HPHA ENVIRONMENTAL SCAN

Executive Summary

Substantial change has occurred in Ontario affecting public hospitals. While some of the drivers of change span across a number of years, there are many new issues and priorities that need to be addressed over the next planning period. This document is intended to provide board members and other readers with a high level view of the Huron Perth Healthcare Alliance (HPHA) of who we are, who we serve and how we meet the challenges to provide excellent services.

This document is organized under the following headings

A. Who we are
    1. The Alliance
    2. Our services
    3. Redevelopment completed and future opportunities
    4. Our staff (demographics and trends)

B. Who we serve
    1. Our community profiles
    2. Disease and illness patterns & Lifestyle Factors
    3. Performance data
    4. Patient flow: ALC, conservable bed days, wait times

C. How we meet the challenges to provide excellent services
    1. Economy & government
    2. Ministry of Health and Long Term Care
    3. South West Local Health Integrated Network
    4. Technology
    5. Risk Management
    6. Accreditation Process
    7. Patient Satisfaction & Expectations
    8. Patient Flow

Table of Contents

A. Who We Are

1. The Alliance

Huron Perth Healthcare Alliance was established in 2003, bringing together four community hospitals into one organization, with one board of directors and one management structure, one operating and capital budget and information technology platform. The four hospital corporations are Clinton Public Hospital, St. Marys Memorial Hospital, Seaforth Community Hospital, and Stratford General Hospital. The Boards of Directors of the founding hospitals recognized that to appropriately respond to the many challenges facing the healthcare system, working closer together and viewing healthcare as a system rather than a standalone function within a community was required. Key issues such as funding instability, attracting and retaining the people required to provide the many and varied services offered, addressing physical infrastructure redevelopment needs, and, acquiring new technology are all better addressed in a coordinated fashion.

2. Our Services

The Alliance's four sites provide a broad range of inpatient and outpatient services to its catchment area.

The Stratford site acts as a regional referral centre for Huron and Perth offering a broad range of medical/surgical inpatient services including critical care and neo-natal intensive care, supported with internists, pediatricians and surgical specialists such as urology, general and orthopedics. The Stratford site also provides mental health, maternal child, complex continuing care and rehabilitation inpatient services.

The Clinton, Seaforth and St Marys sites offer Acute and Complex Continuing Care inpatient services and the Clinton site provides maternal child in-patient services.

All four sites also offer 24/7 emergency services and all of the associated support services such as imaging and lab.

The services at all four sites are supported with diagnostic and therapeutic programs and clinics.

Bed Type	Clinton	Seaforth	St Marys	Stratford
Med/Surg	16	8	15	53
ICU/Telemetry				16
Psychiatry				15
CCC		10	5	20
Obstetrical/Peds	1			15
Rehab				14

HPHA service volumes (all sites combined) 2010/11

- 8,430 acute inpatients
- 10,591 CCC patient days
- 4,747 rehabilitation patient days
- 4,192 mental health patient days
- 1,235 births
- 58,095 Emergency unit visits
- 27,168 physiotherapy and 11,089 occupational therapy visits
- 42,293 x ray and 11,139 CT scans

3. Redevelopment

The Stratford site recently completed a $65 million capital redevelopment project to renovate existing space and add a 75,000 square foot wing to the hospital. The renovated space was occupied in 2009 with a new intensive care unit, pediatric unit, mental health unit and three education meeting rooms. The second phase was completed in August 2010, adding a north wing that features a new central processing department, emergency department and imaging department on the first floor; the second floor included a new surgical services department with day surgery, an endoscopy suite and five operating rooms.

The Ministry of Health and Long Term Care provided 90 percent of the funding for the expansion's construction; the Alliance was responsible to fundraise for the other 10 percent for construction and 100 percent of the new equipment.

The expansion at the Stratford site will allow the site to plan for the consolidation of all services at the Stratford site into the main building for efficiency and improved patient flow.

4. Our Staff

The HPHA is one of the largest employers in the region with over 1,200 staff, upwards of 165 active physicians and approximately 265 active volunteers. The people of HPHA are highly dedicated and skilled individuals, striving to provide the best care to patients in all capacities. Regardless of an individual's role within the organization, their day to day activity has an impact on the HPHA patients and their families. Our people work together with other staff and physicians, family members, and other healthcare providers to ensure that our patients have the best experience possible during their visit.

