



Renew
PRHC's strategic directions
in action

**Peterborough Regional Health Centre
Hospital Improvement Plan**

June 28, 2010
Final - PRHC Board Approved

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Executive Summary

This Hospital Improvement Plan (HIP) is being submitted by the Peterborough Regional Health Centre to the Central East Local Health Integration Network (CE LHIN). The plan, undertaken at the direction of CE LHIN, will restore PRHC's financial position to a sustainable state by March 31, 2012. It maintains quality of care and protects the full scope of our current regional services and programs.

The CE LHIN called for PRHC to submit a HIP by June 30, 2010. PRHC's HIP takes into account recommendations made by a Peer Review study, but differs in significant ways. While our plan, like the Peer Review, finds the necessary annualized savings of approximately \$27M within the two-year time frame, PRHC's interventions include strategies to mitigate against the loss of beds, staff to occupancy levels, and focuses on Length of Stay (LOS) reductions so that PRHC is well positioned for the future. While our plan calls for the restructuring of 182 front line FTEs, they are broadly across the organization and does not focus on a single area or profession.

PRHC engaged front line staff, physicians, volunteers, key stakeholders and health care partners in the development of this HIP. Collectively they generated some 2,400 cost saving and process improvement ideas. These were then distilled, evaluated and ranked. This plan is an organic one; it is based on internal knowledge and protects core programs and services, minimizes job loss wherever possible, and relies on productivity improvement rather than bed closures to deliver bottom line results *and* changes to our organization's culture—so that the changes are sustainable.

Once our new “steady state” is reached, PRHC will be better able to pursue its regional mandate and role as envisioned by the CE LHIN's Clinical Services Plan (CSP) and Integrated Health Service Plan (IHSP). Enhanced programming such as PCI, expanded vascular surgery and radiation therapy will be offered at PRHC in the future—bringing more care, closer to home. PRHC's Board of Directors and management know that getting our financial house in order is the first important step to attract necessary support and convince funders, and donors, that this is a hospital that is worthy of new and expanded investment.

As part of developing our HIP, we hosted open information and consultation sessions both within the hospital, with key health care partners, as well as out in the community and region. We made drafts of the plan public as we went along. The plan changed as feedback was incorporated. This transparent approach will continue in an ongoing manner—as reports on our progress in achieving the plan will be made openly and regularly.

This HIP is a financial recovery plan, but it is also a commitment to our patients, our staff, our community, our funders. PRHC will deliver on this plan, making the

changes necessary to address the deficit and stabilize the financial health of the organization—all the while continuing to provide the care and service expected of us¹. We will pursue our goals as outlined by the CE LHIN's IHSP of reducing wait times in the Emergency Department and reducing the impact and incidence of vascular disease. And, when our financial house is in order, the hospital will begin a new cycle of inclusive strategic planning with the intent to pursue targeted, regional services to bring more care closer to home.

PRHC's Hospital Improvement Plan in Context

Healthcare is changing rapidly. Canada invests almost \$200 billion in healthcare each year. Recently, Ontario's provincial government has made clear that funding to hospitals will be reduced in order to divert funds to community-based, primary care services. This is in order to focus on disease prevention and promote wellness. In turn, hospital deficits have become, by legislation and practice, unacceptable.

PRHC's Board, medical staff leadership, and management support these policy changes.

"Many will view this [Peer Review] as a setback. I, however, am emboldened. I am committed to embracing the challenges ahead and ensuring that we remain able to serve our community with care, skill and compassion."

- Ken Tremblay, President and CEO,
Open Letter to the Community, April 2010

To this end, the Central East Local Health Integration Network expects providers like PRHC to deliver performance and capacity for the funding received. This means PRHC must deliver safe, quality care within the clinical and financial performance parameters contained in its accountability agreements.

In December 2009, the Central East Local Health Integration Network (CE LHIN) commissioned a Peer Review for PRHC following years of deficits and a failure to

deliver on its most recent accountability agreement. The Peer Review Report was tabled on April 20th. It made 60 recommendations on how our hospital might achieve its contractual obligation to balance its budget all the while delivering the clinical volumes and outcomes historically provided by PRHC. And, in the wake of PRHC's recent redevelopment, it did this with the future in mind—one that includes service growth. Finally, in addition to financial targets, it made observations on governance and management practices and provided clear direction for change—change that the organization is already demonstrating.

The savings achieved through this Hospital Improvement Plan are significant: \$27 million on a \$230 million annual budget. This plan, a made-in-Peterborough plan, has been mindful of the work done by the Peer Review team, and it does address specific shortcomings embedded in the recommendations included in

¹ PRHC performance indicators and quality measures can be found on its public website:
<http://www.prhc.on.ca/Site%20Map/Performance%20Indicators%20and%20Measurements.aspx>

the Peer Review. It does, however, benefit from intimate local insight gained through broad stakeholder and public engagement, and a parallel internal process PRHC called “Renew”. As such, PRHC’s HIP presents a comprehensive set of strategies that differ from the Peer Review, but that attain the full financial value and breadth of organizational change needed to achieve and sustain a modest surplus in order to fund growth and longer term debt retirement obligations.

As mentioned, before and during the Peer Review, hospital managers, staff and physicians developed additional recommendations to achieve a balanced budget. More than 2,400 ideas—big and small—were generated and assessed through a validation process to determine which would produce the savings required *and* be right for our hospital and community. For example, the hiring and vacancy freeze—to drive productivity gains and mitigate job losses—generated some 159 vacancies by June 11, 2010. These unfilled positions are a component of this HIP, and are important as they help to buffer the human resource impact felt at all levels of the organization. Vacancies gained through attrition and retirements will further reduce the negative impact of job loss in our recovery plan.

“We appreciate it is a difficult time for staff as we do what is needed to improve our financial health and achieve a balanced steady state for the future. As difficult as this recovery will be, the resultant PRHC will be stronger and better positioned for the programs and services needed in our community and this facility.”

- Barb Cameron, Board Chair,
from “Statement in Response to the Peer Review” read at the May 2010 Board Meeting

The Board of Directors and Management acknowledge that the Peer Review raised many questions and concerns. Our Hospital Improvement Plan is a new agenda of performance and accountability for PRHC—one that will be pursued collaboratively with board members, management, staff, physicians, donors, patients and the community. Our recovery plan will set us on a course toward a new steady state for PRHC. While we remain committed to our strategic plan² and to our proud history of delivering high quality care, our recovery will ensure PRHC is financially secure in order to become a high performance regional

provider, and, ultimately to ensure our vision as “the place to be for care and career.”

Why a Hospital Improvement Plan for PRHC?

The CE LHIN called for a Peer Review of PRHC in December 2009³. The Purpose of the review was the:

² <http://www.prhc.on.ca/Press%20Releases/Strategic%20direction%20brochure.pdf>

³ <http://www.prhc.on.ca/Press%20Releases/News%20Release%20PRHC%20Peer%20Review%20FINAL%20122209.pdf>

“...development of a final report that will identify strategies for PRHC to operate efficiently and effectively within its revenue sources. The Hospital will be expected to use the final report of the Peer Review team to develop a PRHC Hospital Improvement Plan (HIP). The HIP must ensure that PRHC meets all performance requirements.” (Peer Review: Appendix B, 1.)

In the Executive Summary of the Peer Review, the triggers for the Peer Review included:

“Despite this [Hospital Service Accountability] Agreement, PRHC is projecting a deficit of \$13.9 million in 2009/10 and \$25.9 million in 2010/11, on base revenues of approximately \$230 million. The Hospital has operated at a deficit for the past 13 years, despite an increase in revenues of \$95.5 million (62.6%) over the past six years. The Hospital has requested an increase of \$20 million in its 2009/10 base funding to balance its budget as required by the H-SAA. In addition, PRHC has an accumulated working capital deficit of \$77 million, which is expected to increase to approximately \$89M by March 31, 2010.” (Peer Review: i)

In essence, PRHC’s financial situation was in crisis and had become unsustainable.

Turning a Corner: Preparing for the Peer Review

From the outset, PRHC’s approach to the Peer Review was one of cooperation and recognition that it must improve its clinical performance and productivity to achieve needed financial results.

Renew, Phase One

“Renew” is a made-in-Peterborough process to come up with cost-saving ideas from physicians, staff, volunteers, community stakeholders and health care partners. Renew had its roots in an earlier iteration of process redesign first begun in 2009. Staff teams were set up to generate discussion and identify interventions to improve patient flow and improved processes for their work. A first round of clustering of ALC patients began through this process, for example. Prior to the Peer Review, Renew took on a new urgency. Immediate cost saving steps such as holding vacancies and scrutinizing overtime hours were paired with a re-ignited Renew—that would provide a framework for a local solution to the fiscal recovery.

Board Motion

Prior to the Peer Review, PRHC's Board of Directors passed a motion stating the following objectives, thereby setting the stage for change:

MOTION BY THE PRHC BOARD (March 8, 2010)

Whereas the **Board of Directors** wishes to ensure the PRHC has the financial resources to provide a full range of medical services in line with the strategic plan;

And whereas the **Board of Directors** recognizes that financial stability is an important ingredient to maintaining the highest quality of care for patients;

And whereas the **Board of Directors** desires to implement a sustainable operating model which will facilitate the full use of the physical infrastructure made available through the construction of the new hospital;

And whereas the Board of Directors desires that the hospital operate at the top quartile for [peer group] Ontario Hospitals;

And whereas the **Board of Directors** recognizes it has the primary responsibility to address the current operating deficit and accumulated debt;

Be it resolved that:

1. The Board directs the CEO and Chief of Staff:
 - to improve the institution's productivity so that the average weighted cost per patient is reduced to the expected level on a monthly run rate basis for the month of March 2011;
 - to operate at the top quartile for Ontario Hospitals; and
 - to attain a surplus position by fiscal year end 2012;

The Board further directs the CEO and Chief of Staff to present a preliminary plan which details the specific actions they intend to undertake to achieve these objectives. This preliminary plan will detail the specific impact (expressed as average cost per patient) for each action and all associated patient care, staffing, organizational and other significant impacts. This preliminary plan will be presented to the Stewardship Committee at the April meeting.

2. The board directs the CEO and the Chief of Staff to present a final plan which incorporates additional observations made by the current Peer Review, the LHIN and the public through consultation to the Board at the earliest possible opportunity.

3. The Board directs the CEO to present a revenue assessment that identifies whether PRHC is collecting the appropriate revenue (including but not limited to determining the accuracy of ministry billings, appropriate charting, adjusting ancillary fees and other measures as he may determine) as well as assessing opportunities for revenue growth to the Board at the earliest possible opportunity.
4. The Board directs the CEO to prepare and present a debt retirement strategy at the earliest possible opportunity.
5. The Board directs the CEO and Chief of Staff to provide monthly reports to the Stewardship Committee on progress in meeting the goals and objectives outlined.
6. The fiscal recovery plan will be discussed with the public on a regular basis.
7. The Board, the CEO and Chief of Staff will adhere to the principles and values enunciated in the Health Centre's Strategic Plan in its fiscal recovery efforts.

MAC Endorsement of Seven Policy Recommendations

In a parallel demonstration of leadership and accountability, in its March meeting the Medical Advisory Committee (MAC) unanimously endorsed seven policy recommendations to help PRHC take significant strides toward fiscal recovery.

“The issues were discussed at length, recognizing that the way the medical staff conducts business is crucial to the financial health of the hospital. I would like to thank working group members for taking on such a serious responsibility,” Dr. Peter McLaughlin, Chief of Staff, memo to physicians with privileges, March 2010.

A priorities working group with physician representation from Medicine, Surgery, the Emergency Department and the Hospitalist Service, worked with the Chief of Staff (COS) and the CEO to table the policy recommendations, which focused on key issues, including Alternative Level of Care (ALC) patients, Case Mix Groups (CMGs) and Most Responsible Physician (MRP) issues.

The recommendations, as endorsed by the MAC are as follows.

- 1) All appropriate ALC patients are co-located. Medical supervision of ALCs is established that is not dependent on the current hospitalist service model.
- 2) All patients admitted to hospital will have an MRP identified at admission.

