

### About This Document

By drawing on content from [Healthy Debate](#) (see page 2) and key governance documents, this document provides a concise summary of Ontario's healthcare landscape. While the core content is provided in the main text, readers can gain a more in-depth understanding of each topic by referring to the side bars or clicking on the hyperlinks (underlined and emboldened text) throughout the document. This will connect readers to [Healthy Debate](#) stories, opinion pieces and other important resources.

This document was prepared by Ayodele Odutayo, Jeremy Petch and Andreas Laupacis from [Healthy Debate](#), in consultation with the Ontario Hospital Association (OHA) and its [Governance Centre of Excellence](#).

### “Fiduciary Duty”

means that “directors are required to act honestly, in good faith and in the best interest of the hospital and to apply the level of skill and judgment that is reasonable to expect of a person with their knowledge and experience” (2).

Health care in Ontario is delivered by a complex network of health service providers. With the Ministry of Health and Long Term Care (MOHLTC) as the steward and primary funder, each service provider (e.g. hospitals) has its own distinct rules and regulations. This means that each hospital's Board of Directors must understand their own hospital and be well versed on Ontario's health care system and the potential changes that will impact hospitals. This document provides a concise summary of the current health care landscape in Ontario and critically examines the effectiveness of current health care policies and initiatives.

### HOSPITAL GOVERNANCE

Ontario is the only Canadian province with an independent, voluntary governance model for hospitals. As mandated by the [Public Hospital Act](#), a Board of Directors (now referred to as “Boards” or “Directors”) must oversee individual hospitals. These Boards serve in a *governance* role and have a fiduciary responsibility to the hospital when fulfilling their primary duties: providing financial oversight and developing a mission, vision, and strategic plan for the hospital. Within the framework of the [Excellent Care For All Act](#) (ECFA), which was passed by the Ontario legislature in 2010 (1), the responsibility of the Board has been strengthened regarding oversight for the quality of care delivered within hospitals. A broader list of the Board's roles and responsibilities is provided in the table below (2).

| Board Roles<br>(Approaches to Tasks) | Board Responsibilities<br>(Tasks to Complete) |
|--------------------------------------|---|
| Policy-Making                        | Strategic Planning                            |
| Decision-Making                      | Quality of Care                               |
| Oversight                            | Financial Oversight                           |
|                                      | Board Effectiveness                           |
|                                      | Management Performance Evaluation             |

Given these wide-ranging responsibilities, the Board's governance role must be distinguished from the duties ascribed to the hospital's Chief Executive Officer and the staff reporting to him or her (now referred to as “Management”). Whereas Boards focus on “policy formulation, decision-making and oversight” (3), Management guides hospital operations in a manner consistent with policies set by the Board.

Boards are therefore important decision makers in the overall direction of hospitals and must judiciously approve Management's recommendations. Where necessary, Boards must "test and question Management's assertions, monitor progress, evaluate Management's performance and take corrective action" (3).

## Board Composition

Assembling a Board of Directors with diverse but complementary skills is at the core of creating an effective governance body. Legal requirements in this regard are fairly limited except that hospital Boards must include specific members of the Management staff. These individuals are known as "ex-officio" Directors and include the Chief Executive Officer, Chief Nursing Executive, Chair of the Medical Advisory Committee and the President of the Medical staff; all of whom must participate as non-voting Directors (4). Otherwise the Board is a self-renewing entity and selects or nominates the remaining Directors using a competency-based process. This ensures that prospective Directors possess sufficient expertise and will complement the current skill sets within the Board.

In special circumstances such as academic or denominational hospitals, seats on the Board may also be reserved for senior members of academic, religious or municipal political sectors. Additional appointment of directors on a representative basis (e.g. representatives from the community or volunteer association) is generally not recommended due to the risk for conflicts of interest (4).

Some hospitals also include "Corporate Members" (subsequently referred to as Members) within their governance structure. Members are akin to the shareholders of a corporation except that they do not have ownership or a stake within the hospital, nor do they receive profits from the hospital (4). Instead, Members must be consulted by the Board regarding fundamental changes within the hospital (e.g. cessation of services or amalgamation with another service provider). Members may be responsible for electing the Directors of the Board from a pool of candidates nominated by the Board itself (4).