Health care within HPHA is delivered by a variety of health care professionals, support staff, volunteers, and administrators:

HPHA: Working for You	2010
Physicians, Dentists and Midwives	165
Nurses	511
Professional/Technical Staff	191
Clerical Staff	163
Service and Support Staff	260
Management and Non Union Staff	81
Active Volunteers	265

The majority of the Huron Perth Healthcare Alliance staff are represented by the following unions:

- Canadian Union of Public Employees (CUPE) representing Service and Clerical Staff
- Ontario Public Service Employees Union (OPSEU) representing Professional and Technical Staff
- Ontario Nurses Association (ONA) representing Registered Nursing Staff.

Overall, approximately 50% of our staff are full time – although, our ratio of full time to part time registered nurses consistently weighs in at over 70% full time to 30% part time staff.

At the close of 2010 staff distribution across the four Alliance sites was as follows:

- Clinton Public Hospital 101
- St. Marys Memorial Hospital 96
- Seaforth Community Hospital 76
- Stratford General Hospital 890

At present, approximately 163 HPHA staff members are over the age of 55 and as such, are eligible to retire. There have been approximately 114 retirements in the last five years, averaging about 23 retirements per year. Conversely, the Alliance currently employs approximately 119 staff members who are under the age of 30 and are just beginning their HPHA journey.

Canada is experiencing a healthcare professional shortage that moves beyond nurses and physicians and extends to other regulated healthcare professionals. Lack of funding and an abundance of healthcare restructuring have placed greater strains on both employee and employer and there is greater competition to attract talent and become a workplace of choice. The rural setting of the Huron Perth Healthcare Alliance can act as both an attraction and a deterrent for prospective new hires. It is our job to identify a recruitment and retention plan that maximizes our strengths and deals with our shortcomings wherever possible. It is clear that innovation and creative thinking will be required to combat the current and projected future staffing shortages. Over the past five years, the Alliance's recruitment efforts have increased tenfold with a slight drop in urgency in fiscal 2010/11. We anticipate recruitment to continue to be a challenge over the next five years however; we are hopeful that the major crisis is behind us.

# of Interviews within HPHA over the last 3 Fiscal Years

Fiscal Year	Q1	Q2	Q3	Q4	TOTAL
08/09	59	35	50	92	236
09/10	114	64	83	56	317
10/11	80	56	63	80	279

# of Hires within HPHA over the last 3 Fiscal Years

Fiscal Year	Q1	Q2	Q3	Q4	TOTAL
08/09	30	18	29	47	124
09/10	62	24	37	36	159
10/11	41	21	26	41	129

The HPHA is proud of our exceptional staff, physicians and volunteers and we know that they are the key ingredient to delivering outstanding care and services to our communities.

B. Who We Serve

1. Our Community Profiles

Huron and Perth counties are the Central Region of the South Western Local Health Integrated Network (SW LHIN). SWLHIN data indicates the population of Perth and Huron counties is 138,529 within 5,615 kilometers. Fifteen percent (15.1%) is over the age of 65 years as compared to the provincial average being 13.5% over the age of 65. The population is projected to increase to 195,000 by 2016. By 2018 it is projected that there will be a 43% increase in the population over the age of 65 and a 6.3% decrease in the population under the age of 19. It is worth noting that individuals aged 65 and older utilize 50% of health services. With respect to education, 10.9% of the population has not attained a grade 9 education and 33.5% did not achieve a grade 12 education. Forty percent (40.5%) of the population achieved a post secondary education.

With seniors the fastest growing age group, demand on health service is expected to increase. Along with changes in the age composition of the Canadian population are changes to the diversity. When families immigrate to Canada they can bring differing expectations of what a public health system should provide and have different health profiles and risk factors that impact the health status of the population.

Current Region Service Assessment Highlights

- The majority of Continuing Complex Care cases were admitted for slow stream rehabilitation that indicates a need for transitional care units to alleviate pressures in the acute setting and provide care closer to home.
- The central region provides the highest volume of psycho geriatric services with limited availability of mental health day programs.
- The majority of residents of the central region of the SWLHIN (over 61%), received surgical care from central providers.
- A significant proportion of central residents were treated for general surgery(25.6%), orthopedic(29.5%) and trauma(37%) in the south region of the SWLHIN (London)
- The central recorded 17% of total SWLHIN ER visits, slightly higher than the overall LHIN average. The majority of the visits were managing lower acuity cases; only 30% were for managing the higher acuity cases.
- Across the SWLHIN there is a stated gap related to services for children and youth with mental health needs. There are no youth mental health in-patient beds in the central region and there is difficulty accessing youth mental health in-patient beds within the province.
- Hospital births in the central region accounted for 19% of total SWLHIN births.
- Findings suggest that projected practitioner retirements in the near future will impact the obstetrics service model
- The majority of central residents are receiving care from central providers; General Medicine: 90%, Pulmonary: 94.3%, Cardiology: 94.7%, Gastro-hepatobiliary: 93.1%, while 9.1% of residents were treated in the SWLIHN south region for General Medicine.
- Central providers account for 9.3% of total ICU patient days in the LHIN. There will likely be an increase in patients requiring chronic ventilation due to the aging population and an increase in neuromuscular diseases.