- 3) Each CMG must be owned by one and only one of the departments. The Chief of the department is held accountable for the CMGs in his/her department.
- 4) Department of Medicine will establish a section of General Internal Medicine. (Structure to be established.)
- 5) Co-location of groups sharing medical CMGs into one department is optimal for development and implementation of best practice for those CMGs.
- 6) A new compensation model for the hospitalist service be developed. (Reduction in support from hospital funds.)
- 7) Each department will develop and implement strategies to reach top quartile benchmarks for Length of Stay (LOS) in each CMG in its portfolio.

Peer Review's Final Report and Recommendations

The Peer Review's mandate was to identify strategies for PRHC to operate efficiently and effectively within its revenue sources. Although it was a Peer Review, the terms of reference were more reflective of an operational review with a focus on financial performance (Peer Review, ii.)

On April 14, 2010 at an open session of the CE LHIN Board of Directors, a 98-page Peer Review was received⁴. It contained more than 60 recommendations. In its findings the Peer Review Team estimated that, if implemented, the recommendations could save PRHC just under \$27 million in the short to medium term. The report made recommendations relating to Finance, Governance, Management, Medical Leadership, Clinical Programs, Support and Efficiency, and Non-Clinical Support. The Peer Review was, and is, publically posted on the CE LHIN's website.

In receiving the report, the CE LHIN Board passed a motion directing PRHC to review and take into consideration the recommendations in the Peer Review as it prepares its HIP.

PRHC's Response to the Peer Review and Actions Taken

In a joint press release on the day of the release, April 20, PRHC's position and intent was articulated by President and CEO, Ken Tremblay:

"We thank the Peer Review Team for their report and recommendations. This crisis has galvanized the Board, management, employees and medical staff in the need to achieve savings and balanced budget. Our recovery efforts have already begun with robust planning and detailed action plans well underway.

⁴<http://www.prhc.on.ca/Press%20Releases/News%20Release%20PEER%20REVIEW%20RELEASED%20-%20FINAL.pdf>

“Our recovery plan will include recommendations from the Peer Review as well as many ideas generated from internal and external groups. As per the Board of Directors’ direction tabled last month, PRHC is committed to a new steady state for 2012.”

Board Response and Governance Actions Taken

While many of the Peer Review recommendations were related to financial performance and opportunities to improve and are incorporated into the strategies and interventions in this HIP, eight were non-financial and related to Governance. PRHC’s Board has already put these recommendations into action. An accounting of these actions was entered into public record by PRHC Board Chair, Barb Cameron in its May 26 meeting and was reprinted in its entirety by local media. The following is an excerpt of these actions:

...I would like to address each of the eight recommendations directed at the governance processes of PRHC....

In response to the second recommendation, the Board will participate in governance training sessions this fall. Further, as Board Chair, and with the assistance of the CEO, I will be engaging a mentor/coach to assist the Board through the recovery process. I would like to add that individual Board members have attended many OHA sponsored training events, including those on governance. The Board has consistently encouraged and supported such opportunities.

The Board endorses the third recommendation. We will modify and extend our current score cards and key performance indicators to monitor and validate the Hospital’s performance with the CE LHIN.

The fourth recommendation was to amend Hospital bylaws requiring the Board of Directors to ensure the organization lives within its financial means. I am directing the Governance Committee to consider this in its next By-Law review. Combined with other changes, this will ensure that PRHC’s by-laws continue to serve the needs of PRHC into the future.

The fifth recommendation is that the executive of the Board meet with the CELHIN biannually for next two years to review progress and receive guidance and feedback. We welcome the opportunity to work closely with LHIN colleagues as we transform PRHC.

The sixth recommendation was that the Board require that key performance indicators relative to the recovery (Hospital Improvement) plan be developed by management, validated with the LHIN and monitored by the Board quarterly. The Board has had indicators in place.

These will be enhanced and validated with the LHIN and further refined as the recovery plan is put in place.

Recommendation eight in the Peer Review was to replace the Governance and Planning Committee with two separate committees. Draft terms of reference for each individual committee will be brought forward to the Governance and Planning committee next month for consideration.

In response to recommendation nine, the Board believes that it has recruited and nominated members according to generally accepted practices within the sector to achieve a skills-based Board. With the assistance of the mentor/coach we will be retaining, the Board will review its competency matrix to determine where there may be gaps. Further, the Board will examine the number of board members and potential reduction of ex-officio members with consideration given to the new prototype bylaws recently developed by the OHA.

Accreditation Canada: within the HIP context

Contemporaneous with the release of the Peer Review, Peterborough Regional Health Centre welcomed a survey team from Accreditation Canada from April 19-22. While the timing was taxing, PRHC was pleased to achieve a three-year Accreditation (with Condition) meeting 97% of the standards⁵. The team interacted with hundreds of leaders, staff, volunteers, patients and families, observed our processes in action and reviewed key documents.

PRHC achieved full compliance with all 31 Required Organizational Practices (ROPs). ROPs are based on best practice and are critical to patient safety. They include practices and processes to build a culture of patient safety, and to support communication, work-life, medication safety, infection prevention and control, and the assessment and prevention of other risks such as pressure ulcers, falls and suicide.

In their report, the surveyors noted several strengths and innovations, as well as some opportunities for improvement. The hospital was particularly proud of its demonstrated, strong commitment to teamwork, and excellence in high quality, safe patient care highlighted in the Report.

Maintaining this Accreditation status is conditional on our Board members and leaders showing progress on three Governance standards. These standards, aligned with several of the Peer Review recommendations, require us to work more closely with our community partners and stakeholders to set priorities and plan, to better anticipate financial needs and risks, and to more regularly review financial performance and the use of resources. Within the context of this Hospital Improvement Plan, PRHC is already starting to show progress on

⁵ Full report: <http://www.prhc.on.ca/Site%20Documents/Accreditation%202010%20Report.pdf>

meeting these standards and looks forward to confirming our full Accreditation in the fall of 2010.

Organizational Design: A New Design for a New Steady State

After much careful thought and focused consultation, and in preparation for the fiscal recovery, on May 11, Ken Tremblay, President and CEO, announced a new organization design for PRHC⁶. How a hospital is organized is important because it provides the framework to shape culture and improve performance. In PRHC's case, the new structure created and aligned programs to better integrate the organization and better support patient/client-centered care by furthering PRHC's three strategic directions. Finally, having a management and support structure that drives improved performance was cited by the CEO as an important step towards financial recovery.

The principles behind the development of the new design were widely distributed and reviewed with staff and physicians in March. Through that process further refinement and definition occurred. The new design includes standard role descriptions for each non-union category. Some highlights of our new organizational design include:

- The structure integrates the whole operation, avoiding silos. Clinical programs, improving utilization and patient flow are at the core of the design;
- Physician leaders are essential components in the structure. Program Medical Directors and Administrative Directors will jointly lead the programs;
- A new Inter-program Operations Committee (IOC) will now be responsible for the operations of the organization. It will ensure seamless care and cross-divisional efficiencies and performance. Its members include the CEO, COS, VPs, Program Administrative and Medical Directors. It reports jointly to the CEO and COS;
- Senior team is newly constituted. It is responsible for pursuing the organization's vision and mission, policies, business strategy, planning, upholding the values and ethics, and positioning the brand and organization for success. Its members include the Chief Executive Officer, Chief of Staff, the three Vice Presidents, Chief Information Officer and Chief Communications Officer;
- There are four (4) layers from CEO to front line staff;
- A "one stop" helpdesk to support staff requests (IT, housekeeping, and maintenance) is being created, and inline with a Peer Review recommendations, a Program Decision Support Team has been created.

⁶<http://www.prhc.on.ca/Press%20Releases/press%20release%20management%20reorganziation%20may%2011%202010.pdf>

Each role in the organization was described and communicated. The new roles are: Vice President, Administrative Program Director and Medical Program Director, Program Manager and Support Manager, Supervisor and Shift Supervisor, Coordinator, and, Program Support Partner. The following chart summarizes the changes made associated with PRHC's new organizational design.

Positions	Dec 2009	May 2010	Net Positions Change
Executive	6	5	(1)
Directors, Managers, Co-ord/Supervisors	79	63	(16)
Professionals (e.g., Consultants, Analysts)	57	56	(1)
EA/Resource Assistants	15	13	(2)
Total Non Union	157	137	(20)

The reorganization represented a 12.7% reduction in non-union staff at PRHC. The total reduction of 20 positions in the above chart included the elimination of 8 vacant positions, 4 restructured positions from March 2010, and 8 eliminated positions. This returns PRHC's non-union staffing to 2005 levels and is in keeping with current best-practice benchmarks for similar hospitals. As with any major re-design, while existing vacancies were taken advantage of wherever possible, changes to personnel were necessary to accommodate the new structure. In accordance with human resources practices, severances were offered to those restructured employees based upon position and years of service. The annualized savings flowing from the new organizational design is approximately \$1.6M.

HIP Planning Process: Renew

"Renew" was a made-in-Peterborough process to come up with cost-saving ideas from physicians, staff, volunteers, community stakeholders and health care partners. More than 2,400 ideas were ultimately generated between February and April 2010. A four-step process was followed which included:

- 1) Idea generation;
- 2) Idea authentication and quantification;
- 3) Decision making and idea sequencing; and,
- 4) Implementation.

Renew had its roots in an earlier iteration of process redesign begun in 2009. In its new iteration, the process began with a formal invitation to participate from the CEO, Ken Tremblay:

"I would like to personally invite you to participate, as a team member, in the first phase of change. We have selected 150 staff members and leaders, and are, through this letter, putting out a call for several dozen additional participants. If you put your name forward, you'll be rolling up your sleeves, and working with your colleagues from across the

organization to make things better. This is a task that requires participation from across the hospital at all levels. We are especially seeking those with creativity, enthusiasm and ingenuity!

“As a Renew team member, you will be asked to attend brainstorming and planning sessions. You will work to come up with ideas, and decide upon or implement opportunities for fiscal and organizational improvement.”

Additionally, all staff members and stakeholders within PRHC had the opportunity to submit ideas electronically or on paper. Renew, then, was a process to draw out innovative and new ideas, give voice to those who do the work day-to-day, and harness their “insider knowledge.” A special “Recovery Room” was set up to host meetings and provide a physical focal point for the energy and work going into PRHC’s recovery. The room was open to all staff, and media were invited in to see the space, walls being covered in working documents and graphs.

Having captured the 2,400 ideas, teams were then struck to filter the ideas into themes based upon planning assumptions, rank, quantify and authenticate the validity of the ideas, and then decide on which ideas would be the priorities, and in what order they might best be completed in.

Benchmarking Review

As a part of the HIP process, PRHC reviewed the groups of eight (8) and 21 hospitals that the Peer Review used for benchmarking⁷. To ensure standardized and useful comparators going forward, PRHC felt it important to re-evaluate and determine if the benchmarking hospitals were still similar enough to it, i.e., with comparable sites, services and programs, total beds, operating revenues and case volumes. A group of 15 community/regional hospitals⁸ will be used for benchmarking during the implementation process of the HIP and for internal analysis. Criteria used to determine relevant comparators were based on the following:

- Total Funded beds ranging from 250 to 550 beds
- Total revenues between \$200M to \$350M
- Weighted Cases 18,000 to 35,000

Aligning Renew and Peer Review

In the midst of the Renew process, the Peer Review was received. The relevant recommendations were cross referenced against the Renew ideas. Not surprisingly, there was significant overlap, as was expressed in the following diagram later used in the community engagement sessions:

⁷ These groups of comparator hospitals chosen by the Peer Review have also been used by PRHC in prior benchmarking exercises.

⁸ See Appendix B for list of Hospitals



The following chart shows the milestones met in the development of the HIP.

Date	Milestones
March	<ul style="list-style-type: none"> • Staff and Community Partners - Renew Idea Generation Sessions • PRHC Board Motion (March 8) • MAC Endorsement of Policy Recommendations
April	<ul style="list-style-type: none"> • Renew Authentication & Quantification • Peer Review Final Report
May	<ul style="list-style-type: none"> • Renew & Peer Review Timing & Verification • Working Draft of HIP
May 20th–31 st May 31st–June 4th	<ul style="list-style-type: none"> • Physicians, Staff and Volunteer Engagement • MAC (chiefs), IOC, FAC (unions) Engagement • Community Partner and Stakeholders Session • Community Consultation
June 7th–June 16th June 7th–June 19th	<ul style="list-style-type: none"> • HIP Review Process - Stewardship Committee • Decision Making - Inter-Program Operations Committee (IOC) • For Approval - Senior Team, MAC
June 14, 17, 23rd	<ul style="list-style-type: none"> • For Review and Approval - Stewardship Committee
June 28th	<ul style="list-style-type: none"> • For Review, Consideration and Approval - Board of Directors
June 30th	<ul style="list-style-type: none"> • CE LHIN Submission
July 20th	<ul style="list-style-type: none"> • For Final Review, Consideration and Approval - CE LHIN Board Meeting

HIP Planning Assumptions

The following three principles and ten (10) assumptions, based upon the Board's March 8th motion, formed the decision making framework for the development of the HIP as Renew ideas and Peer Review Recommendations were selected for inclusion in the draft plan.