## HOSPITAL FINANCING

Providing financial oversight for hospitals is one of the central responsibilities of the Board of Directors. Broadly, this includes ensuring sufficient funding is available for hospital operations, managing risks related to liabilities and losses, and working towards a balanced budget. The importance of this duty is not surprising, considering that hospitals account for the largest proportion of Ontario's public health care spending (Figure 1) (5).

## About Healthy Debate

Canadians want to know more about their health care system but there are currently few places to go for factual, easy to understand information. [Healthy Debate](#) is a news and opinion website that attempts to fill this gap by providing unbiased information that will lead to thoughtful deliberation and informed opinions.

We hope that accessible information about a wide variety of issues in health care will prove interesting and useful to both the general public and health care workers and that we can work together to make health care better.



## "Tips for Good Governance"

Start each board meeting with a patient story.

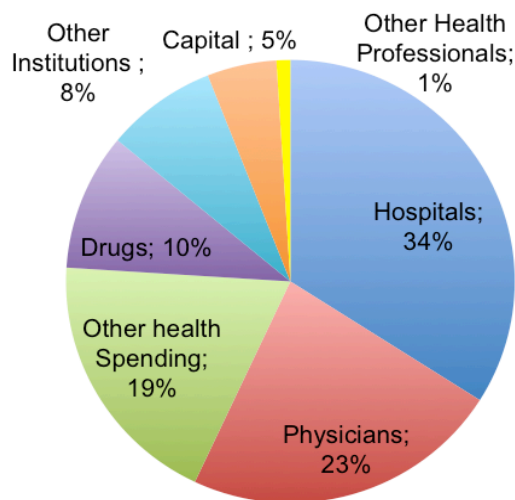
## “HBAM and QBPs”

This radical change to funding is having important ramifications for hospitals and their Boards. Of particular concern is confusion about how the HBAM is calculated, the fact that the costs for many of the QBP procedures have not yet been determined, and uncertainty about whether hospital funding will decrease as a result of the new model. Learn more in:

[Ontario Hospital Funding: Confusion for 2012/2013?](#)

Although this allotment has been more or less stable over the last decade, there have been recent and substantial changes in how individual hospitals are funded (6). Traditionally, a global budget was provided to hospitals, which was based on past allocations and adjusted annually to reflect increases in the costs of health services. This approach provided a stable source of funding to hospitals but also meant that hospitals were paid different amounts to provide the same services, based upon their current and historical negotiating abilities. The MOHLTC is now working toward a goal of allotting 30% of hospital funding as a global budget, 30% based on standardized funding for specific types of care (e.g., dialysis, hip and knee joint replacement) known as Quality Based Procedures (QBP), and 40% based on a complex population-based funding mechanism known as Health-Based Allocation Model (HBAM) (6).

Figure 1 (5)



Once the funding allocation for a hospital has been determined by the MOHLTC, Local Health Integration Networks (LHINs; see *Relationship with hospital stakeholders*) are then used as a conduit to transfer funds to the hospitals within their region. On average the MOHLTC funds approximately 85% of hospital operating activities, excluding research, but this amount varies significantly (78%-92%) because it is easier for some hospitals to generate non-MOHLTC revenues through payments for parking and preferred private and semi-private hospital accommodation. This puts some hospitals at a financing disadvantage, as current funding formulas do not adequately adjust for this variation.

Accountability for MOHLTC funds is enforced by LHINs through a Hospital Service Accountability Agreement (HSAA) that must be co-signed by hospitals and their encompassing LHIN. A balanced budget is a key tenet of the HSAA and in providing financial oversight, Boards must ensure that hospitals meet the commitments of this agreement.