2. Disease and Illness Patterns and Lifestyle Factors

In the SWLHIN there is a lower prevalence of arthritis and rheumatism and obesity though the average remains higher than the provincial average. The prevalence of asthma, high blood pressure and smoking have increased compared to 2005 data which are higher than the provincial average. Diabetes has increased but the reported prevalence is currently lower than the Ontario average. There is a higher prevalence of chronic diseases in older age groups.

Lifestyle Factor	Huron County	Perth County	Ontario
Smoking	29.7%	16.2% 11.7% ↓ F smokers since 2003 2.2% ↓ M smokers since 2003	19.8%
Obesity	40% BMI 25-30 23.1% BMI >30 45-64 yrs more overweight	36.9% BMI 25-30 19.9% BMI > 30 45-64 yrs more overweight	34.95% BMI 25-30 16.3% BMI >30
Alcohol (5 drinks on 1 occasion at least once per month)	22.7%	22.7% Youth & Males heavier drinkers than Ontario peer groups	21.1%

3. Performance Data

Performance Monitoring Reports (PMRs) were introduced to the HPHA in fiscal year 2007/08. The purpose of these reports is to provide a snapshot of the HPHA health system to support evidence-based decision making and operating priorities. The PMRs are intended primarily for the management team and reporting to the Board. They are tools to help management track and review current performance and desired goals. The PMRs have two distinct sections. The left hand side outlines the goals and objectives that are aligned with operating priorities, transformational strategies, Quality Improvement Plans and ongoing projects of the Alliance.

CORPORATE - Huron Perth Healthcare Alliance - All Sites					
PRIORITY - QUALITY and SAFETY					
Priority Statement - To provide safe, high quality patient care					
Goal	***Objective***	***Board Committee Oversight***	***Senior Lead/Project Lead***	***Project Status***	***Project Plan***
1. Strengthen the culture of patient safety	Fully implement:		*M. Cardinal*		
	1.Medication reconciliation on Admission	Quality	*L. McGee*		
	2. Medication reconciliation on discharge		*R. Itterman*		
	3. Avoid medication errors, and improve medication distribution system through the implementation of Automated Dispencing Cabinets by January 2012	Quality	*M. Cardinal* *R. Hulbert*		
	4. Improve provider hand hygiene compliance by developing a leadership accountability framework by March 31st, 2012	Quality	*M. Ormerod* *J. McIntyre*		
2. Improve organization wide risk management and analysis	Develop a risk management framework by June 2012	Audit	*K. Haworth* *L. McGee*		
3. Transform the HPHA culture to embed the principles of person centered health	Develop a person family centered care framework by January 2012	Quality	*M. Cardinal*		

The right hand side outlines performance measurements also referred to as Organizational Outcome Measures. There are different indicators displayed and there are four specifications for inclusion:

a. Relevance – indicators that LHIN and MOHLTC considers a priority/imitative
b. Responsiveness – indicators are sensitive to change in performance
c. Feasibility – data available for timely and meaningful reporting
d. Validity – indicators measure what they are intended to measure