Principles

PRHC's Hospital Improvement Plan will:

1. chart our course to a new steady state; top quartile performance; and growth as a strong regional centre;
2. be a public document that will hold us accountable to our obligations;
3. be accepted as mandated by the CE LHIN as part of the Peer Review process.

Assumptions:

1. Quality and safety standards will be maintained
2. Program capacities will be maintained, even though fewer beds may be staffed
3. Performance targets, such as wait times, will continue to be drivers
4. Job loss will be mitigated by attrition and transfers
5. The need for community-based long-term care capacity will be emphasized - PRHC will apply for interim and other funding strategies to reduce its ALC patient census
6. The most economical staffing patterns/scope of practice standards will be implemented
7. Top quartile indicators have been used to identify savings and performance targets
8. Applicable language and processes contemplated in our collective agreements will be honoured / followed
9. Quality decision-making criteria will be used: "SOAPEER" - safe, outcome-based, accessible, patient experience, efficient, effective, risk.
10. Implementation of initiatives will be complete by March 31, 2012

Assumption 9 above, "SOAPEER" is based upon a quality decision making framework developed by St. Michael's Hospital in Toronto. Along with PRHC's own Ethical Framework⁹, it helped to guide decision making and ensure each intervention was compliant with our core principles and ethics. SOAPEER, expanded, is:

⁹ http://www.prhc.on.ca/Site%20Documents/PRHC_ethics_poster.pdf

Quality decision making criteria: SOAPEER

Safety:	Avoids errors and injuries to patients and staff from the care that is intended to help.
Outcome:	Provides services based on evidence to all who could benefit, and refrains from providing services to those not likely to benefit.
Access:	Maintains capacity, ensures timely access to care and reduces waits for both those who receive and those who give care.
Patient Experience:	Provides patient and family focused care that is in line with our ethical framework.
Efficiency:	Avoids waste, including waste of equipment, supplies, ideas, time and energy.
Effectiveness:	Provides appropriate service and care that aims to meet quality, performance and productivity targets.
Risk:	Considers all aspects of possible harm arising from an action and ensures a risk mitigation strategy is in place.

IHSP and CSP Alignment

A final step in the planning process was to ensure that PRHC's HIP was aligned with both the CE LHIN's Clinical Services Plan (CSP) and Integrated Health Service Plan (IHSP). Available on the CE LHIN's website, both system-wide plans contemplate service-planning and/or set system-wide goals of which PRHC plays a part. Key in PRHC's HIP is that it incorporates the directions set forth by these larger health system plans.

IHSP: Through participation in the province's Process Improvement Program (PIP), partnerships with Emergency Medical Service (EMS) to reduce ambulance offload delays using offload nurses, Geriatric Emergency Management (GEM) nurses, and other strategies, PRHC is pursuing the IHSP LHIN-wide goal of reducing one million hours of ED wait time. PRHC also contributes to the IHSP goal of reducing vascular disease through Diabetes clinics and Safer Healthcare Now initiatives. PRHC intends to work in tandem with the LHIN to ensure its regional role is enhanced over time and that PRHC is a leader in the northeast cluster of the CE LHIN.

CSP: PRHC is pursuing its plans for growth in both cardiac services, specifically, Percutaneous Coronary Intervention (PCI), commonly known as coronary angioplasty, and vascular surgery—see summaries below. As well, PRHC will move forward with its partner hospitals in implementing the CSP with regards to women and children's services and mental health services, to realize its regional role as envisioned by the CSP.

HIP-CSP Alignment: Proposal Summary - Regional Vascular Centre at PRHC

Peterborough Regional Health Centre has proposed, within the CSP framework, to become one of two independent regional vascular centres in the CE LHIN offering a full range of vascular surgical treatment options, including endovascular surgery. The second centre within the CE LHIN is located at The Scarborough Hospital, General Campus. The proposal is congruent with the CE LHIN's Integrated Health Services Plan (IHSP), and one of the CE LHIN's Strategic Aims, namely:

Vascular: To improve access to integrated diabetes care, and in recognition of the significant LHIN investments in chronic disease prevention, early detection, self-management and effective and equitable access to treatment such as stroke care, the Central East LHIN will: Reduce the Impact of Vascular Disease in the Central East LHIN by 10% by 2013.

PRHC's proposal seeks to sustain the significant Durham Region patient volumes that it has been realizing since December 2007 in order to be a comprehensive regional centre providing best-practice vascular care.

Phase 1: Support is being sought in order for PRHC's vascular program to perform Endovascular Aneurysm Repair (EVAR) surgery. Currently patients are being transferred to Toronto for this service.

Phase 2: Recruitment and Hiring of new Vascular Surgeon: Endovascular Aneurysm Repair (EVAR) and other non-invasive endovascular techniques are becoming integral parts of any full service vascular surgery practice, essential for a regional centre. All new graduates (future recruits) are fully trained and expected to maintain skill sets in non-invasive vascular procedures. Any centre providing vascular surgery needs to include endovascular capabilities and should recruit and develop vascular surgeons with EVAR capabilities. EVAR is expected to be in place prior to the recruitment of a third vascular surgeon.

HIP-CSP Alignment: Proposal Summary - PCI program

Primary PCI for early management of acute ST elevation myocardial infarction (STEMI) has become the accepted standard of care. PRHC's proposal calls for the establishment of a stand-alone PCI program at PRHC that will provide timely

and equitable access to this level of care for patients in the eastern and northern geographic parts of the CE LHIN.

There are two important and distinguishing components of this proposal for a stand-alone PCI program at PRHC. The CE LHIN has developed an Integrated Health Service Plan for delivery of integrated care in this LHIN, and cardiac care is one of the priority programs in this plan. A two cluster model for delivery of acute cardiac care in the CE LHIN has been adopted, and PRHC has been designated as the regional cardiac centre for the North East/Durham cluster. The CE LHIN Integrated Health Service Plan has identified establishing a stand-alone PCI program at PRHC as the priority for cardiac services in the LHIN so that access to primary PCI is equitable across the CE LHIN.

PRHC has had a long-standing partnership with University Health Network (UHN) for delivery of diagnostic heart catheterization services, and ambulatory pre/post procedure clinics for PRHC patients referred for elective PCI and cardiac surgery. The PRHC proposal for a stand-alone PCI program with primary PCI for STEMI at PRHC extends this partnership to include a service agreement with UHN. This agreement will provide a sustainable and integrated program with UHN for PCI at PRHC. PRHC cardiologists performing PCI will be cross appointed at UHN and will carry out procedures at both PRHC and UHN, as will UHN PCI operators. This will provide the platform for a sustainable 24/7 program for primary PCI, as well as transfer of knowledge and quality assurance programs to maintain best practice at PRHC. Similarly, nursing education will be integrated to provide knowledge transfer for nurses involved in PCI.

PRHC's new facility has two new state-of-the-art cardiac catheterization labs which are fully equipped for PCI. This places PRHC in position for a rapid implementation of a PCI program. In addition, immediate repatriation of the approximately 600 PRHC patients who currently have PCI procedures outside of the CE LHIN annually will largely provide the financial operating base for the PCI program at PRHC.

Hospital Improvement Plan Schedules

HIP Planned Savings

	Peer Review (\$ million)	PRHC HIP (\$ million)
Health & Safety	1.40	2.90
Absenteeism		1.40
Overtime		1.00
Lost time incidents		0.50
Revenue Enhancements	1.00	1.03
Preferred accommodations		0.64
Parking fees		0.39
Medical Fee remuneration	1.60	1.60
Environmental Services (Housekeeping)	0.86	0.59
Nutrition Services	0.65	0.45
Non-union Management reductions	0.00	1.56
Supply Chain costs*	0.00	1.06
Site Consolidations	0.20	0.19
Clinical Efficiencies	17.00	12.36
Critical care	6.20	0.80
Medicine (includes Telemetry)	7.30	3.83
Sub Acute*	0.00	(0.48)
Rehabilitation services *	0.00	0.73
Surgical	0.40	1.45
Women's & Children	0.40	0.71
Mental Health *	0.00	0.08
Reduce use of diagnostic tests	0.80	0.80
Emergency *	0.00	0.61
Dialysis	0.20	0.64
Diagnostic Imaging	1.00	0.90
Pharmacy*	0.00	0.30
Laboratory Medicine	1.00	0.83
Ambulatory*	0.00	0.77
Other Support areas*	(0.30)	0.38
10/11 Estimated Funding Increase	0.00	2.60
Other Benchmarking Opportunities*	4.00	2.73
Total	26.70	27.07

Notes

1. Asterisked items in Peer Report were included in other areas and not specifically identified individually.
2. Costs and staffing implications are subject to changed based on additional information.
3. HIP savings are aligned with PRHC Board of Directors board motion of March 8, 2010 to reach top quartile performance and attain a surplus budget by March 2012.
4. Subject to approval of CE LHIN Board of Directors.
5. Annualized savings are based on 2009/10 costs.
6. Information sourced from internal Renew processes and external peer review.
7. Excludes one time costs related to restructuring and implementation.

Hospital Improvement Plan Schedules

HIP - Net FTE Impact (full time equivalent)

	Peer Review	PRHC HIP
Environmental Services (Housekeeping)	9.5	9.9
Nutrition Services	11.0	11.1
Non-union Management reductions	0.0	19.5
Clinical Efficiencies	131.0	105.2
Critical Care	38.8	9.0
Medicine (includes Telemetry)	68.5	48.1
Sub Acute*	0	(22.6)
Rehabilitation services *	0	9.0
Surgical	9.5	15.7
Women's & Children	4.5	5.4
Mental Health *	0	1.1
Reduce use of diagnostic tests	0	0.0
Emergency *	0	6.8
Dialysis	0	4.6
Diagnostic Imaging	5.7	9.3
Pharmacy*		0.0
Laboratory Medicine	4.0	7.2
Ambulatory*	0	5.0
Other Support areas*	0	6.5
Other Benchmarking Opportunities*	TBD	36.6
Total Net Reduction	151.5	182.3

Total impact on FTE's will be mitigated by existing vacancies, retirements to the extent possible.

Notes

1. Asterisked items in Peer Report were included in other areas and not specifically identified individually.
2. Costs and staffing implications are subject to changed based on additional information.
3. HIP savings are aligned with PRHC Board of Directors board motion of March 8, 2010 to reach top quartile performance and attain a surplus budget by March 2012.
4. Subject to approval of CE LHIN Board of Directors.
5. Annualized savings are based on 2009/10 costs.
6. Information sourced from internal Renew processes and external peer review.
7. Excludes one time costs related to restructuring and implementation.
8. Net FTE's includes new classifications less position reductions.