## Will More Finance Reform Improve Quality in Ontario's Hospitals?

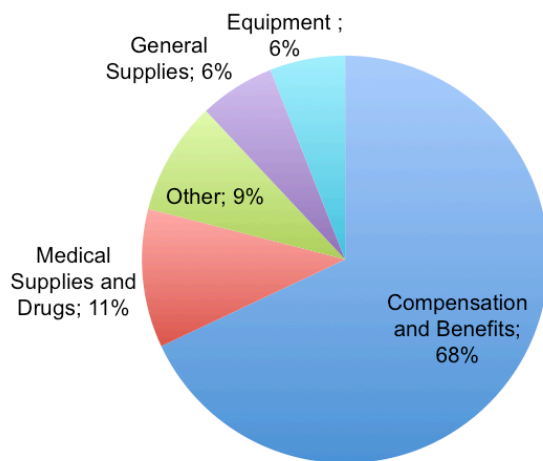
by Jeremy Petch & Andreas Laupacis

After a decade of focusing on access to health care services, the Ontario government appears to be turning its attention to improving the quality and costs of these services. At the moment, there is considerable variation in how health care is delivered in Ontario's hospitals, so patients with the same diseases are receiving different quality of care depending on where they are treated. [Learn more...](#)

For hospitals that fail in this regard, the HSAA requires that a deficit reduction plan be developed in consultation with the LHIN. Where mutual agreement regarding deficit reduction cannot be reached, involvement by the MOHLTC may be required (7, 8). If it is in the public's interest, the MOHLTC may replace hospital Management and appointment a supervisor for the hospital (see *Relationship with Hospital Stakeholders: MOHLTC*).

The largest proportion of hospital expenditure is dedicated to human resources and in 2009-2010, 68% of expenditure was related to compensation and benefits (Figure 2). Hospital staff (e.g. nurses) are often paid directly by the hospital and this rate of pay is typically determined through one of two mechanisms: either a collective bargaining agreement is established between unions and hospitals with the assistance of the Ontario Hospital Association, or wages and benefits are set at a competitive level by hospital Management. Most physicians are not hospital staff and are paid directly by the MOHLTC (see *Board and Hospital Relations with Stakeholders: Physicians*).

**Figure 2 (9)**



## Financing for Other Hospital Activities

In contrast, capital construction projects within hospitals are usually funded through a cost sharing mechanism between the MOHLTC and local community donations to the hospital. Currently, the MOHLTC funds 90% of allowable costs of capital construction projects, with the remainder of the funds provided by the hospital (10). Capital equipment is funded 100% by hospitals, often with assistance from their foundations. Given the importance of donations, many hospitals have established charitable foundations that are primarily dedicated to fundraising. Foundations are governed by a separate Board of Directors and are technically independent from the hospital (4). Therefore, a close relationship between the hospital and its foundation is integral to the success of this fundraising model. To better align the foundation's goals with the needs of the hospital,



## Why Does the Government Appoint Hospital Supervisors?

by Karen Born & Andreas Laupacis

In August 2011, a supervisor was appointed at the Niagara Health System to “restore public confidence” in the hospital. The Ontario Public Hospitals Act allows the government to appoint a supervisor to take over the administration of a hospital if it is considered in the public interest to do so. While appointing a supervisor happens infrequently, it is an important mechanism to attempt to improve public confidence in hospitals.

[Learn more...](#)

## “Tips for Good Governance”

Arrange regular site visits for new and experienced Board members.



some institutions cross-appoint hospital Management to serve on the Board of Directors for the foundation.

## Governance During Economic Crises

Finally, given their dependence on the MOHLTC, financial fluxes at the provincial level may lead to downstream changes in the way hospitals are funded. Boards must therefore be cognizant of the economic landscape and must incorporate this knowledge into their strategic and risk management plans for hospitals. Competency-based selection of Directors, with a particular emphasis on financial literacy, is among the key governance practices that allow Boards to make well-informed decision during volatile economic climates (11).

Furthermore, Boards can improve hospital efficiency by encouraging collaboration between hospital Management and other health service providers (11). Local Health Integration Networks provide the formalized process through which collaboration can be facilitated (see *section on LHINs*) and Boards can take an even more active role in this process by connecting with the governance bodies of other health service providers (11). This is known as collaborative governance (12, 13).