Organizational Outcome Measures	***2008/09 Actual***	***2009/10 Actual***	***2010/11 Actual***	***2011/12 Q1***	***2011/12 Forecast***	***2011/12 Benchmark***	***2011/12 Flag***
% Patients receiving Medication Reconcillation upon Admission from ER (HPHA)	64.0%	92.6%	98%	99.0%	95%	95%	Green
See Embedded Graphs for Risk Monitor Pro Incidents below							
Clean Hands Audit Results : Before Patient Contact for HPHA	60.5%	62.0%	56.8%	56.3%	70.0%	70.0%	Green
Clean Hands Audit Results : After Patient Contact for HPHA	72.0%	84.7%	68.3%	69.5%	70.0%	70.0%	Green
Ventilator Associated Pneumonia (VAP) rate per 1000 Ventilator Days	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	Green
Central Line Infection (CLI) rate per 1000 Line Days	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	Green
c-Difficile Infection Rate (New Hospital Acquired) per 1,000 Pt Days*	0.22	0.30	0.23	0.46	0.10	0.10	Green
MRSA Infection Rate (Hospital Acquired) per 1,000 Pt Days*	0.00	0.04	0.05	0.00	0.00	0.00	Green
VRE Infection Rate (Hospital Acquired) per 1,000 Pt Days*	0.00	0.00	0.00	0.07	0.00	0.00	Green
% Surgical Site Infections following Hip Replacement Surgery within 30 days	0.7%	0.6%	5.4%	0.0%	2%	2%	Green
% Surgical Site Infections following Knee Replacement Surgery within 30 days	2.5%	0.9%	1.2%	1.6%	1.0%	4%	Green
% Hip Pts receiving Prophylactic Antibiotics within 60 minutes of Cut Time	100.0%	97.6%	100.0%	100.0%	99%	95%	Green
% Knee Pts receiving Prophylactic Antibiotics within 60 minutes of Cut Time	99.6%	99.6%	99.4%	100.0%	99%	95%	Green
% Surgical Checklist Completed - Clinton *N.B. reporting July 2010 onward*	n/a	new 10/11	94.5%	99.1%	100.0%	100%	Green
% Surgical Checklist Completed - Stratford *N.B. reporting July 2010 onward*	n/a	new 10/11	96.5%	100.0%	100.0%	100%	Green
	2008/09 Actual	***2009/10 Actual***	***2010/11 Q3***	***2011/12 Q1***	***2011/12 Forecast***	***2011/12 Benchmark***	***2011/12 Flag***
Hospital Standardized Mortality Rate HPHA (Actual from quarter previous)	98	95	81	n/a	98	< 100	Green
	2008/09 Actual	***2009/10 Actual***	***2010/11 Actual***	***2011/12 Q1***	***2011/12 Forecast***	***2011/12 Benchmark***	***2011/12 Flag***
# Risk Monitor Pro Incidents Reported 	690	516	857	200	see graph	see graph	Green
Breakdown of Incidences by Severity and Type (embedded graphs)							
	2008/09 Actual	**2009/10 Actual**	**2010/11 Actual**	***2011/12 Q1***	***2011/12 Forecast***	***2011/12 Benchmark***	***2011/12 Flag***
Would you Recommend Hospital to Family and Friends - Definitely Yes - Inpt	81.8%	85.2%	80.5%	n/a	80.5%	74.3%	Green
Would you Recommend Hospital to Family and Friends - Definitely Yes - ER	77.3%	78.2%	78.0%	n/a	78.0%	78.0%	Green

Organizational Outcome Measures shows trended data from previous years, actual performance for the fiscal year quarter, forecast and benchmark. Stop-lighting techniques are used as flags to highlight performance of forecast to benchmark.

4. Patient Flow

Wait Times – Hips and Knees

With a significant senior population in its region, HPHA was faced with a high demand for hip and knee replacement surgery. Public reporting in 2007 revealed that the wait times at HPHA for these surgeries were much higher than the provincial target of 182 days. In order to improve patient access, HPHA had to strengthen performance monitoring, improve wait time data entry processes and strategize on ways to reduce wait times for hip and knee surgery. To improve patient access for hip and knee replacement surgery, HPHA launched a number of improvement approaches.

A standardized care map was implemented to assist in this process. The wait times for these surgeries was added to the corporate scorecard "to track and inform decision-makers of wait time performance and, and foster greater accountability towards its senior management and Board of Directors. Using the corporate scorecard as a foundation, HPHA published a dashboard on its external website to show the wait time performance metrics for each service area to foster greater transparency and accountability to the community."

1. Improving Hip and Knee Replacement Surgery Wait Times Making Wait Times a Corporate Priority. Case Study by Keary Fulton-Wallace, Dr Kevin Lefebvre, Donnalene Tuer-Hodes, Dr. Nancy Whitmore and Andrew Williams Access to Care Informatics Performance Improvement Product, 2010.

Following the successful reduction of hip and knee replacement times, the surgery team developed a hip facture guideline to ensure hip surgery occurred within 48 hours of admission. This guideline has increased the percentage of patients who receive surgery with 48 hours of admission from 64.35% in 2007/08 to 89% in 2010/11. In Q1 2011/12 our performance was 93%.

