Top Performance	>47	43-47	<=42	PCPC
			Staff injuries related to workplace violence are reduced from 55 to less than or equal to 44. (reduced by 20%)	The incidents of workplace violence is reduced from 50 to 44		**N/A**	**N/A**	**44**	**50 YTD**	Internal Stretch Target to Achieve Top Performance	>49	45-49	<=44	PCPC
	Phase 2 construction is under way and KGH is clean, green, and carpet free	Advance phase 2 redevelopment and improve hospital cleanliness	Phase 2 redevelopment advances to stage two approval status	Stage 2 approval status	**2**	**As per stated project milestones**	**As per stated project milestones**	**Approved**	**Not Approved**	Internal Stretch Target to Achieve Top Performance	No	N/A	Yes	FAC
			Cleaning audit performance reaches 85 percent	Percent compliance with cleaning audits	**2**	**85%**	**85%**	**85%**	**81%**	Internal Stretch Target to Achieve Top Performance	< 75%	75%-84%	>= 85%	PCPC
	Rapid transmission of information improves care and operational efficiency	Focus organizational project resources on strategic technology projects	Strategic technology projects are implemented on schedule and on budget	Number of strategic technology projects implemented on schedule	**2**	**N/A**	**As per implementation schedule**	**As per implementation schedule**	**Yes**	Internal Stretch Target to Achieve Top Performance	No	N/A	Yes	FAC
	Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures	Increase our capital spend to $20 million	**KGH total margin is greater than zero (QIP)**	**Total Margin - the percent by which total corporate revenues exceed or fall short of total corporate expenses, excluding the impact of facility amortization, in a given year - (QIP)**	**1**	**0**	**0**	**0**	**2.99**	Match Best Performance Obtained By Other Leading Organizations	< 0	N/A	>= 0	FAC
			Our capital budget reaches $20 million	Total dollars for capital equipment, technology and infrastructure ($000s)	**2**	**17.5**	**20**	**20**	**19.7**	Match Best Performance Obtained By Other Leading Organizations	< $18M	$18M - <$20M	>= $20M	FAC

Level 1: These indicators are tried and true. They have well established methodologies, established external benchmarks/targets, readily comparable, subject to 3rd party validation, and are obligated through MoH contracts (e.g. HSAA, WTIS reporting, ED Pay for Performance etc.)

Level 2: These are KGH specific indicators. They have established methodologies, limited comparability, internally established stretch targets, and are easily trended over time.

Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Kingston General Hospital
Outstanding care, always™

4/7/2015

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Kingston General Hospital (KGH) is a community of people dedicated to transforming the patient and family experience through innovative and collaborative approaches to care, knowledge and leadership. As southeastern Ontario's leading centre for complex-acute and specialty care and home to the Cancer Centre of Southeastern Ontario, KGH serves the South East LHIN through its Kingston facility and 24 regional affiliate and satellite sites. Fully affiliated with Queen's University, KGH is a research and teaching hospital which is home to 2,400 health-care students and 175 health researchers. Research Infosource has ranked KGH as one of Canada's Top 40 Research Hospitals since 2011. The KGH 2015 strategy for achieving Outstanding Care, Always, has lead the organization on a journey of quality improvement enabling our vision to be a top performer making Outstanding Care, Always a reality for every patient, every day. KGH has maintained an unyielding focus on four strategic directions to achieve this goal:

1. Transform the patient experience through a relentless focus on quality, safety and service
2. Bring to life new models of interprofessional care and education
3. Cultivate patient-oriented research
4. Increase our focus on complex-acute and specialty care

The KGH Quality Improvement Plan (QIP) 2015-16 will focus on the following eleven key improvement objectives within their associated quality dimensions:

Access:

i. Reduce wait times in the emergency department

Effectiveness:

ii. Improve organizational financial health
iii. Reduce unnecessary deaths in hospitals

Integrated

iv. Reduce unnecessary time spent in acute care
v. Reduce unnecessary hospital readmission

Patient-centred

vi. Improve patient satisfaction

Safety

vii. Increase proportion of patients receiving medication reconciliation upon admission
viii. Reduce hospital acquired infection rates
ix. Reduce rates of deaths and complications associated with surgical care
x. Improve patient skin integrity
xi. Reduce the number of level 3 and 4 falls

Our commitment to transforming the patient experience and providing care that is consistently safe and patient-centered is deeply rooted within the improvement objectives. Along with the principles that guide our work , namely respect, engagement, accountability, transparency and value for money, our QIP 2015-16 fosters a culture of continuous quality improvement and integration where the needs of patients come first.