## BOARD AND HOSPITAL RELATIONS WITH STAKEHOLDERS

In order to work in the best interest of the hospital, Boards must provide oversight and guidance to Management in fulfilling its accountability and maintaining its relationship with stakeholders.

### 1. Ministry of Health and Long Term Care

As discussed in *Hospital Financing*, the MOHLTC is also the primary funder of the health care services and capital projects undertaken by the hospital. In addition, Directors and Management are both subject to the supervisory role of the MOHLTC and can be relieved of their duties if the MOHLTC deems it to be in the public's best interest. This is typically followed by the appointment of a supervisor with the power to act as the Board and Management. Although infrequent, supervisor appointments have been made in at least five hospitals since 2008, primarily due to concerns regarding the financial management of the hospital, and in one case due to concerns about the quality of care (14-18).

### 2. Local Health Integration Networks (LHIN) and Voluntary Integration

With the introduction of the [Local Health System Integration Act](#), 14 LHINs were formed in 2006 to devolve



## LHINs and Ontario's Health Care System

by Karen Born & Terrence Sullivan

In many provinces across Canada, governance of health care has been moved to regional authorities based on the belief that local authorities can better integrate and coordinate services, and contain costs. Ontario created 14 LHINs in 2006, with the mandate to plan, fund and integrate health care services for more efficient care in their regions.

[Learn More...](#)

## “Tips for Good Governance”

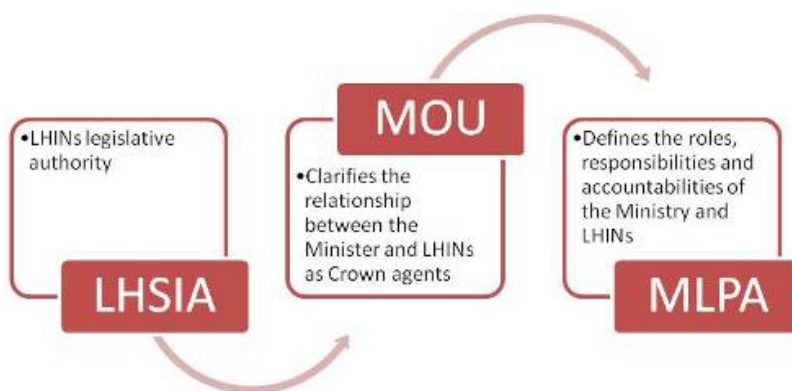
Consider how e-governance solutions may help your board better manage its time and materials.

healthcare administration from the provincial level to the local level. The MOHLTC ensures consistency in health care delivery among LHINs through articulating strategic goals and priorities in legislation (e.g. ECFA).

The relationship between LHINs and the MOHLTC is detailed within a memorandum of understanding (MOU) and performance accountability is enforced through an annually revised Ministry-LHIN Performance Agreement (MLPA, Figure 3) (19). Broadly, the MLPA provides LHINs with a plan for the use of MOHLTC funds and details the LHINs' performance goals, and reporting requirements. While the MLPA should be a mutual agreement between the MOHLTC and LHIN, the terms can be unilaterally set by the MOHLTC where consensus cannot be achieved (20).

Oversight of LHIN operations is provided by its own Board of Directors, which must be appointed by the Lieutenant Governor of Ontario (20). A three-tier model of health care accountability therefore exists in Ontario, with provincial-level governance provided by the MOHLTC, local-level governance provided by the Board of LHINs and organizational-level governance provided by the Boards of health service providers such as hospitals. LHINs are at the centre of this model of governance and clarity regarding their function and responsibilities is essential for the effective delivery of health care.