Fast Facts (ALC and Conservable Bed Days)

- Length of stay for 2010/11 is 4.1 days decreased from 4.5 days in 2009/10 (from 07/08 of 4.1) along with the percentage of days considered conservable at all sites
- In 2010/11 over 8566 days were considered conservable or 24% of our acute inpatient days. This number includes acute Alternate Level of Care (ALC) days which account for 10% of the conservable days number. (8516 days = approx 28/29 beds)
- From 2009/10 to 2010/11 decrease of 2% in conservable days
- In 2009/10 over 9915 days were considered conservable or 26% of our acute inpatient days. This number includes acute Alternate Level of Care (ALC) days which account for 10% of the conservable days number. (9915 days = 33 beds)
- Overall the readmission rate within 1 week remains lower than the provincial average at 0.8%.
- Looking at the surgery specific 28 day readmission rates following surgery, the Stratford site continues to be significantly lower than the Ontario for all rates (Hysterectomy, Prostatectomy, Hip Replacement and Knee Replacement). Surgery specific rates do not apply to other sites due to low or no inpatient surgery volume.
- The 5 day mortality following major surgery (rate per 1,000) of 5.77 is also lower that the provincial rate of 9.8/1,000.
- The Hospital Standardized Mortality rate for HPHA is less than 100 indicating the hospital mortality is less than expected when adjusting for patient age and sex and condition. (fewer patients die than expected)

- Surgery program has no change in catchments areas or age analysis
- The % of Hip Fracture Surgeries which occur within 48 hours of admission have increased from 64.35 % to 89% from 2007/08 to 2010/11
- A Hip Fracture guideline was implemented to facilitate quicker access to surgery from any HPHA bed

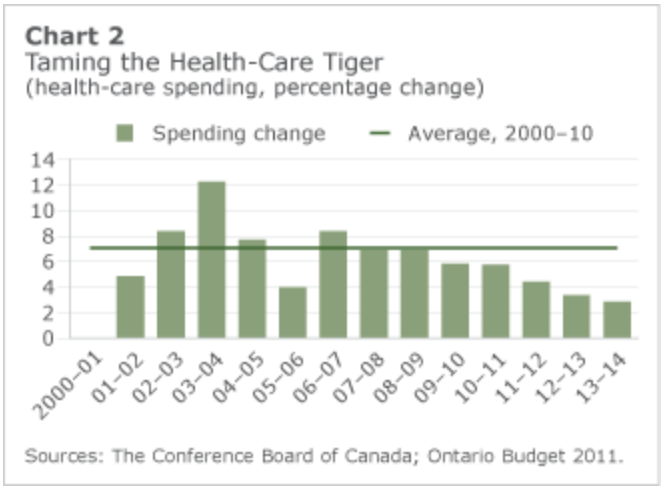
C. How We Meet The Challenges to Provide Excellent Services

1. Economy & Government:

Among all the provinces, Ontario is in the most difficult fiscal position. The Ontario government has run large deficits over the last three years, and according to the 2011 Ontario Budget, the government will not balance its books for seven more years. Despite a large stimulus program, which pushed up program spending by almost one-fifth over the last two years, the government will not make any reductions in overall program spending. Instead, the Ontario government plans to tightly control further growth in spending over the next seven years. Health care and education will be protected, but spending on other items will decline. The result is an additional $67.5 billion in accumulated deficits over the next seven years before the books are finally balanced in fiscal year 2017–18.

Controlling the growth in overall program spending hinges on the province's ability to control health-care costs, since health-care spending consumes approximately 43 cents of every dollar collected in revenue. The government plans to hold growth in health-care spending to three per cent per year from fiscal year 2012–13 through 2017–18, but an aging population, cost of living and increases in operating costs will make this a difficult task. Over the past 15 years, health-care spending has grown at an average pace of 6.5 per cent annually.

Over 44 per cent of the total health-care budget today is spent on caring for those age 65 and over—a group that accounts for only 14 per cent of the population in Ontario. But the 65-and-over population is growing at a rate that is more than three times that of the overall population, putting enormous pressure on health-care costs. It is partly because of these demographic pressures that health-care spending has increased by almost seven per cent per year over the last five years. This year, the Ontario government plans to slow this increase to 4.4 per cent, and then reduce it further—to just 3.4 per cent in fiscal year 2012–13 and 2.8 per cent in 2013–14 (***see Chart 2***). (1)



(1) Source: Conference Board of Canada – 2011 Ontario Budget analysis

A provincial election will be held in October 2011 and regardless of which party is successful in this election, they will face the same fiscal reality and their approaches will undoubtedly be similar with regard to healthcare spending growth curtailment. How this is done and how quickly will vary dependent upon which party forms the government.