Hospital Improvement Plan Schedules

HIP - Net Impact on Beds

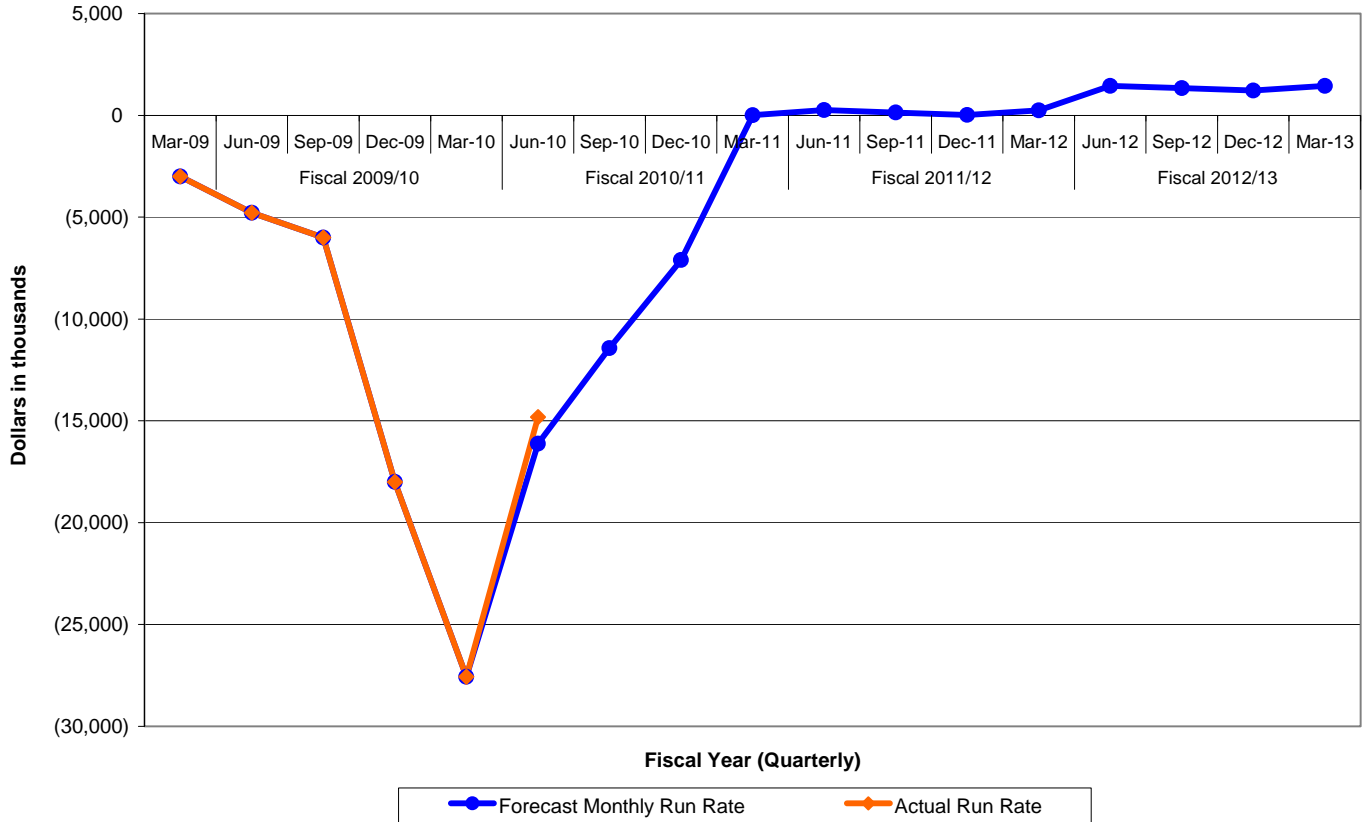
	Peer Review	PRHC HIP
Clinical Efficiencies		
Critical care	(17)	(4)
Medicine (includes Telemetry)	(42)	(12)
Sub Acute* (24 beds opened Jan 2010)	0	8
Rehabilitation services *	0	0
Surgical	(6)	(8)
Women's & Children	(6)	(4)
Mental Health *	0	0
Other benchmarking opportunities*	TBD	TBD
Total	<u>(71)</u>	<u>(20)</u>

Notes

1. Asterisked items were included in other areas and not specifically identified individually.
2. Costs and staffing implications are subject to change based on additional information.
3. HIP savings are aligned with PRHC Board of Directors board motion of March 23, 2010 to reach top quartile performance and balance the budget by March 2012.
4. Subject to approval of CE LHIN Board of Directors.
5. Annualized savings are based on 2009/10 costs.
6. Information is based on internal renew processes and external peer review.
7. Excludes one time costs related to restructuring and implementation.

Hospital Improvement Plan Schedules

PRHC - FINANCIAL ANNUALIZED RUN RATE 2010-2013



HIP: Twenty-Eight Interventions

1. Health and Safety: Reduce Absenteeism

Goal: To reduce absenteeism costs in every department to benchmarked levels of peer group hospitals.

Target: That by March 31, 2012, PRHC achieves \$1.4M in annualized savings by proactively managing absenteeism and improving health and safety for staff. The goal is an average of 10 days absent per full-time staff member down from the current 13 and better matching staffing levels with patient or service needs. Additionally, PRHC will continue to develop a healthy workplace program that will assist staff with managing change and facilitate staff input into their work design.

Risk Mitigation: This intervention may be impacted by staffing changes and staff members' uncertainty within the current environment impacting PRHC's workplace culture. To mitigate these risks, PRHC will be consistent in its attendance support program and continue to educate and support all managers and staff in the application of the program as well as ensuring appropriate resources and supports are in place to assist employees through the change, i.e., Employee Assistance Program.

Status: Planning Phase Underway Complete



2. Health and Safety: Reduce Reliance on Overtime

Goal: To reduce PRHC's use of overtime to benchmarked levels of peer group hospitals.

Target: That by March 31, 2012, PRHC achieves an estimated \$1M in annualized savings by more effective and efficient regular time scheduling in every department and decrease overtime. An overtime approval process has been implemented in all departments. All overtime is being tracked and monitored.

Risk Mitigation: This intervention/change may impact workload, and nurse/patient ratios. To mitigate these risks, PRHC will monitor health and safety indicators for staff, as well as quality indicators to ensure patient needs are being met.

Status: Planning Phase Underway Complete

3. Health and Safety: Decrease Lost Time (LTI) Incidents

Goal: To improve PRHC's staff LTI rates.

Target: That by March 2012, PRHC achieves \$500K in annualized savings by decreasing the WSIB "NEER index" score to 1 (average for health care organizations) and no longer incurs a penalty. PRHC has had steady improvement in the NEER INDEX over the past year. Although well underway, safe work practices will continue to be developed for all areas. Monthly safety reports will be circulated to all leaders to ensure PRHC is improving on its culture of safety. Comprehensive health and safety inspections will be done by JHSC as well as Senior Team.

Risk Mitigation: This intervention may be impacted by staffing role changes. To mitigate these risks, PRHC will provide training, orientation to new roles and ongoing support.

Status: Planning Phase Underway Complete



4. Revenue Enhancements: Preferred Accommodations

Goal: To improve the capture and recovery of revenues.

Target: That by March 2012, PRHC achieves \$640k in annualized revenue improvements by changing processes to better capture and recover revenues.

Patients will be placed in the appropriate accommodation as per their request at the time of admission to reduce any unnecessary patient moves. Should patients be moved to preferred accommodations to meet the hospital's operational needs, no additional cost would be incurred by the patient. Staff will be available to our patients to answer questions about the costs of each type of accommodation. PRHC's billing processes will be improved to capture all charges not covered by personal insurance coverage or OHIP. Revenue is based on estimate of 4 additional beds per day. PRHC will also optimize business opportunities to increase non-Ministry of Health revenues in outpatient service areas and uninsured services.

Risk Mitigation:

This intervention requires patients to be aware of their personal insurance accommodation coverage when advising the hospital of their preferred type of accommodation. To mitigate these risks, PRHC will work with patients and families to provide a better understanding of costs as requested.

Status: Planning Phase Underway Complete

5. Revenue Enhancements: Parking Fees

Goal: To maximize revenues through parking rates.

Target: That by March 31 2012, PRHC achieves annualized revenue improvements of \$390K by setting parking rates at benchmarked levels for peer group hospitals (done in January 2010).

Risk Mitigation: This intervention does impact public satisfaction and reflects the ongoing upgrades to our parking facilities and exterior security. To mitigate these risks, PRHC will continue to explain its need to recover revenues through this method, and that it offsets related expenses, i.e., security, parking attendants, snow removal etc., and protects more dollars for patient care purposes. There is some additional risk that clients may choose other service providers because of our perceived parking costs, i.e., outpatient diagnostic imaging clients.

Status: Planning Phase Underway Complete



6. Medical Fee Remuneration

Goal: To shift the remuneration structure to be inline with benchmarks and current patient care needs.

Target: That by March 31, 2012, PRHC achieves \$1.6M in annualized savings through new physician remuneration models. Multiple strategies will be in play including, but not limited to, enhanced recoveries of physician billings and standardized contracts with clearly described physician accountabilities within the new programmatic structure.

Risk Mitigation: This change may impact physician engagement. PRHC will work with medical staff leadership to ensure mutually agreeable outcomes.

Status: Planning Phase Underway Complete

7. Environmental Services: Improve Efficiencies

Goal: To gain improved efficiencies in housekeeping and building services through achieving benchmark targets while maintaining high standards and recognizing its essential role in high quality care.

Target: That by March 31, 2012, PRHC achieves \$590K in annualized savings through process improvements, optimized scheduling practices and an evaluation of full time and part time staffing ratios. Work plans will be reviewed throughout the hospital. There will be a reduction in staff by implementing process changes. Service level agreements will be established with internal clients. Staffing levels will move to be in line with activity/volume within the hospital.

Planning has begun with the review of all work routines to ensure that cleaning activities are harmonized with the various activities of the internal hospital client groups. Audit processes are being established to monitor compliance to environmental standards.

Risk Mitigation: This intervention/change may impact staff satisfaction. To mitigate these risks, PRHC will work with staff to ensure that positive work environment is maintained and the level of cleanliness of the health centre is maintained.

Status: Planning Phase Underway Complete



8. Nutrition Services: Improve Efficiencies

Goal: To gain improved efficiencies in nutrition services through achieving benchmark targets.

Target: That by March 31, 2012, PRHC achieves \$450K in annualized savings through process improvements, review of staffing and scheduling practice.

Nutrition Services Department requested an external review of its department in an effort to find operational efficiencies and strategies for cost reduction. The review involved coordinators of the department and the Director. Areas reviewed included: information systems, storage of food, tray line set up, menu-costs, dish room staffing, delivery of meals to patients, ward stocks, outpatient activity, an organizational review including department structure, training, staffing, and workload assessment. Meaningful process redesign opportunities and actions

were identified and the strategies will be implemented through a phased approach so that targeted savings in Nutrition Services can be achieved by March 2012.

Risk Mitigation: This intervention/change may impact staff satisfaction in the short term. To mitigate these risks, PRHC will work with staff to ensure a positive work environment is maintained.

Status: Planning Phase Underway Complete



9. Management & Non-Union Restructuring

Goal: To bring inline PRHC's management structure with benchmarked hospitals and build a new organization design that is programmatic.

Target: In May 2010, PRHC announced a new organizational structure, eliminating 20 non-union/management positions, achieving an annualized cost savings of \$1.56M.

(For further information, see previous section "Organizational Design: A New Design for a New Steady State".)

Risk Mitigation: With increased spans of control (approx 100 direct reports) this change may negatively impact managers' ability to be effective. PRHC will monitor via performance appraisals, sick time and turnover and will support this change through increased education and new-manager orientation.

Status: Planning Phase Underway Complete



10. Supply Chain Costs

Goal: To reduce supply costs across the hospital.

Target: That by March 31, 2012, PRHC achieves \$1.06M in annualized savings through contract efficiency gains and leveraged purchasing power, waste reduction and cost control.

There are a number of initiatives and strategies related to purchasing goods and services that have occurred in the past and will also be part of the HIP. These initiatives include:

- **Staffing in Supply Chain (\$200K)**
Continued participation in a regional supply chain initiative known as COHPA (Central Ontario Healthcare Procurement Alliance). Savings include reduced operating expenditures related to our internal supply chain.
- **Group Purchasing (\$185K)**
Continued participation in group purchasing and supply chain efforts with Group Purchasing Organizations (GPOs) such as St. Joseph's Buying Group, HealthPRO and COHPA to leverage economies of scale for the purchases of common goods and services as well as capital equipment.
- **Contract Savings (\$144K)**
Long term contracts for goods and services are negotiated with suppliers to leverage discounts over multiple years.
- **Logistics and Inventory Control (\$522K)**
Best practices initiatives include leveraging Logistics and Inventory Control. This includes our JUST-IN-Time (JIT/Stockless) program, utilizing video conferencing and web meeting technologies to minimize travel expenses for attending meetings and educational workshops, and Green/Energy Management plan.

Risk Mitigation: This intervention/change may impact product quality. To mitigate these risks, PRHC will follow robust internal product quality guidelines and clinical evaluative tools and processes.

Status: Planning Process Underway Complete



11. Site Consolidation: Nicholls Building and WHCC Downtown

Goal: To consolidate two external sites into existing PRHC facility and maintain current services.