**Figure 3**



Integration is a core mandate for LHINs and provides a mechanism through which coordination and efficiency can be improved in health care. “Integration” includes any of the following: coordinating services and interactions between service providers; partnering or merging with another service provider; and ceasing to provide services (20). Hospitals are accountable for voluntarily identifying opportunities to integrate their services with those of other health care providers (20). At a minimum, voluntary integration efforts initiated by Management must be approved by the Board before a proposal is forwarded to the LHIN (2). Where integration affects hospital services or human resources,

## “Who Does the LHIN Oversee?”

LHINs are responsible for:

- Hospitals
- Long-term Care Homes
- Community Care Access Centres
- Community Support Services
- Community Health Centres
- Mental Health Agencies

LHINs are NOT responsible for (21):

- Physicians (including primary care physicians)
- Public Health, Laboratories
- Ambulance Services
- Provincial Networks (Ontario Renal Network)

## “Tips for Good Governance”

**Establish a community advisory committee as a way of providing meaningful opportunities for engagement.**



## Hiring Doctors – Whose Interests Should Come First?

By Bob Bear

A typical doctor working in a community hospital is not an employee of the hospital, but has been appointed to the hospital medical staff as an ‘independently contracted professional’, and is paid by the government on a fee-for-service basis. Structuring the relationship between a hospital and its doctors in this way is the historical norm in Canada, but is problematic.

[Learn More...](#)

## “How Are Doctors Paid?”

The following excerpt from an article, “How Should Hospital Doctors be Paid”, clarifies how doctors are paid: “For hip replacement surgery, hospitals pay for the artificial hip joints, operating room staff and the equipment needed to do the surgery, while the surgeon bills the Ontario Health Insurance Plan (OHIP) for performing the surgery and seeing the patient on the surgery ward.”

[Learn more...](#)

strategic oversight by the Board is required (2). With these broad powers, LHINs are theoretically well placed to reform and improve the coordination of health care within their region. However, hospital funding is determined by the MOHLTC and performance accountability is enforced by the LHIN. This results in limited discretionary funding allotted to LHINs for the purpose of encouraging integration (22).

## 3. Health Care Professionals

Physicians, nurses, pharmacists, and physiotherapists are among Ontario’s [23 self-regulated health professions](#). This means that each of these professions has its own regulatory college, which establishes and enforces professional and educational standards for their members. Another key mandate is to protect the public and each college provides a complaints process to investigate concerns from the public and caution or discipline physicians. These colleges operate under Ontario’s [Regulated Health Professions Act](#).

Except for most physicians, members of regulated health professions are often hired by the hospital as staff. The terms and conditions of hire are either detailed in a collective agreement between unions and hospitals (with the help of the OHA) or set at a competitive level by hospital Management.

### A. Nurses

With the inclusion of a biannual staff survey in the quality improvement reporting for hospitals, Boards may become more involved in providing strategic oversight for the workplace environment. Nurses are a key part of the human resource infrastructure within hospitals and adequate staffing levels are crucial for patient safety and health care quality. Retention and recruitment of nurses falls within the realm of Management duties and the most recent report by the Canadian Institute for Health Information points toward a renewal and strengthening of the workforce within the nursing profession (24).

### B. Physicians

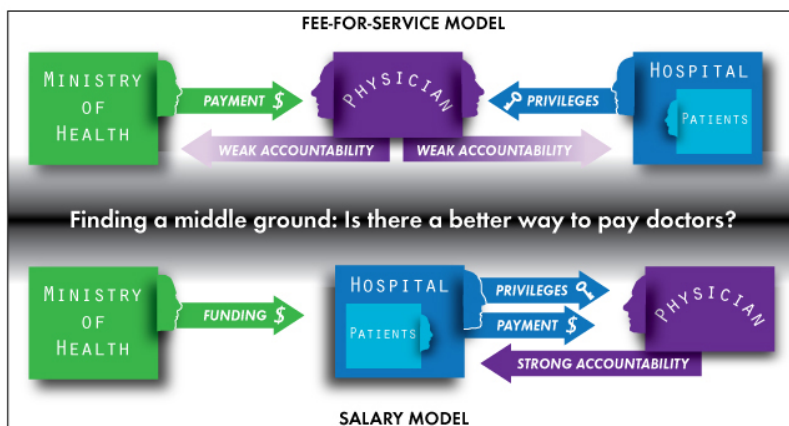
Hospital Boards are responsible for appointing and managing physician practice privileges within the hospital. This is based on the recommendations from the hospital’s Medical Advisory Committee: a team of physician leaders within the hospital. Hospital Management also works with medical department heads to carry out physician human resource planning. In order to recruit or retain high caliber physicians, some hospitals provide financial incentives to these individuals (23).