HPHA has a reputation for strong fiscal management; however the hospital has and will undoubtedly continue to face challenges related to the realities of larger scale economic uncertainly coupled with freezes or reductions in public sector spending. HPHA has attempted to mitigate risk associated with financial pressures by adhering to conservative and comprehensive budgeting processes and financial controls, as well as reviewing provincial funding formulas such as Health Based Allocation Methodology formula (HBAM) for efficiency opportunities. HPHA is also focusing on its culture and its impact on fiscal management and decision making, ensuring accountability exists at all levels of the organization.
Additionally, ongoing quality initiatives typically result in a financial savings or cost avoidance. Our ability to identify these initiatives and measure the financial impact is a key requirement in ensuring HPHA captures these savings or measures the cost avoidance.

Legislation:

1. Excellent Care for All Act

Excellent Care for All Act (ECFAA), also known as Bill 46, came into effect in June 8, 2010. It ensures Ontarians receive healthcare of the highest quality possible. Hospitals across Ontario are required to develop and make public an annual Quality Improvement Plan. The legislation also stipulates that senior executives of hospitals must have a portion of their compensation tied to the achievement of specific initiatives and outcomes identified in the Quality Improvement Plan.

What is a Quality Improvement Plan?

A Quality Improvement Plan (QIP) is all about continuous improvement. It provides an opportunity for organizations to focus on how and what to improve, in the name of better patient-focused care. As such, it is a unique document, designed by, and for, each individual organization. Overall, a QIP should be seen as a tool, providing a structured format and common language that focuses an organization on change. The QIP will drive change by formalizing a plan and facilitating shared dialogue to support continuous quality improvement processes. The QIP also provides the means for the Alliance to communicate accountability and transparency to the public, patients, and staff.

Huron Perth Healthcare Alliance is focused on creating a positive patient experience and delivering high quality and safe health care. The initiatives of the Alliance are described in the Huron Perth Healthcare Alliance Quality Improvement Plan 2010-11

Meeting the challenge

Operational Priority:
Quality and Safety; To provide safe high quality care

Goal: Strengthen the culture of patient safety:
Objectives:

- ✓ Avoid medication errors & improve medication distribution system through the implementation of Automated Dispensing Cabinets by January 2012.
- ✓ Improve provider hand hygiene compliance by developing a leadership accountability framework by March 31, 2012.

2. Broader Public Sector Accountability Act

The Broader Public Sector Accountability Act, 2010 (BPSAA) was introduced on October 20, 2010 and received Royal Assent on December 8, 2010. The BPSAA establishes new rules and higher accountability standards for hospitals, Local Health Integration Networks (LHINs) and broader public sector organizations.

The BPSAA:

- Bans the practice of hiring lobbyists using public funds
- Increases accountability for hospitals and LHINs
- Establishes new procurement and expense rules for certain large BPS organizations
- Adds accountability measures related to compliance and expenses rules
- Brings hospitals under the *Freedom of Information and Protection of Privacy* Act (FIPPA)

New Procurement Practices – Broader Public Sector Procurement Directive

The government has issued a directive governing the procurement of goods and services by designated broader public sector organizations (BPS Procurement Directive)

New Personal Expense Guidelines

The government has issued a directive requiring designated broader public sector organizations (listed in the act) to establish expense rules where expenses are reimbursed from public funds.

The directive requires designated BPS organizations to post their expense rules on their websites. The directive requires the following to be addressed in the rules:

1. An accountability framework
2. Prohibition on reimbursement of meal and hospitality expenses for consultants and other contractors
3. Rules specific to serving alcohol
4. Rules for hospitality events
5. Good record keeping practices
6. Rules for individuals making claims (e.g. all appropriate approvals should be obtained before incurring the expense, original itemized receipts are required)
7. Rules for individuals approving claims (e.g. cannot approve their own claims, provide approval only for expenses incurred in the performance of organization business)

Compliance Reports

The Broader Public Sector Accountability Act, 2010 (BPSAA) requires the Chief Executive Officer of every Local Health Integration Network (LHIN), and public and private hospital, to prepare attestations with respect to compliance with the requirements of the BPSAA.