Integration & Continuity of Care

Health care in the SE LHIN is undergoing a major health care restructuring project with the development of a sustainable regional model of hospital care. With a vision to improve access to high quality care through the development of regional systems of integrated care, KGH is partnering with its 6 regional partner hospitals and CCAC to develop options for joint services integration and reconfiguration. This will include administrative, support and clinical services. Options will be developed based upon evidence and leading practice models. Engagement with patients during all phases of the project will inform the process. The outcome will be an improved,high quality and sustainable regional model of hospital care. Areas of focus and resulting work plans include:

1. Business Function/Corporate Services
    a. Finance
    b. Human Resources
    c. Information Technology
    d. Hotel Services

2. Diagnostic and Therapeutics
    a. Diagnostic Imaging
    b. Laboratories
    c. Pharmacy

3. Clinical
    a. Urgent/Emergent
    b. Complex Chronic Care/Frail Elderly
    c. Elective
    d. Tertiary/Quaternary Services

KGH, Kingston and the region are actively involved in Health Links. The SE LHIN has seven Health Links that are looking at ways to connect family physicians and their patients with hospital specialists and community supports. The Kingston and Kingston Rural Health Link will develop plans and measure results to:

- Improve access to care for patients with multiple, complex conditions
- Reduce avoidable emergency department visits
- Reduce unnecessary readmission to hospitals shortly after discharge
- Reduce the wait time for referral from the primary care doctor to a specialist

The South East LHIN CCAC and Hospital Executive Forum (SECHEF) composed of LHIN, hospital and CCAC leaders meet monthly addressing issues affecting patient care in the south east. The members will jointly begin to address readmissions as a combined quality improvement initiative. Timely acquisition of data and a review process with full engagement of all hospital partners will be the measure of success in the first year of implementation.

Challenges, Risks & Mitigation Strategies

KGH is the lead hospital in the SE LHIN providing adult tertiary complex-acute care. As a result, high occupancy levels remain an ongoing challenge. The increasing frequency of gridlock status and the admitted Alternate Level of Care (ALC) patient population has prompted KGH to make improving patient flow a top

corporate priority. An extensive continuous improvement process with broad stakeholder engagement has identified many process improvement cycles encompassing key QIP metrics including emergency department flow, length of stay, discharge identification and readmissions.
Nevertheless, there are challenges and risks we face in relation to the proposed QIP:

1. External challenges and risks:
   - Fiscal challenges with the implementation of the new funding model as it evolves with new additional QBP initiatives
   - Human resource requirements to support the Health Care Tomorrow initiative in the SE LHIN

2. Internal challenges and risks:
   - A sustained gridlock status in KGH for 4 months secondary to the rising volume of ED activity and ALC volumes
   - Sustainability of the targets we have reached and organizational capacity to meet any additional external challenges and risks

KGH is committed to providing a patient centred model of care at all times while developing or implementing strategies to maintain efficiencies.

Information Management

KGH tracks 116 indicators in depth on a quarterly cycle. Each indicator is purposely aligned to improvement priorities and milestones that are set annually to support the KGH 2015 strategy. Clinical programs with continuous-improvement tactics manage priorities specifically linked to the QIP. Each indicator has its own stretch target based on best practice, provincial best or theoretical best achievement. Corporate accountability for review lies with the Quality of Patient Care Committee of the Board.

Engagement of Clinicians & Leadership

The initiatives and performance targets set out for the 2015-16 QIP are the outcome of a comprehensive planning process, priority setting and engagement. Success and challenges with the QIP 2014-15 have guided selection of QIP initiatives with identified action plans that have been established with stretch goals and targets. Additionally, an internal quality of care audit of skin integrity has prompted inclusion of this care concern into this years QIP. The QIP is integrated into an ongoing cycle of planning and performance management at KGH and fully embedded within the annual corporate plan of the hospital. The rigor of this process enables leaders to be held accountable for results. Systems have been put in place to monitor our progress and communicate results to all levels of the organization, the community and Ministry. All programs and departments will be formulating tactical plans using continuous improvement principles to address the QIP and initiatives. Physicians working through the Medical Advisory Committee's (MAC) Quality Committee have created clinical department-specific QIP's that align to the KGH QIP. Commitment to drive quality of care into the clinical departments is evident with physician specific metrics focusing on patient care.

Patient/Resident/Client Engagement

KGH is a national and international leader in patient and family centred care. Patient advisors have been incorporated into all operational and clinical program committees engaged in hospital decision-making. Patient advisors also sit on the selection committee for all key leadership positions at KGH. The QIP 2015-16 Steering Committee membership included a representative from the Patient and Family

Advisory group. This committee led the development of the QIP and selection of improvement initiatives, targets and change priorities. The process for approval of the QIP includes support from the Patient and Family Advisory Council.

Accountability Management

KGH has a comprehensive performance management program. Each year, KGH creates an Annual Corporate Plan (ACP) that includes: improvement priorities, targets and indicators to deliver on our hospital's strategy. The QIP targets and initiatives are incorporated into the Annual Corporate Plan. Regular reporting of progress against the plan is delivered to leaders, staff, the Board and our community. Quarterly reviews of the ACP are completed by the Executive and Board.

Performance Based Compensation [As part of Accountability Management]

Executive compensation is linked to the ACP and to the QIP targets and initiatives in that plan. Each Executive, including the President and CEO, has pay at risk that is tied to achieving QIP goals for 2015-16. The amount of pay at risk for Executives ranges from approximately 3% to 25% percent of total cash compensation. The payment of pay at risk occurs following the fiscal year end evaluation of results. The amount awarded will be based upon the Board of Directors' evaluation of performance against specific thresholds.