Target: That by March 31, 2012, PRHC achieves annualized savings of \$190K through a single site for its services by moving programs and services into the main hospital building, and divesting of obligations of old infrastructure and associated overhead costs.

WHCC Site Consolidation

The Women's Health Care Centre (WHCC) on Charlotte Street will end its lease in 2010. Savings will be realized through elimination of rent and overhead costs for the downtown site. The plan is to move staff, supplies and equipment to the main hospital site.

The programs that will come to the main site include Adult Sexual Assault and Domestic Violence (SADV), Pediatric Sexual Assault, Eating Disorders and Unplanned Pregnancies. Other programs/patient groups that are currently seen at the clinic include the Well Woman Program, Pregnancy Testing, Health Education Program, Counseling for Post-Natal Mood Disorders, Resource/Lending Library and Drop-In Client Care and Counseling for marginalized women.

Nicholls Site Consolidation

Building upon earlier work done by the Board on the future of the Nicholls building, and taking into account the Peer Review recommendation of site consolidation, PRHC will move the final remaining Mental Health outpatient programs to the main building and demolish the former site.

Risk Mitigation: WHCC: This intervention may create primary care gaps of service for some women unable to travel out of the downtown core for service. To mitigate these risks, PRHC will work with our community partners to ensure gaps are properly identified, that the WHCC philosophy and culture is maintained in the hospital, and the care needs of women are addressed in a collaborative way. The Centre is a valuable service for its clients and PRHC intends to organize delivery of these services in a more cost effective manner, and/or offer services that are better inline with the acute care mandate of a hospital.

Nicholls: Risks include attaining one time decommissioning funding from other sources, relocating programs and modifying space designed for other clinical use.

Status: Planning Phase Underway Complete



12. Clinical Efficiencies: Critical Care

Goal: To improve Medical Constant Care (MCC) and the Intensive Care Unit (ICU) efficiencies and patient volumes through bed consolidation and maximizing existing physician human resources.

Target: That by March 2012, PRHC achieves \$800K in annualized savings. There are two different initiatives in this intervention. The first is the closing of 4 MCC beds and the moving of the remaining 4 MCC beds into the ICU. The rationale for this change is based on utilization data which shows in that in the past 5 months there has not been the need for 8 MCC beds open, but rather only 4 were needed. The annualized savings is \$500K.

The second initiative is staffing efficiencies associated with improving the critical care schedule. Annualized savings is \$300k.

Risk Mitigation: This intervention/change may impact patient flow. To mitigate these risks, PRHC will work with physicians to ensure optimal utilization and maintenance of high quality patient care.

Status: Planning Phase Underway Complete



13. Clinical Efficiencies: Medicine (includes Telemetry)

Goal: To implement an effective and reliable utilization management program to reduce length of stay (LOS) and improve patient flow throughout each patient's stay in hospital. In collaboration with our community partners (e.g. CCAC, Hospice Peterborough, LTCH and retirement homes) we will also improve transitions of care for our patients. Cost savings will be achieved through benchmarking (LOS and staffing) at the top 25th percentile and maintaining an appropriate skill mix.

Targets: That by March 31, 2012, PRHC achieves \$3.8M in annualized savings through relocation of medical beds to improve efficiency, reduction in LOS, improved patient flow throughout the system, and changes in staff skill mix. Five medical units will be consolidated into four, each 24-32 bed unit having a

specialized area of clinical focus (cardiology, nephrology, stroke & palliative); Overall 12 beds within the medical program will be closed.

Utilization Initiatives to Support 25th Percentile LOS Goal:

- Interdisciplinary bullet rounds on each unit
- “Home First” approach to discharge planning starting in the Emergency Department and working collaboratively with our community partners, coordinated by Discharge Planners
- Pursue discharges by 1100h
- Development and implementation of Care Maps based on best practice guidelines for top CMGs
- Review/Revise and implement Open Sources Order Sets for top CMGs that will standardize diagnostic tests, treatments and other care; these will be based on best practice to ensure quality patient care is being delivered.
- Clearly define admission criteria in Palliative Care
- Clearly define indications for a patient to be started on telemetry
- Reliably establish, post, and communicate with patient/family of an Expected Date of Discharge (EDD) for each patient on admission

Staff Efficiencies

- A reduction from utilization improvements and closing 12 beds.
- Staff scheduling efficiencies in palliative care
- Medicine/Stroke (B4): staff scheduling efficiency
- Medicine/Cardiology (A4): change in skill mix from an all RN unit to RN/RPN mix
- Transfer of 24 medical beds to open ALC unit in January 2010 in sub acute.

Clinical Improvements

- Support for a 5th gastroenterologist will be added.

Risk Mitigation: This intervention may impact readmission rates and ED wait times for admitted patients in the short term until LOS changes occur. To mitigate these risks in the short term, during the transition period bed numbers will fluctuate to meet demand until all initiatives are fully implemented so PRHC will be available to reduce/maintain ED wait times for admitted patients. PRHC will continuously monitor quality indicators and patient satisfaction survey results to ensure quality of care is maintained.

Status: Planning Phase Underway Complete



14. Clinical Efficiencies: Sub-acute Care

Goal: To consolidate and cluster similar patients based on needs and provide appropriate staffing to meet patient needs.

Target: That by March 31, 2012, PRHC will seek support for \$477K to cluster sub-acute patients to a make a 32 bed unit, through transitional care, slow stream and convalescent care initiatives. This includes opening 7 new ILTC-funded beds; C3 unit opened January 2010.

Savings and support sought across sub-acute care are detailed as follows:

Additional costs/savings or New Revenue Stream	
*ALC C3 - New staff hired (Jan 2010)	(938)
*Increase beds C3 - new staff mix	(296)
Planned for 2010	
C2 - skill mix change	107
ILTC New funding	373
Slow stream rehab new funding	278
Total	(477)

*Savings associated with closing medical beds are recognized under initiative #B

Risk Mitigation: This change reflects the current state of bed requirements at PRHC, reducing the number of acute medical beds. It should in no way impact the hospital's acute care, regional mandate. To mitigate these risks, PRHC will ensure it works with the CELHIN to ensure our community has appropriate level of supports to meet ongoing ALC needs.

Status: Planning Phase Underway Complete



15. Clinical Efficiencies: Rehabilitation Services

Goal: To ensure that Rehab Services are inline with benchmark peer group hospitals.

Target: That by March 31, 2012, PRHC achieves \$730K in annualized savings by having the right professional provide the right care for the patient. Through skill mix changes - decreasing nursing care and increasing rehab care - capacity will increase to 7 day per week coverage.

Rehabilitation services that include high tolerance short duration rehabilitation is largely based on a multidisciplinary approach that includes nursing with allied professionals like physiotherapists, occupational therapists, speech language pathologists, as well as Occupations Therapy Assistants (OTA) and Physiotherapy Assistants (PTA), amongst others. Internal consultation with stakeholders as part of Renew¹⁰ identified the need to:

- Build on current movement based on functional gain;
- Rehab to CCC (slow stream);
- Changes in nurse patient ratios from 1:4 to 1:6 on A2 (inpatient rehab), opening full compliment of 30 beds and adding in rehab therapy services;
- Need to ensure weekend rehab therapies;
- Need to hire dual trained / multi skilled staff OTA/PTA
- Ensure staffing of Rehabilitation Services is at the top 25th percentile.

The model of care within Sub Acute Care will ensure system access and smooth transitions across the continuum of care specific to managing the ALC patient flow out of the acute care hospital setting to an appropriate level of care in collaboration with various referral destinations (e.g. home with community services, supportive housing, rehabilitation, complex continuing care, mental health, long-term care home) to reduce the average length of stay.

Risk Mitigation: This intervention/change may affect staff engagement but is positive for patient care. To mitigate these risks, PRHC will work with staff to ensure a positive transition.

Status: Planning Phase Underway Complete



¹⁰ Continuing Care Renew/ Redesign Working Group Recommendation December 4 2009

16. Clinical Efficiencies: Surgical

Goal: To implement efficiencies in staff scheduling and work processes and restrict admissions to the surgical unit to surgical patients only (ensuring that medical patients are admitted to a medical unit.)

Target: That by March 31, 2012, PRHC achieves \$1.45M in annualized savings by improving efficiencies and restricting surgical beds for surgical patients.

Operating Room (OR) Efficiencies

- Realignment of scheduling, based on utilization of OR session time
- Transfer of Thoracic service resulted in staffing and supply cost reductions

Surgical Out Patients/Endoscopy/PACU (recovery room)

- Utilizing RPN's at their full scope of practice
- One less RN assignment one day per week in cataract surgery
- Realigned staff start and stop times, achieve the elimination of one float nurse position

Sterile Processing Department

- Reduction of aide positions based on the realignment of the new OR schedule and gained efficiencies by changing and balancing start and end time of shifts, and due to the install of the Macerator systems.

A5/B5 Inpatient units:

- Restrict admissions to the surgical units to surgical patients only.
- Transferring 8 surgical beds to medicine transition beds

Staff Scheduling

- Reduce surgical in-patient staffing during the OR closures, i.e., Christmas, March break and summer slowdowns. When the surgical units become restricted it will align the OR schedule and staffing with the surgical units' staffing resulting in efficiencies and savings.
 - Close 32 beds at Christmas and March break shut down
 - Close 16 beds during the 4 week slowdown in the summer
- A reduction of clerical staff supporting the above initiatives. This was achieved through efficiencies in the chart prep area, inpatient scheduling efficiencies due to the OR closures, educator, and clerical support.

Risk Mitigation: This intervention/change may impact patient flow in medicine and ICU during times of surge. To mitigate these risks, PRHC will drive down length of stay and improve flow.

Status: Planning Phase Underway Complete



17. Clinical Efficiencies: Women’s and Children

Goal: To find efficiencies in Women’s and Children areas to ensure benchmarks are met against peer hospitals and to restrict admission to the unit to only appropriate patients (ensuring that medical patients are admitted to a medical unit.)

Target: That by March 31, 2012, PRHC achieves \$710K in annualized savings through skill mix changes using RPNs, closing 4 beds and moving to more tightly managed admissions to the Women’s and Children units. Cross training nursing from Labour & Delivery (L&D) with Special Care Nursery (SCN) and post partum to better meet the needs of our patients to better meet the fluctuation in patient volumes.

Cross training of staff has commenced in the Birthing Suite, SCN and Post Partum areas in order to decrease overtime and improve patient safety. Staff RNs currently share skills and knowledge related to the care of the woman in labor, following birth and the care of the newborn. Expanding on this shared knowledge will allow for more scheduling flexibility and better coverage during peak times and during fluctuations in patient volumes.

A6 is currently a 33 bed unit that supports L&D, SCN, Post Partum, Gynecological Surgery and Pediatric patients. This area will decrease by 4 beds to become a 29 bed unit. Admission to the beds in the Women’s and Children’s area will be exclusive to the Obstetricians, Family Physicians, Midwives and Pediatricians, providing a safer environment for our clients. Associated staff reductions will occur.

Risk Mitigation: This intervention/change may impact staff satisfaction. To mitigate these risks, PRHC will work on positive employee relations and provide education and training to support changes.

Status Planning Phase Underway Complete



18. Clinical Efficiencies: Mental Health

Goal: To ensure that Mental Health costs are inline with benchmark peer group hospitals.

Target: That by March 31, 2012, PRHC achieves \$80K in annualized savings by having the right professional provide the right care for the patient.

Renew initiatives in Mental health with respect to skill mix change have been taking place prior to the HIP. Some of these initiatives include:

- Staffing by census
- Use of RN and RPN resources in Psychiatric Intensive Care Unit (PICU)

However peer review comparisons and benchmarking exercises did demonstrate higher costs in comparison to the 25th percentile.

The changes to the FTEs, increased occupancy rates, and maintenance of targeted length of stays in inpatients will ensure that average inpatient costs within mental health are closer to the benchmark.

Risk Mitigation: This intervention/change may impact staff engagement. To mitigate these risks, PRHC will work with staff to ensure a positive transition.

Status: Planning Phase Underway Completed



19. Reduce Use of Diagnostic Tests

Goal: To optimize the ordering of PRHC's lab, diagnostic and other inpatient tests.

Target: That by March 31, 2012, PRHC achieves \$800K in annualized savings through a reduction in inpatient diagnostics to best practice; and shifting some diagnostics to be done on an outpatient basis.