The attestations will confirm the organizations:

- completion and accuracy of reports on the use of consultants
- compliance with the prohibition on engaging lobbyists using public funds
- compliance with the expense directives issued by the government
- compliance with procurement directives issued by the government

Amendments to the Freedom of Information and Protection of Privacy Act

The Broader Public Sector Accountability Act, 2010 (BPSAA) amends the Freedom of Information and Protection of Privacy Act (FIPPA) to make hospitals subject to FIPPA.

It is anticipated that these changes will help to increase transparency of the hospital system in addition to the other measures in the BPSAA.

FIPPA will apply to hospitals as of January 1, 2012, but is retrospective to January 1, 2007. As a result, records that came into a hospital custody and/or control on or after January 1, 2007 are subject to the Act.

This amendment does not change rules applicable to personal health information. The *Personal Health Information Protection Act, 2004* will continue to apply to the hospitals collection, use and disclosure of personal health information.

As of January 1, 2012, FIPPA will be amended so that to certain types of hospital records will be excluded from the application of the Act. For example:

- records that relate to the operations of a hospital foundation
- the administrative records of a health professional in relation to their personal practice
- records that relate to charitable donations made to a hospital

Meeting the challenge

- ✓ **updated Personal Expense Reimbursement policy**
- ✓ **updated General Purchasing policy**
- ✓ **implementing processes to comply with Freedom of Information requirements and associated document management routines**

2. Ministry of Health and Long Term Care:

The role of the Ministry of Health and Long Term Care (MOHLTC) has changed in recent years from managing the health care system to providing strategic leadership planning and central oversight as Ontario's health system steward. The MOHLTC sets the policy directions, key priorities and performance targets for health care in the province. As outlined below, the funding management, administration of service agreements and community engagement will be overseen by the Local Health Integration Networks (LHIN), however, the MOHLTC remains a key and important player, whose policy directions will continue to affect the functioning of Ontario's hospitals and the operations of the LHINs.

The MOHLTC priority areas for the province, as directed by the government continue to be reducing wait times with a special focus on emergency rooms (ER) and improving access to community-based health care. The priority areas are similar to previous years, requiring broad system level solutions with continuous efforts needed over many years.

Reducing wait times has been a priority for the MOHLTC for a number of years. While in the past much effort had been directed at wait times for diagnostic and surgical procedures with demonstrated improvements, attention is now shifting to wait times for access to ER services. The strategy to improve ER wait times includes building capacity within hospital emergency departments to have patient's seen and cared for more rapidly and faster discharge for patients in acute setting requiring lower levels of care (i.e. Alternative Level of Care or ALC patients). Building capacity within the community health setting is another strategy to decrease demand on ER service and to also improve access to primary care. Investments and expansions of Family Health Teams are a key activity for the Ontario government. This

'upstream' investment in the health system focuses more on prevention and management of chronic diseases and promotion of health, further decreasing utilization needs of acute care. These two priorities have cascaded down to all LHINs in Ontario, including the SW LHIN.

Meeting the challenge

Operational Priority:
Patient Access:
Goal: Improve Patient Flow and Access for all out-patient clinics
Manage bed utilization on all patient care areas to provincial benchmarks

RHPA: Professional Practice

Over the last two decades there has been a growing recognition at provincial, national and international levels of the need to revise the traditional care delivery models in all sectors of the health care system. Increasing patient acuity and complexity have resulted in increased demands on healthcare resources. These realities, combined with increased fiscal pressures, demand changes that will realize improvements in the efficiency of care provision. The Ministry of Health and Long-Term Care has identified interprofessional care as a key strategic focus to achieve sustainable improvement in the quality and cost-effectiveness of healthcare in the province, throughout the entire spectrum of healthcare delivery. Interprofessional care results in improvements in access to appropriate care, patient outcomes, cost-effectiveness, organizational efficiencies, and patient and staff satisfaction. Health care professionals are able to work to their full scope of practice in such a model

In 2010, the HPHA implemented a Corporate Lead Professional Practice position to work with leadership, staff and physicians in the development and implementation of an interprofessional practice model. The HPHA Interprofessional Practice Model (IPPM) promotes all regulated professionals working to their full scope of practice, in accordance with the parameters and requirements of the clinical area, and enhances professional practice expectations. The HPHA IPPM is person-centered and based on a model of interprofessional collaboration between all health care providers. The IPPM will assist healthcare providers to manage workloads more effectively, reduce wait-times for patients and improve patient outcomes; the outcomes are closely aligned with the process optimization (Lean) philosophy the HPHA has embraced. An Interprofessional Practice Council (IPPC) consisting of representatives of all regulated healthcare professions employed in the Alliance has been established and a philosophy statement has been adopted: "The Professionals of the HPHA are committed to provide safe, quality patient care through interprofessional collaborative teamwork." Unit Action Councils (UACs) will be formed for each patient care
unit/program at all 4 sites of the HPHA and will function based on the principle that collaborative practice on patient care units achieves optimal results when all staff (regulated and unregulated) who provide care to patients on that unit are involved in planning, problem solving, decision making and goal setting.