For physicians with approved clinical privileges, hospitals absorb most of the costs associated with managing patients, including tests and equipment for procedures. Hospitals also provide the materials, staff and space needed to adequately care for patients, but in many hospitals physicians pay some amount for the rental of office space.

Payment for the medical services provided by physicians within a hospital is generally covered by the MOHLTC through the Ontario Health Insurance Plan (OHIP) and does not flow through hospitals. Most physicians in Ontario submit a bill to OHIP on a fee-for-service (FFS) basis but the proportion of physicians' earnings that come from non-FFS sources has been increasing.

It is arguable that accountability for quality of care is weak among physicians and that FFS models encourage physicians to do unnecessary tests while neglecting the un-incentivized task of chronic disease management. However, proponents of the FFS model suggest that it **encourages physicians to be more efficient** with their time and without this incentive, wait-times would be longer. The search for better models of funding for physicians is an emerging topic that may drastically alter the relationship between hospitals, physicians and ultimately the Board. Figure 4 depicts one scenario, a salary-based payment model, which could alter the physician accountability relationship with hospitals. A more detailed discussion of physician payment is provided in the articles **"Debate on Paying Doctors"**.

**Figure 4**



## 6. Community Engagement

Approaches to community engagement are not standardized across the province (25), but hospitals are increasingly involving community members through community advisory committees that report to Management (25). Some hospitals have also used community engagement to facilitate their efforts for deficit reduction.



### Self Regulation: Should Cautions Issued to Health Professionals be Publicly Reported?

by Jeremy Petch & Mike Tierney

There have been recent calls for the CPSO and other regulatory bodies to begin publicly reporting 'cautions.' Cautions are intended to correct a problem in a professional's practice and are not legal findings of professional misconduct. Would publicly reporting cautions help protect patients from medical errors, or could it have unintended consequences that undermine patient safety?

**[Learn More...](#)**

### "Citizen Engagement"

Northumberland Hills Hospital in Cobourg, Ontario was facing a significant deficit. The hospital convened a citizens panel to advise the board about which services could be removed from the hospital. The experiment was successful – should it be used by other hospitals?

**[Learn more...](#)**



While it is important that hospitals prioritize citizen engagement, extensive community involvement can also complicate the functioning of the Board (25). This is particularly pertinent where hospitals make Membership positions available to community donors. Because Members may have the ability to elect Directors to the Board, a conflict of interest may ensue. There is currently no legislation regarding seats for community Members, but allowing the Board to initially screen applicants to their Membership may circumvent this issue. It can also be avoided by passing bylaws that limit membership to a small number of people. This practice will gain greater importance as the rights of Members will be broadened considerably under the new [Not For Profit Corporations Act](#), due to come into force in January 2014. Members will have greater access to financial statements and the right to object to major changes within the hospital.

## 7. Patients and Families

The ECFA provides increased standardization regarding the interactions between hospitals and patients. Although many hospitals were already responsive to their patients, the ECFA requires that each hospital consult patients, caregivers and stakeholders in their community in developing a patient declaration of values (DoV), also known as a Bill of Rights, Philosophy of Care Document or Patient Code of Conduct. The DoV is a critical document and must be made publicly available and used to guide the hospital's patient relations process and quality improvement (1). Values related to patient centered care are typically included in a DoV and often focus on engaging patients in healthcare decision making, [respecting cultural diversity](#) and providing patients with a means to express opinions about their health care experience (26).

Best practices also suggest that hospitals should appoint a staff member to attend to patient relations enquiries and evaluate the patient relations process. Measurement of patient satisfaction is a key tenet of the ECFA and hospitals are required to perform an annual survey of patients and caregivers who have used the hospital's services within the last 12 months. As patient surveys were already a common practice for many hospitals, the ECFA sets the minimum threshold and serves as a call to action for improved performance in quality of care (27). Some hospitals have taken a greater step towards engaging with patients by maintaining an active social media presence.