PRHC currently subscribes to Open Source Order Set (OSOS). OSOS incorporates the most recent, evidence-based best practices from content experts across the country. This leads to standardizing and improved quality of care. With OSOS and links to care maps, there is improved compliance with evidence-based practices, which leads to improved patient outcomes and reduced lengths of stay, mortality, and hospital visits.

Risk Mitigation: This intervention/change may require a change in physician order practice. To mitigate these risks, PRHC will work with physicians and staff using standardized physician order sets to ensure best practice to maintain or improve quality care.

Status: Planning Phase Underway Complete



20. Clinical Efficiencies: Emergency Department Staff Scheduling

Goal: To improve staff scheduling in the Emergency Department.

Target: That by March 31, 2012, PRHC achieves \$600K in annualized savings through staff scheduling and by better matching patient volumes with staffing levels.

To support staff work-life balance a mix of 12 hour and 8 hours schedules were developed to meet staff needs. While the schedules met the needs of the staff, they were inefficient in their design.

A review of patient flow within the ED made it clear that the staffing schedule needed to be revised. The revisions will increase efficiency and match peak periods when the patients present to the ED. The smoothing of the schedules will result in a decrease use of overtime and improve patient and staff satisfaction. These changes will not impact the quality of patient care.

Risk Mitigation: This intervention/change may impact staff satisfaction. To mitigate these risks, PRHC will provide support during the transition.

Status: Planning Phase Underway Complete



21. Clinical Efficiencies: Dialysis

Goal: To find efficiencies in Dialysis to ensure staffing benchmarks are inline with peer hospitals.

Target: That by March 31, 2012, PRHC achieves \$640K in annualized cost savings through skill mix changes using RPNs and other initiatives.

PRHC currently has an all RN staff in our renal clinics and hemodialysis areas. Our patients receive excellent, safe care from these RNs. However, there is evidence to support a more cost effective staffing mix which includes the RPN in the dialysis unit. Many hemodialysis units across Canada have adopted such a skill mix and have maintained an excellent patient safety record. In fact, PRHC is one of very few dialysis units in Ontario that does not employ RPNs.

The gradual introduction of RPNs into the skill mix of the hemodialysis suite will commence in the summer of 2010. A projected mix of 70:30 (RN:RPN) will be completed during 2010-2011¹¹.

By promoting efficiencies in the Renal Insufficiency (RI) and Peritoneal Dialysis (PD) clinics savings and improved utilization will be realized. We have looked at standardized nurse: patient ratios for both areas and will remain within provincial guidelines. Reorganizing the scheduling of the clinics will allow for a reduction of staff in the RI Clinic area and in the PD Clinic area.

During 2011-2012 we plan to introduce a small number of “Self Hemodialysis” patients to the client mix at PRHC. This type of client group completes their own dialysis – including preparations, time on the machine and removing themselves safely from the machine. The Dialysis Assistant’s support is not required for machine prep or cleaning with this type of client group. Once this patient group is trained and functional, we will downsize our Dialysis Assistant group.

Risk Mitigation: This intervention/change may impact staff satisfaction. To mitigate these risks, PRHC will work on positive employee relations and provide education and training to support changes.

Status: Planning Phase Underway Complete



¹¹ Florence, E, MacPhee, S, Pritchard, L, (2007). Introduction of RPNs/LPNs into hemodialysis units: experiences in three units across Canada. CANNT Journal

22. Clinical Efficiencies: Diagnostic Imaging

Goal: To find efficiencies in Diagnostic Imaging to ensure staffing benchmarks are inline with peer hospitals.

Target: Through benchmarking and comparing examination volumes and staffing in the various modalities (excluding CT, Ultrasound, General Radiology, Nuclear Medicine etc.) efficiencies were identified. These efficiencies resulted in the following: a reduction of FTEs, patient scheduling was adjusted to allow for additional outpatient bookings to increase revenues through technical fees, WTIS funding was approved for additional incremental hours in CT and decreased in MRI over the previous year. As a result of these Renew initiatives; \$900K of annualized savings will be achieved. One of the D.I. peer review initiatives identified was to reduce FTEs to meet existing funded hours in CT for a savings of \$80K. At the current hours of operation in CT, PRHC has approximately 520 patients waiting up to 40 days for a CT scan which exceeds the provincial wait time target of 28 days.

Risk Mitigation: Reduced CT staffing hours to match our current funded operational hours would result in an increase wait time of 30 days based on current referral patterns. To mitigate again this increase, PRHC will seek support to maintain or improve current wait times for our patients.

Status: Planning Phase Underway Complete



23. Clinical Efficiencies: Pharmacy

Goal: To improve the utilization of PRHC's pharmacy resources.

Target: That by March 31, 2012, PRHC achieves \$300K in annualized savings through drug utilization. The following are proposed initiatives to achieve these savings.

Drug Formulary Review: Stream-lining the medications in the existing formulary and the medication prescription practices by physicians will result in drug costs savings to the organization. The formulary review will be done through a Formulary Review Working Group which will report to the Pharmacy and Therapeutics Committee. This group will have representation from all clinical areas with strong physician involvement.

Inventory Review: A review will be conducted of processes relating to the existing drug inventory. Stream-lining the inventory processes will target results in optimizing drug procurement costs to the organization. This work has already been initiated by the pharmacy department staff.

Risk Mitigation: This intervention/change may require a change in physician order practice. To mitigate these risks, PRHC will work with physicians and staff using standardized order sets and the formulary to ensure best practice to maintain and/or improve quality care.

Status: Planning Phase Underway Complete



24. Clinical Efficiencies: Laboratory Medicine

Goal: To ensure optimal utilization benchmarks are inline with peer hospitals.

Target: That by March 31, 2012, PRHC achieves \$830K in annualized savings through contract and staffing efficiencies.

To support staff work life balance, schedules were developed to meet staff needs. The schedules were inefficient in their design, which resulted in increased FTEs. The smoothing of the schedules will result in a decrease in FTEs and improve staff satisfaction. Optimizing skill mix changes to enable staff to work to their full scope of practice and ensure the right tasks are being done by the right people, e.g., technologist/technician ratios will result in efficiencies.

LEAN principles have been incorporated into the redesign of Laboratory work patterns thus reducing batching and waste. The electronic Laboratory Information System provides health information online to reduce delays, errors, test duplication, and financial and environmental costs.

The changes to the schedule will result in \$600K in annual savings. Procurement Alliance (COHPA) has been able to achieve cost reduction on reagent and supply contracts resulting in \$230K in annual savings.

Risk Mitigation: This intervention may impact turnaround time. To mitigate this risk, PRHC will work with physicians and staff is to ensure performance targets and quality standards are met.

Status: Planning Phase Underway Completed



25. Clinical Efficiencies: Ambulatory

Goal: To find efficiencies in medical outpatient and other outpatient care areas to ensure staffing benchmarks are inline with peer hospitals.

Target: That by March 31, 2012, PRHC achieves \$770K in annualized savings through efficiencies in staffing and operations.

These clinics include Medical Outpatients (MOP), Neuro and Breathing Clinics, the Breast Assessment Clinic and Diabetes Education (DEC).

A plan to introduce a different staffing mix that includes RPNs in the MOP clinic is in development. Such a staffing mix is more cost effective. The varied nursing skills necessary in MOP are within the scope of practice of RPNs working at full scope of practice. There will be a reduction of some part time RN staff due to this staffing mix change.

In the Neuro and Breathing Clinics there are planned reductions of staff as reductions in services are required. Some services currently provided in the Neuro and Breathing Clinics are available within our community; it is the intention to discontinue offering the Sleep Lab service for this reason.

The Breast Assessment Centre currently utilizes RN examiners who provide examinations and education to many patients having routine mammography. This model has not been proven to be clinically effective as a detection modality in studies done through other breast assessment sites in Ontario. We plan to eliminate these positions to align with other assessment centre models.

Risk Mitigation: This intervention may impact access to care. Whenever possible, PRHC will provide those specific services that are not otherwise available to our clients in the community and/or necessary to be provided in an acute care setting.

Status: Planning Phase Underway Complete



26. Clinical Efficiencies: Other Support Areas

Goal: To provide the right level of service support to the patient care areas of hospital.

Target: That by March 2012, PRHC achieves \$380k in annualized savings through benchmarking with other hospitals. Services in each of these areas were reviewed and actions have been taken to reduce support staff where necessary. This will be done in conjunction with the initiative to set up the centralized staff scheduling office to ensure all areas of the hospital are appropriately staffed in a cost effective manner. Support areas reviewed include Finance, Admitting & Health Records, Transport team, Parking & Security.

Risk Mitigation: This intervention/change may impact staff satisfaction. To mitigate these risks, PRHC will require change management planning and support.

Status: Planning Phase Underway Complete



27. 2010/11 Ministry of Health Funding increase - \$2.6M

Ministry of Health and Long Term Care funding for fiscal year 2010/11 has been estimated at a 1.47% increase to PRHC's base totaling \$2.6M. Funding increases for fiscal 2011/12 have not been included as they are unknown at this time. Any additional funding for new initiatives supporting the clinical service plan (CSP) over the next 24 months would be determined outside of the hospital improvement plan.



28. Other benchmarking opportunities - \$2.73M

Based on benchmarking with hospitals in PRHC's peer group, further savings will be pursued from improvements in utilization, i.e., reducing LOS so that, within the next 12 months, PRHC can staff to reduced occupancy or increase patient volumes in helping with realizing PRHC's Post-construction Operating Plan (PCOP) targets and associated revenues.

Peer Review – Unused Alternatives

As mentioned, within these 28 strategies to achieve the required \$27M in savings, there was some congruency between the Peer Review and PRHC's own HIP. However, there was a divergence in strategy in one key area. The Peer Review called for bed closures in critical care and medicine. While PRHC is consolidating and optimizing utilization, our focus in achieving the savings will be on improving our actual cost per weighted case to move closer to or equal the expected cost per weighted case. Over time, as our performance improves, the ability then exists for PRHC to improve throughput and increase volumes to recognize PCOP revenue, or, to then match staff to the reduced occupancy levels. The risk to PRHC's approach is that if performance on LOS does not improve, then the savings will not be realized. However, the alternative is, in the short term, of greater concern—that being to pursue the Peer Review bed closures and be sure of the savings. This direction is not being taken because without the performance gains, closing beds would mean an untenable influx of admitted patients waiting in the Emergency Department for a bed. With the cooperation and leadership of the medical staff, PRHC's approach will, over time, generate savings, provide better access to beds, and improve patient outcomes.

Moving from Plan to Results

Once PRHC's HIP is approved, it is PRHC's intention to proceed immediately with all HIP initiatives that do not have staffing implications and are within one unit/dept. All other initiatives must be coordinated centrally and be worked through with appropriate unions for a consolidated approach.

Detailed budgets and cash flows (April 1, 2010 to March 31, 2012) will be completed at that time and project charters will be developed for all initiatives. These charters will outline strategies to reach HIP target savings, timelines, milestones and final completion dates, and designated leader accountable for results.

In addition, following approval of the HIP, PRHC's H-SAA will be amended for 2010/11 by the CE LHIN in consultation with PRHC. Outcomes of our new steady state will be incorporated into future accountability agreement planning.

PRHC's new Project Management Office and Program Decision Support Team will provide results against HIP targets monthly to PRHC's leadership and Board. These results will be publically available. These results will include:

- HIP performance (financial and statistical)
- Utilization Management (LOS, CMG)

Finally, monthly variance reports with analysis and root causes analysis will be completed by Managers to ensure internal rigor. Each initiative has a project lead and they will be incorporated into key performance indicators. Gant chart reporting, sequencing of events, and both tracking success overall and for each of the initiatives, will also be added as monitoring tools.

PRHC At-a-glance: Today Versus New Steady State

While the culture at PRHC will change to one of high performance, the following chart demonstrates that the organization will **maintain or improve its core services, programs and patient volumes**.