Health System Funding Reform (HSFR)

HSFR has been a significant transformational change for health-care organizations. The management of Quality Based Funding (QBP) activity within the domains of volumes, quality and funding has added a new dimension of complexity in patient care. A QBP Steering Committee at KGH has operational oversight of all QBP initiatives supporting the clinical leadership and programs directly involved in implementation. KGH also works closely with its local partner hospital and the SE LHIN to track and monitor activity. KGH participates in the HSFR Local Partnership quarterly meetings with the LHIN and partner hospitals supporting close collaboration on tactics and initiatives to promote QBP activity.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair Scott Carson
Quality Committee Chair Dr. David Zelt
Chief Executive Officer Leslee Thompson
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)

2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	693*	32.42	29	Target assigned by SE LHIN as part of the MLPA	1)Discharge Prediction on all clinical units: GRIDLOCK is a state of total congestion where patient need (inputs) far outweighs available bed capacity combined with an inability to move patients out of the ED to an inpatient bed in the necessary timeframes. KGH has made Gridlock a top priority in the organization. Prediction of discharge is a key component of knowing what resources are available on a daily basis to initiate processes to make the bed available in a timely fashion.	A discharge prediction PDSA has been initiated to identify all steps in the discharge prediction process. A bed utilization flow sheet is updated every 8 hours and electronically circulated to all program leaders, directors and managers. The predicted discharge initiative will aim to have all discharges predicted in the subsequent 24 hours listed on the bed utilization.	A predicted discharge date for every patient is entered into the patient care system. A metric of predicted discharges / all discharges for each unit will be used to assess compliance.	80% of clinical units will record predicted discharges daily into the patient care system	
Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	693*	2.99	0	Industry standard	1)Execute and monitor approved operational efficiencies and clinical activity targets (QBPs)	Monthly program / department budget/activity variance reviews will occur to ensure operational efficiency targets are met in relation to QBP volumes and associated QBP quality targets where available.	Performance with respect to QBP volumes and quality targets will be monitored monthly	A fully developed QBP dashboard with individual QBP templates that include activity, quality, and case costing profiles will be used to communicate and monitor progress.	
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100.	Ratio (No unit) / All patients	DAD, CIHI / April 1, 2013 to March 31, 2014	693*	97	100	The target is set at a rate of 100 but the most important aspect of quarterly performance is to have our HSMR deemed not statistically significant.	1)A formal mortality review will be conducted on all patients dying within 5 days of major surgery. In the same fashion as the existing Critical Incident Reviews conducted under the ECFAA, recommendation will be made focusing on process improvement opportunities.	Mortality reviews for all mortality within 5 days of major surgery will be conducted by the respective department's quality committee.All recommendation will have a MRP assigned for implementation/completion. Completion rates for reviews will be monitored by the MAC's Joint Utilization and Quality Committee.	Rate of completion of the mortality reviews.	100%	NOTE: 11/12 performance (most current available) 10.52, peer target 8.68. Waiting for updated data from CIHI
Integrated	**Reduce unnecessary time spent in acute care**	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	693*	10.32	10	Target assigned by SE LHIN as part of the MLPA	1)To complete a value stream map on the entire ALC process. It will initially focus on KGH processes then expand to engage local health care partners including the SE LHIN and community stake holders as well as our local Healthlinks.	Using continuous improvement techniques, a value stream mapping exercise will be conducted that will include input from a multidisciplinary team.	Process measures will include PDSA improvement cycles, rapid improvements events as well as the use of performance dashboards.	Improve ALC patient flow across the region and reduce the number of ALC patients and days at the KGH.	
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	693*	17.16	16.25	The target is set by the MoH as a calculated expected rate	1)With support of SECHEF, work with regional partners to develop a regional hospital based analytical approach to understanding readmissions and develop recommendations for minimizing the number of readmissions.	Starting with MoH supplied readmission data on regional hospital specific multi-site readmissions, a detailed retropsective analysis of readmissions will occur at the CMG level. The readmission analysis and approach will be done in cooperation with all local SE LHIN hospitals in addition to CCAC and our Healthlinks.	A process to account for and track readmissions (and rates) across SE LHIN regional hospitals will be developed. VSM mapping and PDSA improvement cycles will be incorporate where possible.	Reduce the number of avoidable admission (readmissions) by developing better care processes across hospitals as well as leveraging community services to support patients in the community.	
Patient-centred	**Improve patient satisfaction**	From NRC Canada: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good").	% / All patients	NRC Picker / October 2013 - September 2014	693*	94	97	Current benchmark identified by Health Quality Ontario is set at 96.4%	1)Adoption of the Cleveland Clinic's Communicate with H.E.A.R.T. (SM) Model. KGH has shown itself to be a leader in the patient centred model of care. The H.E.A.R.T. program will clearly take that foundation of the patient experience to the next level and be very complimentary to existing systems including the Patient and Family Advisory Committee and the Patient Advisors participating on all corporate committees of the hospital.	Communicate H.E.A.R.T. (SM) will be rolled out to all staff with a series of training sessions. Focus will be on the creation of staff awareness of the impact of every patient, visitor and employee interaction. In addition, creating an understanding of the role of caregivers in providing world class care through 9 service behaviours will be emphasized (Acknowledge the other person, introduce self and role, Use person's preferred name, clearly communicate expectations, offer to resolve concerns or move to the appropriate person, use active listening, communicate empathy, use common courtesy and offer help)	The number of staff participating in the training sessions	1500 staff will participate in the training sessions by March 31, 2016	
									2)Increase adoption of patient and family centered care standards in every clinical area.	All 5 patient and family centered standards (use of white boards, name tags worn correctly, patient-family led forum completed, hourly rounding, HEART communication) are implemented in all clinical areas.	Percent compliance with each of the 5 standards utilizing audit tool results.	98% compliance within each of the 5 standards across clinical areas.	