The Board's role is to provide oversight for efforts in patient relations and develop policies that encourage a meaningful interaction between Management and the patients and families that access the hospital.



### Hospitals Begin to Recognize Social Media's Potential to Improve Patient Experience

by Ann Silversides & Joshua Tepper

Call up the website home page for any large Canadian hospital and you'll likely spot the familiar icons that link to the institution's facebook, Twitter and YouTube accounts. Hospitals are inherently conservative institutions and, as such, have been relatively latecomers to adopt social media. As they enter the social media fray, hospitals face a host of challenges and decisions. These range from basic upkeep to deciding how interactive to be with patients, and what staff should be trained and involved in social media use.

[Learn More...](#)

## QUALITY OF CARE

A key mandate within the ECFA (1) is that Boards are responsible for oversight of the quality of care within their hospital. This includes the establishment of a Quality Committee that develops an annual quality improvement plan (QIP) for the hospital (1). The QIP must draw upon an annual survey of patients and families who have received care at the hospital and a biannual survey of health care providers within the hospital (1).

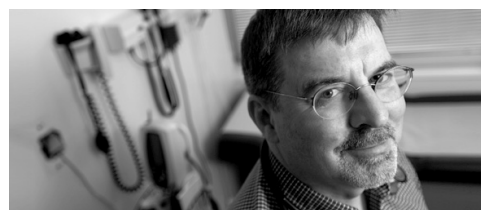
To facilitate ongoing monitoring and comparisons among hospitals, the QIP has been standardized by Health Quality Ontario (HQO), with the assistance of the Ontario Hospital Association, to include specific dimensions of quality in health care (Appendix A). Within each dimension of care (e.g. Safety), a pre-defined list of metrics is provided to hospitals (Appendix A). For 2012-2013, HQO required hospitals to report on at least one metric within each quality dimension (28) and create annual performance improvement targets based on the metric. Boards are responsible for overseeing the development of the QIP and guiding subsequent implementation of the plan (29). A draft of the QIP must also be sent to LHINs for approval.

A mix of financial incentives and reporting requirements have been legislated to encourage hospitals to act on the QIP (1) but the evidence underlying some of these approaches is inconclusive. For instance, some financial compensation for Management is contingent upon achievement of the performance improvement targets and it is the Board's responsibility to determine whether the targets have been reached. Where these targets are unmet, Management is at risk of losing a proportion of their pay. However, studies on [financial compensation and performance](#) have produced [varied results](#) and can often be difficult to apply consistently across hospitals.

Similarly, the ECFA requires that the QIP be submitted to HQO, which also serves as a central hub where QIPs are assessed, inter-hospital comparisons are performed and feedback on QIPs is provided. The QIP must be made publicly available but whether the current approach to public reporting of the QIP will improve quality of care is unclear: [How 'Public' Are Hospital Performance Rating?](#) and [Can "Bottom Up" Measurement Improve Canadian Health Care?](#)

### The Utility of Quality Metrics

It is noteworthy that there is no infrastructure in place to ensure that hospitals collect quality metrics in the same way, and do so accurately. This presents an opportunity for Boards to understand how quality metrics are obtained at



### Is it Time to Abandon "Pay-At-Risk"?

By Andreas Laupacis

As a former member of the Alberta Health Services Board who had my own disagreement with the previous Minister of Health, the news about the recent dismissal of the entire AHS Board over a dispute about pay-at-risk for senior executives had emotional resonance. [Learn More...](#)



### How 'Public' are Hospital Performance Ratings?

by Karen Born & Andreas Laupacis

Although there is lots of talk about making measures of health system performance available to the public, the reality often falls short of the aspirations. Not only are these measures often difficult for public users to understand and access; evidence suggests that they have little impact. [Learn More...](#)



## Can “Bottom Up” Measurement Improve the Quality of Canadian Health Care?

by Jeremy Petch, Roger Palmer & Mike Tierney

At Jack Kitts’s first performance review as CEO of The Ottawa Hospital in 2003, he was able to report that the budget was balanced and that he was “feeling good” about the hospital’s finances. He also had a plan in place to improve morale at the hospital. When the Chair of his board asked him whether the hospital was now providing quality care, Kitts replied “of course.” But then his Chair asked him a question he couldn’t answer: “How do you know?”