	Today 31-Mar-10	New Steady State 31-Mar-12 Projected Estimates
Revenue	\$224M	\$230M estimate
Expenses	\$238M	\$230M estimate
Surplus/Deficit	\$(14M)	\$0M
Current Ratio	0.24	0.25
Total Margin	-6.20%	0%
Total Staff Members	2,141	2,000
Physicians	350	350
Volunteers	600	600
Number of Beds	412	392
Cost Per Weighted Case	\$5,888 (08/09)	\$5,400
Inpatient Weighted Cases	20,935	Same or greater
Day Surgery Weighted Cases	3,422	Same or greater
Ambulatory Clinic Visits	95,115	Same or greater
Emergency Dept. Visits	70,255	Same or greater
Laboratory Tests/Procedures	2,042,877	Same
Diagnostic Imaging Exams	120,446	Same or greater
Births	1,477	Same

Community Consultations

Since PRHC's new CEO's arrival in February 2010, he has been on a concerted outreach circuit to set the stage for the recovery, speaking to more than 15 different municipal councils, service clubs, and community groups across the region and giving dozens of local media interviews and editorial board meetings. The message delivered on PRHC's fiscal situation and its pressing need to change, improve performance, and find a new steady state, has been consistent.

In preparing the HIP, in accordance with the Local Health System Integration Act, and the obligation therein for hospitals as LHIN funded health service providers to, "engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services," PRHC presented a working draft of its HIP via internal hospital forums for stakeholders, as well as at open public forums to inform and consult with its publics on the strategy and details of its plan.

Internal Stakeholder Engagement: HIP

A working draft of the HIP, presented by the CEO, was presented at a series of internal consultation sessions with key stakeholder groups including staff, union leaders, doctors, community and provider partners and volunteers. Feedback was incorporated from these sessions before the general public consultations. The following is a record of these sessions:

Session	# Attendees	Date
All Staff – President's Forum	500+	May 21 May 26 June 4
FAC & Renew Leadership (unions reps, front line reps on Renew steering committee)	25	May 21
PRHC Foundation Board	15	May 21
MAC (physicians, Chiefs of Depts.)	10	May 25
PRHC Board & Stewardship Committee	15	May 26
Corporate Members	12	May 27
Leadership Forum (management)	60	May 27
IOC (Admin and Medical Directors, Snr team)	18	May 27
PRHC volunteers	20	May 27
Community partners/providers and other hospitals	15	May 28

General Public Consultation Sessions

CEO Ken Tremblay, along with members of the hospital's Board of Directors, presented a working draft of its Hospital Improvement Plan (HIP) at public information sessions the week of May 31. The sessions included a detailed presentation and a question and answer discussion. This presentation was posted on the home page of PRHC's website for a further two weeks for those unable to attend in person.

The public was informed at each of the sessions, and through the news media¹², that the purpose of the sessions was three fold:

1. To ensure that the community hears firsthand that PRHC's current state is unsustainable;
2. That there is good understanding who had input into the HIP, and there is recognition that those who did are both committed to, and charged with, executing it once approved;
3. To ensure that nothing was overlooked and that all good ideas and initiatives have been heard and included.

Seven formal community consultation sessions were scheduled and conducted.

Session	# Attendees	Date
Open Session 1, at PRHC 5:30 pm	25	May 31
Open Session 2, at PRHC 7:00 pm	15	May 31
Open Session 3, Millbrook, 5:00 pm	7	June 1
Open Session 4, at Lakefield 5:30 pm	15	June 2
Open Session 5, at Lakefield 7:00 pm	3	June 2
Open Session 6, at PRHC 5:30 pm	11	June 4
Open Session 7, at PRHC 7:00 pm	7	June 4
Total	83	

Each of the sessions were 90 minutes in length and consisted of an introduction and welcome by a PRHC Board member, and a 60 minute slide presentation by CEO, Ken Tremblay. A 30 minute Q&A followed that focused, initially, on answering three prepared questions:

1. Now that you are familiar with the Hospital Improvement Planning process, are there any opportunities we may have missed?
2. Are there any risks and mitigating strategies you feel should be addressed?
3. As PRHC embarks on its Hospital Improvement Plan, what programs or services do you believe are most important for us to protect, or invest in going forward?

¹² Press release:

<http://www.prhc.on.ca/Press%20Releases/Press%20release%20Public%20%20consultations%20on%20HIP.pdf>



Lakefield Herald front page following community session



CEO Ken Tremblay at Community session in Millbrook



Open Forum for Staff, volunteers and Physicians

Summary of Community Consultations

PRHC was pleased by the lively questions and, on one or two occasions, spirited debate brought to the sessions by members of the public. Many commented both during the sessions and afterward that they were pleased to be given the opportunity to participate and hear about the plan first hand, and while still in draft form, from the CEO. This was especially true in the two regional sessions held in Lakefield and Millbrook.

The purpose of these sessions was not to conduct statistically-relevant opinion research, nor was it to develop consensus. Rather, these public sessions were held to inform and educate. PRHC makes the following observations following these sessions, and the public exposure of the plan generally:

- The questions posed and positions taken by those present at the sessions did not outright oppose the strategies taken by PRHC in its HIP, beyond a general desire to see layoffs minimized and services protected—with which the hospital agrees.
- Key health care issues on the minds of participants were long term care beds and local access and long wait times in PRHC's Emergency Department and diagnostic imaging department. Many aspects of the HIP address PRHC's role in improving results in these areas. In some cases erroneous assumptions were addressed or data or information was provided to explain clinical processes—PRHC welcomed the opportunity to educate interested members of the public on these matters.
- No single intervention was widely opposed. Nor were wholly new or innovative solutions tabled that had been overlooked by our staff in generating ideas through Renew and into the HIP. We did receive some very thoughtful feedback at the sessions however, as well as via formal written submissions and via submissions to the Board in its May meeting. Those ideas will all contribute to PRHC's future strategic planning processes (see Appendix B for a list).

- Local media attended all sessions and coverage was thorough. In our opinion, reporting was accurate and balanced. Reporters interviewed participants who freely gave opinions and often told personal health care stories. PRHC would like to thank the media for their interest in our sessions and especially for assisting to promote attendance at the sessions.
- Leading up to the sessions, between February and June, well over 200 media articles, interviews, letters and editorials have been written or aired on local media (print, TV, radio) covering the hospital's financial situation. There has been keen interest in hospital finances as a media story and the hospital has worked hard to meet all interview requests and provide as much information and documentation as possible.
- Beginning in February, 2010, CEO Ken Tremblay began a regular "blog" to communicate directly with the public. On several occasions he wrote about PRHC's financial situation, the Peer Review and the HIP¹³.
- Members of PRHC's front line staff (both current and retired) and union leaders attended some public sessions and presented their views in a respectful way.
- The Health Care Coalition held a number public sessions and rally-style events of their own at local venues to oppose the Peer Review and voice their opinions and positions. These were well covered by the media. They made a presentation to PRHC's Board of Directors, sponsored a lawn sign campaign, and tabled written submissions and responses¹⁴ (listed in Appendix B.)
- A common theme at the sessions was an expressed need for PRHC to put more emphasis on planning – both our own internal strategic and operating planning but also working with our many partners [CCAC, Family Health Teams (FHT), other hospitals in the region, health related agencies, Long Term Care facilities, retirement residences, etc., in health care in the greater community with a view to improving all aspects of health care in the region.] While these comments did not suggest any material changes needed in the HIP they did address a need for PRHC to be better integrated into the larger health care picture.

To this end, PRHC will begin its own strategic planning in the fall. This public consultation was a good learning for PRHC's planning processes and the hospital will broaden the scope of its public input process during the next planning phase.

¹³ <http://www.prhc.on.ca/Site%20Map/CEO%20Blog.aspx>

¹⁴ <http://www.web.net/ohc/june2010hospital.pdf>

Furthermore, the local FHT leadership and the local MPP, Mr. Leal, held a well-attended press conference at the hospital on May 28 announcing a commitment to do community-wide health planning. PRHC is looking forward to participating in a community-wide health system planning group being envisioned for Peterborough. For its part, PRHC would look to the CE LHIN within its new framework for community engagement for support in this initiative through its system planning mandate and to coordinate partners across the north east cluster of the CE LHIN¹⁵.

PRHC Board Deliberations

As governors for the hospital, the members of PRHC Board of Directors have ultimate accountability for this plan, and will, in turn, hold management responsible for its execution. From the Board's March 8 motion that set the framework for the development of this HIP, through the receiving of the Peer Review and the subsequent response, to the community consultations and final approval, PRHC's Board has set the direction and ensured milestones have been achieved. The Governance Committee responded with action items that addressed the eight governance-related recommendations made by the Peer Review in May. Through its Stewardship committee, the Board did its due diligence and thoroughly reviewed the Plan with management. In open session at a special meeting of the Board on June 28, the PRHC Board of directors again reviewed and considered the plan with the intent to approve its passage to the CE LHIN.

Conclusion and Next Steps

This Hospital Improvement Plan (HIP) will restore PRHC's financial position to a sustainable state by March 31, 2012. It maintains quality of care and protects the full scope of our current regional services and programs.

PRHC's HIP takes into account recommendations made by a Peer Review study, but differs in significant ways. While our plan, like the Peer Review, finds the necessary annualized savings PRHC's interventions engaged front line staff, along with physicians to collectively come up with some 2,400 cost saving and process improvement ideas. These were then distilled, evaluated and ranked. Our plan is an organic one; it is based on our internal knowledge and protects our programs and services and relies on productivity improvement rather than bed closures to deliver bottom line results *and* change to our organization's culture.

Once approved, this HIP will form the basis of PRHC's accountability agreement with the CE LHIN, or our "H-SAA". As per the Peer Review recommendations,

¹⁵ See: CE LHIN website for details on engagement structures:
www.centraleastlhin.on.ca/getinvolved.aspx?ekmensele=e2f22c9a_72_192_btnlink

increased dialogue between PRHC's Board and the CE LHIN's board will occur, improved metrics and monitoring scorecards will be developed for PRHC's Board, as well as systematic review by PRHC's Board and the CE LHIN of PRHC's progress against these HIP targets will occur.

Once our new "steady state" is reached, PRHC will be able to further our regional role. PRHC's Board of Directors and management know that getting our financial house in order is the first important step to attract and convince funders, and donors, of new and expanded investment. PRHC will deliver on this plan, making the changes necessary to address the deficit and stabilize the financial health of the organization—all the while continuing to provide the care and service expected of us. And, when our financial house is in order, the hospital will add targeted, regional services to bring more care closer to home.

Appendix A – List of Community Submissions / Responses

The following is a list of formal submissions that PRHC received. They are available for review upon request.

1. “Reply to the Peer Review: Peterborough Regional Health Centre Geriatrician’s Perspective” by Dr. Jenny Ingram, April 28.
2. “Critique and Challenge to the CE LHIN Hospital Peer Review” by Health Care Coalition, May 2010
3. Reminders from the Peterborough Health Care Coalition, via email, June 17.
4. Ontario Health Coalition Analysis of the Peterborough Hospital Peer Review & Hospital “Improvement” Plan (HIP) June 21, 2010
5. Presentation to PRHC Board of Directors (May 26) on ALC and LTC issues by John and Sharon Chapman-Sheehan
6. PRHC’s CEO Open Letter in response to the Peer Review¹⁶
7. Media: PRHC has archived copies of most Peer Review and HIP related media

¹⁶ CEO Open letter:

http://www.prhc.on.ca/Press%20Releases/Open%20Letter%20to%20the%20Community_Ken%20Tremblay%20April%202023.pdf

Appendix B - PRHC Peer Group Comparison for Benchmarking

Peer Site Hospitals

- 1 Lakeridge Health, Oshawa**
- 2 The Scarborough Hospital**
- 3 Credit Valley, Mississauga**
- 4 North York General, Toronto**
- 5 Southlake Regional, Newmarket**
- 6 Rouge Valley, Toronto**
- 7 Grand River, Kitchener**
- 8 Windsor Regional**
- 9 Halton Healthcare, Oakville**
- 10 St Joseph's, Toronto**
- 11 Toronto East General**
- 12 Peterborough Regional Health Centre**
- 13 Hotel Dieu, Windsor**
- 14 York Central, Richmond Hill**
- 15 Royal Vic, Barrie**

Appendix C – Further Background on PRHC Sub-acute Strategies

PRHC continues to face growing pressures from patients who no longer require acute level of care and hence designated as requiring alternative level of care (ALC). It is recognized that a broad-based, system-wide approach that includes consideration of all elements contributing to ALC days is required to fully manage the complexities underlying ALC issues (e.g. factors precipitating acute care admissions, availability of health resources and support services, bed capacity etc.)