2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Kingston General Hospital
Outstanding care, always™

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.	% / All patients	Hospital collected data / most recent quarter available	693*	77	100	Set as an internal stretch target in accordance with Accreditation Canada standards	1)Providing all patients with the best possible medication history (BPMH) has been actively supported by dedicated Pharmacy Technicians in the ED for all admissions. Alternate admission points to the hospital are being address through the development of Order Sets (standardized preprinted orders). Expansion of the order set to all clinical programs will be initiated.	Order Set development the includes the BPMH with a standard set of admission orders will continue to rolled out to all patient care areas.	Hospital wide compliance with medication reconciliation on admission will be monitored. Current performance is 77%	100% by March 31, 2016	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2014, consistent with HQO's Patient Safety public reporting website.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	693*	0.33	0.25	10th percentile performance for Ontario teaching and community hospitals with more than 300 beds	1)Antibiotic Stewardship Program implementation	Recruit physician leadership to the antibiotic stewardship program with a focus on rolling out a hospital-wide approach to antibiotic stewardship.	Antibiotics dispensed quarterly to ED and admitted patients per 1000 patient days. Current performance = 243	20% reduction in antibiotic defined daily dose	
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	693*	85	95	Set as an internal stretch target.	1)Monthly hand hygiene audits on all units and wards.	Auditors will collect hand hygiene compliance for all 4 moments of care. Data will be collected electronically using the audit tool and recorded by provider group and clinical unit. Monthly data will be reviewed at the Patient Safety Quality and Risk Committee and MAC. Emphasis will be placed on strengthening teachable moments as well as the re-education of glove use protocols	Unit and provider rates will be tracked. Education on hand hygiene compliance and value will be supplemented on all units by the Infection Prevention Team Specialists. Percent compliance by clinical unit will be posted publicly on the units and overall hospital compliance will be posted at main entrances. Percent compliance by provider will be reviewed at the Patient Safety Quality and Risk Committee and MAC. Unit educators will support education to staff.	Achieve goal of 95% compliance by March 2015	
	Reduce rates of deaths and complications associated with surgical care	Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed (briefing; time out; and debriefing) divided by the total number of surgeries performed, multiplied by 100 -	% / All surgical procedures	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	693*	98.92	100	Achieve Best Practice	1)Compliance for all three phases of the surgical safety checklist by all surgical disciplines will be monitored with daily reporting of compliance with each phase for all surgical procedures.	Reporting will be separated by discipline and sent to the respective Department or Division for review and comment. Rolled out to all other procedural units throughout the hospital (e.g endoscopy, cath lab)	Compliance with performance on all 3 phases of the surgical safety checklist including expanded procedural areas.	100%	
	Improve patient skin integrity	reduce the prevalence of skin integrity incidents	Counts / All patients	Hospital collected data / Fiscal Quarters	693*	0	3	Set as an internal stretch target. Twenty-five per cent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) with the	1)Twenty-five per cent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) with the highest prevalence. This will result in 4 less incidents in the ICU, 2 on C10, and 2 on K6.	1) Braden score completed on admission for 100 per cent of patients on ICU, K6, and C10 2) Braden score and skin assessment completed daily for all patients with documentation in chart	Published compliance with Braden score at admission.and Braden score and skin assessment daily. Incident checks on each patient on each of the 3 units will occur on a daily basis	100 % compliance with Braden scores on admission, 100% compliance with daily assessments and 25% reduction in the prevalence of pressure ulcers on each of the 3 units.	
	Reduce the number of Level 3 and 4 falls	Patient Falls	Counts / All patients	Hospital collected data / Fiscal Quarters	693*	10	4	Set as an internal stretch target	1)Reduction in Level 3 and Level 4 Falls: Recent Critical Incident Reviews have identified falls as a serious patient safety concern.	1) Every patient upon admission will have a Falls Risk Assessment form completed including daily updates. 2) Apply the Falling Star protocol/assessment with every patient in the hospital 3) Using the Move On approach, have a safe, mobilization plan for every inpatient.	Falls Risk Assessment form completion compliance, daily assessment compliance, and high risk patients are appropriately identified (Falling Star) and have a documented/actioned mobilization plan.	100% compliance with assessment form completion, falling star identification, and documented and actioned mobilization plan.	