[Learn More...](#)

## “Tips for Good Governance”

Enable generative governance by preserving time at the end of each meeting for an open discussion.

their hospital and question methodology when the results are unrealistic. Consider the remarkable inter-hospital variation in hand washing rates in 2009: [“Are Hand Washing Rates Posted by Ontario Hospitals Believable”](#)

The interdependence among hospitals and other health service providers is also an important factor in determining quality of care within the hospital. For instance, Ontario has one of the highest proportion of hospital beds that are occupied by patients whose care could be better addressed in long-term care homes (LTCHs), rehabilitation facilities or even within the patient’s own home (31, 32). These patients are identified as requiring an [“alternate level of care” \(ALC\)](#) and their presence within hospitals highlights challenges with finding placements in nursing homes, rehabilitation, [complex continuing care beds](#) or with [arranging home care for complex patients](#).

Many of these system-level issues are beyond the direct control of Management but affect quality metrics within the hospital. See: [Despite Strains, Ontario Hospitals Aren’t Lobbying for More Beds](#)

## Accreditation

In addition to the requirements of the *Excellent Care for All Act* (1), almost all of Ontario’s hospitals undergo an extensive accreditation process on a voluntary basis. Accreditation occurs on a four-year cycle and involves a full on-site review. Unlike the QIPs, public accessibility to the accreditation review is at the discretion of individual hospitals. The following article provides an assessment of the benefits and disadvantages associated with public reporting of hospital performance: [“Hospital Accreditation and Quality Improvement”](#). Boards can contribute to quality improvement in their hospitals by ensuring quality improvement efforts also align with the recommendations from [Accreditation Canada](#) (29).

## Governance During Health Pandemics

Pandemics represent high acuity situations wherein traditional governance practices may not be feasible (33). Furthermore, rapid decisions may be required of hospital Management, which either deviate from previous arrangements with the Board or cannot be formally approved by the Board (33). In anticipation of pandemics, Boards can contribute by ensuring that [hospitals have well developed and updated crisis management plans](#) that align with the overall strategic goals of the hospital (33). Many hospitals in Ontario have developed such plans since the severe acute respiratory distress syndrome (SARS) crisis in 2003.

## CONCLUDING STATEMENTS

Over the last decade in Ontario, the role of hospital Boards has been strengthened. Not only are Boards responsible for the hospital's financial viability and stakeholder accountabilities, they now have a greater role in improving quality of care. An understanding of hospital relationships with stakeholders and the ever-changing health care environment is an indispensable asset to the Board of Directors of Ontario's hospitals.

### **Appendix A (30)**

| Quality Dimension      | Quality Metric (example)  |
|------------------------|---|
| <b>Safety</b>          | C-Difficile Infection Rate  |
|                        | Rate of Hand Hygiene Compliance Before Patient Contact                                      |
|                        | Ventilator Associated Pneumonia Rate  |
|                        | Rate of Central Line Blood Stream Infections  |
|                        | Rates of New Pressure Ulcers  |
|                        | Rates of Falls  |
|                        | Number of Patients in Physical Restraints Prior to Full Admission                           |
| <b>Effectiveness</b>   | Rate of In-Hospital Mortality Within 5 Days of Major Surgery                                |
|                        | Proportion of Patients Receiving Medication Reconciliation                                  |
|                        | Number of Deaths Compared to Number Forecasted  |
| <b>Access</b>          | Improve Organizational Financial Health   |
|                        | 90 <sup>th</sup> Percentile of Emergency Room Wait Times                                    |
| <b>Patient-Centred</b> | Percentage of Patients that Would Recommend Hospital  |
|                        | Percentage of Patients that Considered Care at Hospital Good, Very Good or Excellent        |
| <b>Integrated</b>      | Percentage of Days Patient Spend in Hospital as ALC   |
|                        | Number of Patients Re-admitted Within 30-days Compared to Forecasted Number of Re-admission |

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