ALC LOS for the past 7 months has ranged from 30.2 to 16.2 days. However acute care length of stay (LOS) has shown a decreasing trend from a high of 10.2 days in Sept 09 to low of 7.9 as of March 2010.

To build a more efficient and effective healthcare system, Alternate Level of Care options need to be addressed on a multi-sector level and in a coordinated manner. Generally, ensuring right bed capacity, and staff skill mix would help improve hospital throughput and improve outflow for patients waiting in hospital for long-term care placement or other community alternatives. There is a need to ensure system access and smooth transitions across continuum of care specific to managing the ALC patient flow out of the acute care hospital setting to an appropriate level of care in collaboration with various referral destinations (e.g. home with community services, supportive housing, rehabilitation, complex continuing care, mental health, long-term care home) to reduce the average length of stay.¹⁷

To this end, a number of initiatives have been targeted at PRHC. The changes in sub acute care are one of the multi pronged strategies to address ALC rates and pressures at PRHC at the same time resulting in operational savings. Initiatives to compliment this include:

- | | | |
|--|---------|-------------|
| • Cohorting of ALC (waiting LTC) | 24 beds | Jan 18 2010 |
| • Expanding Interim Long term Care | 7 beds | Fall 2010 |
| • ALC Cohort expan. & design. (Transitional) | 8 beds | Fall 2010 |
| • Convalescent Care (skill mix change) | | Fall 2010 |
| • Slow Stream Rehab | 10 beds | Fall 2010 |

Cohorting ALC waiting Long Term care (LTC)

Research confirms that 34-50% of hospitalized elders experience decline in their functional status between hospital admission and discharge and that muscle strength loss of 10% can occur within one week of hospitalized bed rest.¹⁸

¹⁷ Alternate Level of Care Systems Issues and Recommendations- CE LHIN ALC Task Group Report June 2008

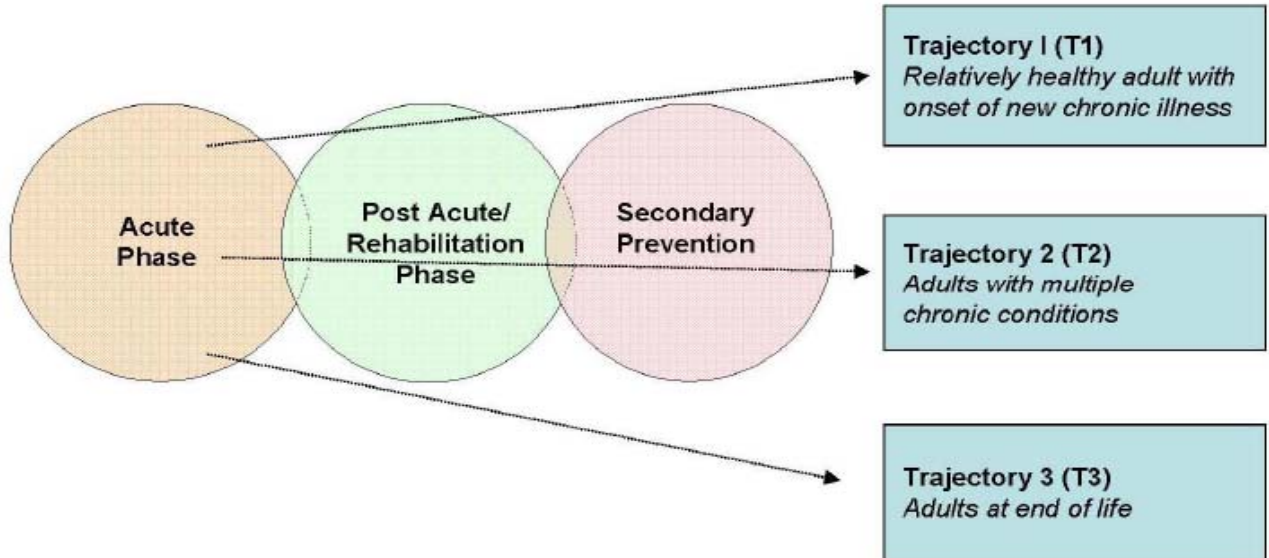
¹⁸ Graf, Carla.(2006). Functional decline in hospitalized older adults. *AJN*, Vol. 106 (No. 1), 58-67.

Literature and review of peer hospitals have also shown that the need to cohort ALC patients so that one can ensure the right skill mix to care for this population. The longer a patient remains in the hospital the more likely they will experience functional decline...thus require additional supports to return home. Patient who requires assistance or is dependent on others for self-care is at higher risk of requiring LTCH placement.¹⁹

Transitional Care

It is well recognized that patients go through varying trajectories along an episode of care. All along this process they may require care at an alternate level. There is a need to stratify hospitalized population based on needs/risks

- lower risk groups (T1) – apply proven interventions to improve “hand-offs”
- higher risk groups (T2) – apply proven interventions to enhance longer-term outcomes
- adults at end of life (T3) – facilitate transition to palliative care/hospice



Context for Transitional Care: Acute Episodes of Care²⁰

Frequently, when the acute phase of a frail older person's illness resolves, the patient is too weak to function independently and cannot be discharged from hospital. Acute care staff often lacks the ability and resources to deal adequately with these situations. A program of transitional care has been shown to fill this gap in the continuum of care by improving the functional level of frail elders and ensuring better bed utilization.²¹

¹⁹ Assessment and Coaching Team Report: Peterborough Regional Health Centre Alternate Level of Care Review and Recommendations. June 2009

²⁰ Naylor M. National Health Policy Forum, Washington, 2009

²¹ MacLeod F, Head D. Transitional care: filling the gap for older patients. Leadership Health Serv. 1994 Nov-Dec;3(6):28-32.

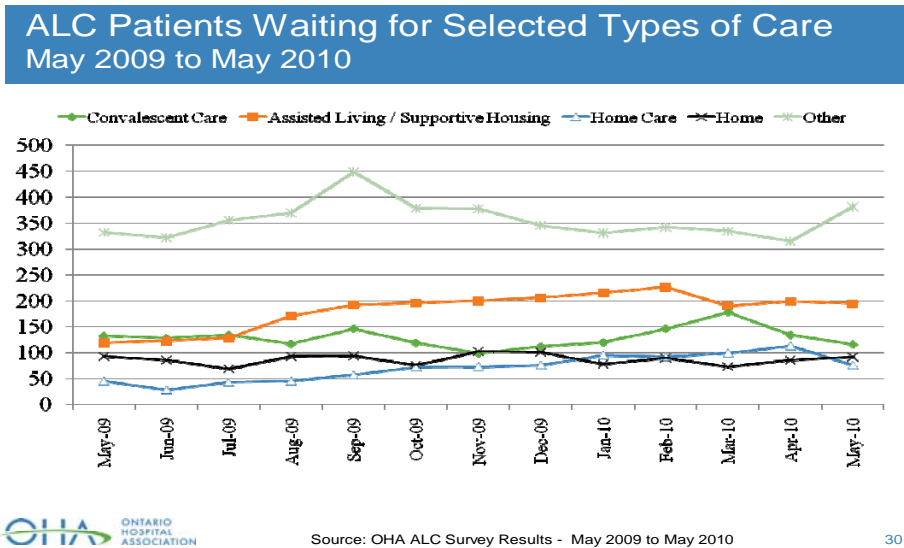
Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.²² Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.

PRHC hopes to operate a transitional care unit (TCU) that is designated for the provision of care for patients who no longer require acute inpatient services but still have medical issues and are not yet ready for discharge home and/or who are awaiting supportive placement. Therapies offered on the TCU are physiotherapy, occupational and speech language therapy. The goal of therapy is to maintain/optimize patient's current level of functioning. Exercise and dining programs will be held during the week.

Transitional care would serve patients who are medically complex and whose conditions require a hospital stay, regular onsite physical care and assessment as well as active care management from an interdisciplinary team.

Convalescent Care

Surveys of Ontario hospitals conducted by the OHA have consistently shown the need for convalescent care. ALC patients waiting for convalescent care has been relatively larger when compared to other types of care.



Source: OHA ALC Survey Results - May 2009 to May 2010

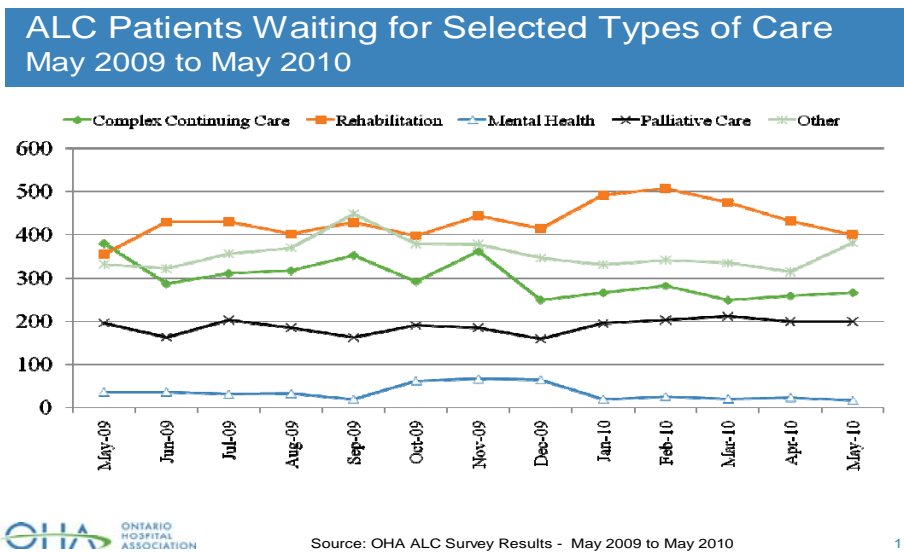
²² Coleman EA, Boulton CE on behalf of the American Geriatrics Society Health Care Systems Committee. [Improving the Quality of Transitional Care for Persons with Complex Care Needs](#). *Journal of the American Geriatrics Society*. 2003;51(4):556-557.

A goal-oriented, case-managed low intensity convalescent care service, will be provide on a short term basis to individuals who, following an acute medical or surgical episode, require a longer period of time to heal and regain their maximum functional levels in order to return home.

This program will provide:

- skilled therapy and nursing care
- 24-hour assisted living environment
- encourages increasing activity and convalescence

Slow Stream Rehabilitation (Complex Continuing Care)



Source: OHA ALC Survey Results - May 2009 to May 2010

OHA surveys determining discharge destinations of ALC patients have shown that ALC patients wait both Rehabilitation services and Complex Continuing Care. The GTA Rehab Network has also shown that the largest rehab population groups waiting in ALC as determined by primary rehab need were²³:

- Geriatric (43%)
- Stroke (16%)
- MSK (13%)
- ABI, Neurology and Cardiac (each 7%)

Length of Stay in ALC: Longest *total* ALC days were seen in descending order in the following rehab population groups:

- Geriatric (365 days)
- Stroke (79 days)

²³ ALC Survey: Mapping the way to targeted Solutions, GTA Rehab Network 2006

- Neurology (70 days)
- MSK (61 days)
- ABI (58 days)

There is a need for low tolerance long duration (LTLD) rehabilitation for these groups of patients. Patients awaiting LTLD rehabilitation often exhibit higher acuities, more complex care needs, higher resource needs, longer lengths of stay, and demonstrate slower gains in recovery. As a result, many patients in need of LTLD rehabilitation are often not accommodated by regular stream stroke rehabilitation programs. Instead, these patients are frequently discharged to long-term care facilities without a trial of rehabilitation. It is estimated that 11%-15% of stroke survivors are discharged directly to long-term care facilities. At other times, patients with more complex medical needs who are in need of LTLD stroke rehab are admitted to complex continuing care (CCC). Although *some* rehab services may be available in *some* CCC facilities, adequate funding may not be available to provide the needed level of rehabilitation. Since patients who require LTLD stroke rehabilitation are typically older, the size of this group will continue to increase as the population ages.

The lack of adequate LTLD stroke rehab services notwithstanding, research findings have shown that patients who do receive LTLD stroke rehab can make significant gains. Some patients improve to a level where they can be discharged home. Others continue to require residential care but at a reduced level of personal care support. There are also other patients who make sufficient functional gains to allow for a possible discharge home, but are unable to do so because of a lack of social support within the home environment. Nevertheless, whether patients are discharged home or require ongoing residential care following rehab, a reduction in the burden of care and improvement in quality of life are worthwhile rehab outcomes.