2015-16 HAPS Narrative

Hospital Name: Kingston General Hospital
Facility Number: 0693

SECTION 1- General Narrative

Planning Assumptions:

- **The hospitals HAPS forms include the assumptions used to construct the budget for fiscal 2015.**
- **There is no need to duplicate those planning assumptions unless the assumptions are material and you wish to highlight them to the LHIN. All other major planning assumptions not built into the HAPS forms should be highlighted here**

Kingston General Hospital (KGH) has not included any change from the current level of the HBAM component of funding in the fiscal 2015 - 2016 Hospital Annual Planning (HAPS) submission. The hospital's percentage share of this funding has remained relative constant since the implementation of Health System Funding Reform (HSFR) and the hospital does not have any data to support this not continuing forward. KGH did not receive any mitigation on this funding in fiscal 2015 and therefore is assuming the same level of funding in next year's planning submission. KGH has incorporated the changes from fiscal 2015 for the Quality Based Procedures (QBP) component of the funding formula into the fiscal 2016 planning submission. The information received to date indicates only one new QBP that would be applicable to KGH for next year. We have assumed a net neutral change for this component of the funding model.

The hospitals HAPS forms include the assumptions used to construct the budget for fiscal 2015 - 16.
All other planning assumptions built into the HAPS are included on the HAPS submission form.

Expense inflation for compensation has been included based on executed union agreements. Inflation on other operating expenses has been included based on identified impacts (e.g. maintenance contracts, estimate from utility companies, etc.).

Health System:

- **The hospital's role in the health system:**
  - **Who is served and why**
  - **How provincial and local priorities are met**
  - **The determination of current and future services**

Who is served and why

Kingston General Hospital is a community of people dedicated to transforming the patient and family experience through innovative and collaborative approaches to care, knowledge and leadership. As southeastern Ontario's leading centre for complex-acute and specialty care, and home to the Cancer Centre of Southeastern Ontario, KGH serves almost 500,000 people through its Kingston facility and 24 regional affiliate and satellite sites. These people count on us to be there when they have high-risk pregnancies, cancer, very sick babies, heart attacks, strokes, life-threatening injuries and respiratory failure. They come to us when they require specialized care that is not available in their local community: when they need heart surgery, life support, dialysis, brain surgery, stem cells, radiation and special imaging. Our Emergency Department is open 24 hours a day.

2015-16 HAPS Narrative

Fully affiliated with Queen's University, KGH is a research and teaching hospital which is home to 2,400 health-care students and 175 health researchers. KGH is ranked as one of Canada's Top 40 Research Hospitals by Research Infosource.

To learn more, visit www.kgh.on.ca or join the conversation at www.kghconnect.ca

This information is consistent with the prior year and we have no information at present that would suggest there will be a significant change in the next fiscal year.

How provincial and local priorities are met

KGH's annual planning cycle is informed by considering our provincial and local priorities as well as the operational and organizational needs of our organization, through our various programs and services, to meet these commitments. Our 2015 - 2016 plan incorporates our currently assigned activity targets as well as our fiscal commitments under the current Hospital Services Accountability Agreement (HSAA).

We expect to continue to meet Quarterly with the Southeast Local Health Integration Network team to monitor our progress on plans and correct where appropriate to ensure priorities are met.

The determination of current and future services

The way healthcare is funded by the Government is continuing to change. Hospitals will need to change how they are delivering their services to reflect the needs of their patients and the funding structures.

KGH is excited to engage patients, services providers and community partners in shaping a strong and sustainable future and defining the future provision of services.

Our service expectations for Fiscal 2016 are outlined in the HAPS and HSAA, and by mutual agreement with our SELHIN and peer hospitals in the region if changes are desired or manifest during the year they are reported to SECHEF for review, discussion, and then as appropriate submitted to the appropriate Ministry or LHIN process for approval.

Hospital Performance: Efficiency and Effectiveness:

- **Areas the hospital has identified that require the most improvement with regard to efficiency, effectiveness, and performance**
- **Strategies planned and/or adopted to manage such desired improvements**
- **Where savings will be reinvested, if applicable**

KGH has established a very formal process of benchmarking both its clinical and financial / operational performance. Clinical performance is typically benchmarked against our Ontario teaching hospital peers. Based on either individual or collective peer performance, stretch targets are established and ultimately approved by the KGH Board of Directors. Each member of Patient Safety, Quality and Risk (PSQR) team are trained in continuous improvement techniques and are uniquely assigned to programs and departments throughout the hospital. They act as a resource for process improvement initiatives (e.g. value stream mapping, PDSA cycles). At present patient flow remains a high priority for the organization. There are a number of process improvement initiatives that are now in sustainability mode (e.g. accurate and timely data to bed allocators, process for handover from the Emergency Department to inpatient unit, and the process for bed status notification). There are others that are currently underway or planned for fiscal 15/16 (e.g. the allied health consult process, physician on-call schedule, Operating Room cancellations, regional health care provider engagement, process for decision

2015-16 HAPS Narrative

to admit, discharge prediction / discharge planning process). All these initiatives are supported by our PSQR team and monitored biweekly by the Patient Flow Task Force. Financial and operational performance analyses are based on setting performance targets at the 25th percentile of our peer hospitals. Through the routine sharing of trial balance data amongst peer hospitals, KGH has established a rigorous internal process of review that focuses on understanding and explaining variance to benchmark while seeking out opportunities for operational and financial efficiencies. Our budgets continue to be built to meeting our activity and performance targets to ensure safe and quality care, and to meet our aim of Outstanding Care Always.

Fiscal challenges are significant at present and savings achieved are all being allocated to address inflationary pressures, and meeting base capital replacement needs.

Service Delivery

- **Service changes proposed to improve the local health system and/or achieve a balanced budget (with supporting justification) and the expected impact on patients/clients and costs**
- **Describe how health partner engagement will be/has been utilized in determining proposed changes to ensure a sustainable system for the region**
- **Critical risks to success and mitigation/management plans to proposed changes**

Choices made to achieve a balanced budget

The fiscal 2015 -16 HAPS incorporates approximately $6.5 million in new revenue generating or cost savings initiatives to offset the impact of unfunded inflationary factors (mainly compensation) in order to achieve a balanced budget submission. A further $2 million in initiatives was required to sustain a minimum investment capacity for the required replacement of technology, medical equipment and building infrastructure improvements. The accompanying HAPS submission does not contemplate any changes from the present provision of patient care services. Minimizing any negative impact on staff was considered in all supported changes. There is no provision in the current submission to sustain the over 95% occupancy level in inpatient programs or approximate 10% increase in Emergency Department activity that is occurring in the current fiscal year. Further operational efficiencies will need to be identified and implemented should this rate of activity occur without considering service changes and the associated impact to patients.

Health partner engagement

Consistent with its principles of engagement, accountability and transparency, KGH collaborates with provincial, regional and local partners in numerous ways.

Provincially, KGH actively partners with organizations such as Cancer Care Ontario, the Ontario Renal Network, Cardiac Care Network, Trillium Gift of Life Network, Criticall, and Provincial Council for Maternal Child Health, etc. Depending on the specific association the collaboration is enabled with designated positions, or participation in committees and processes that support of delivery of service volumes, 'access to care' targets, enabling and monitoring adherence to quality standards, and all with the ultimate goal of productive system level improvements.

Regionally, KGH populated and contributes to structures and processes that facilitate shared understanding of issues and problem solving. The South East LHIN CCAC and Hospital Executive Forum (SECHEF) provides venue for enabling strategic, operational and clinical excellence. It meets monthly and is structured into 3 gatherings of the Chief Executive Officers (CEO's), the Clinical Leaders (medical

2015-16 HAPS Narrative

and operational) and the CEO with the Clinical Leaders. LHIN representatives participate in each. These meetings are critical to integrated planning and oversight of service delivery at a regional level. KGH also partners in venues designed to support regional planning focused on populations or Ministry of Health initiatives, such as the regional cancer, stroke, renal, or maternal child networks, and with the HealthLinks initiative and Mental Health and Addiction redesign as examples.

Resources are currently being directed to enabling a process whereby the comprehensive care plans, presently initiated by primary care providers in the community, can now be initiated on patients who are predictably at high risk for revisit or readmission. The goal, through this enhanced discharge and care planning, is to achieve comparable results as to what is being seen in the community with avoiding need for presenting to the acute care setting. This will be a meaningful step toward integrating process into both acute and community settings.

Locally, KGH supports engagement on committees and with improvement processes with local health service partners. The HDH and KGH Clinical Executives Committee facilitates planning and decision making about programs and services that, given the missions of the two hospitals, rely upon shared support. Examples of collaboration include planning for living donor kidney transplantation, pain program, bariatric surgery program and location of renal clinics. Providence Care and the CCAC are integral members of groups addressing patient flow, and the perpetual challenge with the volume/percentage of patients designated as Alternate Level of Care. At program level councils, there is engagement on a routine basis of local partners aligned to the focus of the program, and others in the community and region as needed. Process improvement teams working on strategic priorities predictably include both internal and external stakeholders.

With its commitment to meaningful engagement of patients, families and volunteer patient experience advisors, KGH models and continues to influence the practice of ensuring the patient voice is present to influence change and co-design improvements at the organizational, local, regional and provincial levels.

Critical risks to success and mitigation/management plans

Given the ongoing constraints with funding, decisions are principle based to ensure best allocation of time, energy and resource for making and sustaining improvements. Design of all strategic improvements is guided by the KGH Strategy and enabled through rigorous adoption of continuous improvement, change management, leadership development and strategic communication methodologies. Stretch performance targets have been incorporated into the KGH Annual Corporate Plan, the Quality Improvement Plan, the Hospital Annual Planning Submission and the Hospital Services Accountability Agreement with transparent reporting on each within KGH to the broad community.

We continue to be concerned about the capacity of our leaders to meet the growing demands of initiatives both from the region and province for change, while we continue to deal with clinical and operational pressures at KGH. KGH fully supports the work being undertaken aligned to the Health Care for Tomorrow initiative but recognizes that this will be a further draw upon our leadership capacity to participate in the various working groups and input mechanisms. It is understood there are no new resources to address these demands. As we move through the next year, expectations of how these competing demands are met will need to be carefully managed to make sure the priorities that impact the patients and overall performance are addressed first. Some difficult choices may need to be made. We will utilize the SECHEF forum to highlight these issues.

The hospital will also be required to address increased legislative requirements. For example, training, and the expansion of the Occupational Health and Safety Act/Regulations to non-employees such as

2015-16 HAPS Narrative

students and changes to the Employment Standards Act.

Alignment and System Contributions

- **Initiatives in place or to be implemented to contribute to the achievement of provincial and LHIN priorities and contribute to a more integrated health system.**

Provincial and LHIN Priorities (examples)	Hospital initiatives to contribute towards the achievement of priorities
eHealth initiatives	• Continue to provide project management leadership for the Ontario Lab Information System (OLIS) project in collaboration with the South East LHIN hospitals • As Service Delivery Partner (SDP) provide project leadership for the Connecting Northern and Eastern Ontario (cNEO) Project within the South East LHIN
Health Links Development	• Continue to provide technical support and data transfers in support of the South East Health Integrated Information Portal (SHiiP)
Participation in Health System Funding Reform	• KGH has established a QBP Steering committee to oversee the introduction and ongoing management of QBPs as they come online. In addition, QBP specific teams have been established to act at a more operational level with volume management as well as the implementation and monitoring of quality metrics as they get introduced. KGH is an active case costing hospital and continues to improve its submission timeliness to the Ministry in addition to focusing efforts on improving its data quality and moving towards supporting quarterly submissions. Currently, KGH co-chairs the HSFR Local Partnership committee with the SE LHIN and has active membership/participation from both administrative and clinical staff. Relevant members of the KGH staff attend all local HSFR Ministry information sessions and are recognized for providing constructive and helpful feedback.
Quality Improvement Plans	• Priorities for the QIP 2014/15 were all aligned to the KGH Strategy 2015. Metrics were imbedded into the quarterly reviews by all clinical programs and leadership. The quality committee of the KGH Board also reviews the QIP performance quarterly with deep dives on QIP metrics in its work plan • The QIP 2015/16 will be generated with engagement of our Patient and Family Advisory Council and clinical programs.
Senior Friendly Hospital Strategy / Senior Friendly Improvement Plan	• With its approach to patient and family centered care, and in partnership with patient experience advisors, there are a number of initiatives underway in support of patients who with age have delirium and functional

2015-16 HAPS Narrative

	decline. These include the falls reduction (Falling Star) and mobilization (Move On) strategies; Advance Care Planning; implementation of comprehensive care planning through Health Links; purchase of capital equipment selected with needs of elders as criteria; exploration of having a pharmacist with geriatric pharmacy credentialing; long standing support of the Hospital Elder Life Program (HELP)
French Language Services Act	• Integration of French language services into Human Resources Plan • Past years have focused on signage and printable communication tools for patients and families. • A short term funding request has been submitted to assist with this year's priorities; o To assess current capacity and build infrastructure which will support movement towards designation. o To work with the community hospitals to build community engagement and involvement o To continue translating and printing patient and family utilized information
Other LHIN Initiatives 1. Initiative 1 (please describe) 2. Initiative 2 3. Initiative 3 4. Initiative 4 5. Initiative 5	
	SECHEF Clinical Leaders Committee – Monthly meeting of clinical leadership composed of all regional partners; focused on patient flow and access to care in an integrated fashion
	Healthcare Tomorrow – Executive leadership on Business Functions Steering Committee. KGH Senior leadership involvement with various working groups
	Continue to provided leadership to the Regional Hospital Information System RFP project

Risks

- **Key risks and mitigation strategies should include:**
  - **Strategic**
  - **Clinical**
  - **Financial (including working capital)**

The KGH has continued to focus significant efforts towards the development an active risk register. As a member of HIROC, the KGH participated in a complete HIROC risk assessments which lead to the identification of risk issues (including mitigation strategies currently in place) that formed the basis of our risk register. To assist with the prioritization of issues on the register, the KGH sought input from peers across the country and developed a "prioritization matrix" that has since been piloted internally and applied against all the issues on the register. The risk register is considered a live document in that it contains current risk mitigation strategies as well as MRPs etc. It is reviewed by our Planning and Performance committee as well the Finance and Audit committee of the Board. The risk register classifies all issues into risk domains that include Strategic (which includes governance, leadership, stakeholder relations), Operational (which includes patient care, human resources, information

2015-16 HAPS Narrative

technology, and physical assets), Compliance and Financial. The Compliance domain focuses on legislative compliance. KGH has done a full review of it legislative compliance and has engaged its legal counsel to provide analytical support with respect to better understanding all aspects of the relevant legislation. This is a work in progress. Our safe reporting system (RL Solutions) remains an integral component of our overall patient, safety, and quality and risk issue identification process. All reported incidents are well documented and followed up. All critical incidents follow our critical incident review process and recommendations are shared and followed up through the office of the Chief of Staff.

Strategic Risks

As the HealthCare for Tomorrow project begins to take shape, KGH recognizes that it will have implications on how the hospital approaches our strategy development for the next few years. KGH is committed to working collaboratively with our partners in developing a sustainable integrated model of hospital care, across the continuum, for the residents of the South East LHIN and in making sure that the options developed best meet the needs of our patients now and in the future.

There is increasing evidence of the relationship between volume and the quality of care for many services. The aging population and patients with an increasing number of chronic diseases and increasing intensity of care for those requiring care is our reality. We are facing an aging workforce and increasing competition for health professionals when they are most needed. Health system funding reform which is intended to improve system quality and efficiency has come at a net negative financial impact.

Clinical Risks

It is critical for the organization and region to address the increasing trend with the number of patients designated as Alternate Level of Care (ALC). In the short term, the number of ALC's at KGH creates challenge in patient flow as evidenced by the number and duration of patients awaiting beds in the Emergency Room, the number of patients in overcapacity (unbudgeted) beds on the inpatient units, and inefficient use of resources by holding patients in critical care or recovery room settings. The increased occupancy, 100% in 2015 Q2, is a marker of impeded flow and overextended human resources. In the longer term, if the volume of ALC's is not addressed either through promotion of wellbeing in the community setting, prevention of need for designation in hospital setting or access to greater options for non-acute care, there will be risk at KGH to delivering on expectations associated with improved access and care, including wait times, surgical/diagnostic volumes, Quality Based Procedures (QBP's), and surgical cancellations as examples. Further, recognizing that KGH is not alone in its experience of increased clinical activity and ALC numbers, there is risk to region's vision and planning for a sustainable acute care sector.

Financial Risks

KGH is not unique in having to address fiscal constraints due to provincial budget pressures that limit hospital funding increases.

Based on the assumptions included in the HAPS planning submission the estimated inflationary operating cost impact for next year is approximately $6.5 million. The HAPS submission includes various operational efficiency revenue generating or cost reductions plans to eliminate this unfunded inflationary component. Without details from Government at the time of submission of the annual operating plan there is always a risk that the assumption utilized will not mirror actual funding.

During the first 8 months of fiscal 2014 – 15 KGH experienced a significant increase in patient activity above the normal occupancy rates that the annual plan incorporated. The plan for fiscal 2016 is formulated using a return to previous occupancy levels (e.g. 95%).

2015-16 HAPS Narrative

Since 2010 KGH has put a concerted focus on increasing capacity to invest in required building infrastructure upgrades and the replacement of aging clinical equipment and information technology. The fiscal 2016 operating plan provides for this ongoing investment at the same level as the prior fiscal year including support from the Ministry of Health and Long-Term Care (MOHLTC) Health Infrastructure Renewal Fund (HIRF) and donations from our community through the University Hospitals Kingston Foundation and the Kingston General Hospital Auxiliary.

The funding received in fiscal 2013 and 2014 through the MOHLTC Hospital Working Funds initiative has contributed to the increased working funds position. KGH made submission through the established process to request the final year of funding for fiscal 2015. In submitting a balanced budget for fiscal 2016 there is no ability to further enhance this working funds position in the upcoming fiscal year.

Quality

- **Identify whether the submission reflects the quality improvement initiative and targets included in the hospital's annual QIPs**
- **Note specifically how the hospital will be achieving the best practice guidelines for the QBPs**

Our Quality Initiatives in the 2014/15 KGH Quality Improvement Plan (QIP) met the initiatives in the 2014/15 HAPS. The Ministry has just released the 2015/16 QIP navigator template. The priority initiatives for this QIP will be reflected in the HAPS submission with a particular focus on patient centered care and integration within the region.

KGH currently has 14 active QBPs. The oversight is through a steering committee in keeping with the Ministry's toolkit for QBP implementation. The steering committee provides support for the QBP working groups and an organizational level oversight for focused attention to challenges in meeting volumes. Each QBP is led by an operational director and physician lead. Although at this time there is no direct accountability to the quality metrics of the QBP program, the adoption and awareness of each QBP's metrics is underway. Decision Support has generated scorecards for each QBP that will provide a clear and concise presentation of targets, volume activity, gaps and quality metrics.

Fiscal 2016 Budget Planning

Kingston General Hospital

- **Operating results**
  - Balanced budget submission required
  - $7.8 million of operational efficiencies incorporated to offset inflationary factors (impact on next slide)
  - Current draft incorporates approximately $ 500 thousand placeholder for position vacancies turnover allowance to address leap year cost
- **Capital expenditures**
  - $Current capital budget provides $19 million annual capacity for capital spending
  - $1 million utilized to realign Emergency Department budget

Updated 2015/16 Operating Budget ($000's)

Hospital Operations	2014/15 Sept				2015/16
	Updated Budget	Adjustments/Carry forward	Inflation	Operational Efficiencies	Proposed Budget
Revenue					
- Ministry	341,890	3,504		1,800	347,194
- Non-Ministry	49,483	2,022	**(524)**	348	51,329
Sub-total	**391,373**	**5,526**	**(524)**	**2,148**	**398,523**
Expenses					
- Compensation and benefits	264,617	986	4,352	3,237	266,718
- Supplies and other expenses	126,683	5,622	1,792	2,370	131,727
- Sub-total	**391,300**	**6,608**	**6,144**	**5,607**	**398,445**
Surplus/(Deficit) before building amortization	**73**	**(1,082)**	**(6,668)**	**7,755**	**78**

2015/16 Updated Capital budget ($000's)

	2015/2016 Updated	2014/2016 Original Target	
Patient care equipment provision	9,416	12,000	
Technology plan (includes HIS investment $3.3 million	5,000	4,500	
STATCAP provision	1,000	1,000	
Minor equipment provision	500	500	
Facilities infrastructure provision	3,084	2,000	
Sub-total	**19,000**	**20,000**	
Funding source			
Ministry HIRF (estimate)	1,584	925	
KGH Auxiliary	400	400	
UHKF Foundation	500	500	
Amortization expense, net	16,516	18,175	
Sub-total	**19,000**	**20,000**	