The HPHA commitment to an interprofessional practice model of care aligns with the well established Care Teams which are specific to each clinical service and are compromised of clinical leadership, clinical staff and physicians. Embodiment of the IPPM will be of significant benefit in supporting the integration and realignment components of Vision 2013.

3. South West Local Health Integrated Network (SWLHIN):

While the MOHLTC provides overall system direction, the LHINs translate the Ministry vision into reality at the local level with input from local health care providers, consumers and communities. LHINs established alongside the Local Health System Integration Act, 2006 are a "critical part of the evolution of health care in Ontario from a collection of services to a true system that is patient-focused, results-driven, integrated and sustainable. The legislation places significant decision-making power at the community level and focuses the local health system on the community's needs."

Under the original Act, LHINs were required to undergo a comprehensive Legislative Committee review in four years after their establishment. It should be noted that opposition party members have not been supportive of LHINs and would likely challenge their structure and function at this time.

The MOHLTC provides funding to the 14 LHINs using the Health-Based Allocation Model (HBAM), a population-based funding methodology with adjustments for health status, patient flows and cost of service provision. HBAM informs a fair and rational allocation to LHINs and helps LHINs and their providers improve efficiency. As a management tool, HBAM allows for the analysis of performance, equity and efficiency at the LHIN, health sector, and health service provider levels. LHINs have the discretion to apportion funds to their provider organizations.

Under the Local Health Services Integration Act, 2006, LHINs are required to negotiate service accountability agreements with the health service providers they fund. Each hospital submits their Hospital Accountability Planning Submission (HAPS) on an annual basis, with the expectation of a signed Hospital Service Accountability Agreement (H-SAA) with the LHIN by March 31, the end of the fiscal year. In addition to base funding negotiated through the H-SAA, the MOHLTC and more recently LHINS, also link targeted funding programs to Accountability Agreements. These programs provide funding to hospitals to finance specific programs associated with regulations on reporting expectations and other accountabilities. Examples of targeted funding programs include specific agreements reached under the Ontario Wait Times Strategy.

In November 2009, the SWLHIN released their second Integrated Health Service Plan (IHSP-2). Health equity and eHealth are noted as two essential components to meet the priorities. Health equity is of particular concern in the South West LHIN, where the range and diversity of incomes, languages, education and other cultural and socio-economic factors have led to disparities in access to services and in health outcomes. To address health inequities the LHIN has been developing a comprehensive strategy in accordance with identified priorities for 2010-13. Each hospital has completed a Health Equity Plan, describing several promising practices clearly identifying the need for the LHIN and hospitals to collaboratively address challenges,

e.g. defining success at hospital and system levels, promoting coordinated action and developing effective performance measurement and management systems. eHealth activity is discussed further in the Safety section of this document.

Every Canadian hospital, through its organizational board, has the responsibility to be accountable and transparent regarding business financial affairs, operations, and results.
"The competing expectations of quality care, efficiency, responsive service, ready access, fairness and provider morale are a reality in all hospitals. These expectations provide significant challenges, not only for health service providers, but also for hospital Boards of Directors who have an unprecedented need for sound governance structures, policies and processes and well-understood accountabilities."

Demands for increased hospital accountability are driven by three primary drivers:
- Fiscal responsibility
- Growing industry interest in quality improvement
- Increasing usage of performance measure

Meeting the challenge

Operational Priority:
Fiscal Health:
Goal: Improve the culture of fiscal responsibility and accountability:
Objective:
✓ Development and implementation of Operational Analysis framework with all management by September 2011

Goal: Improve HPHA performance in the Health Based Allocation Methodology (HBAM) funding formula.

Objective: Develop a zero based planning approach to ensure efficient and effective program delivery targeting HBAM expected costs for major programs exceeding MoHLTC expected

SWLHIN Blueprint: service integration

Health care in Ontario has experienced year-over-year growth. Reasons for this growth include rising demand and use of services; an increasingly aging population; inflation and new, more expensive treatments and medications; increased public expectations; new diseases; and an increase in the prevalence of chronic diseases. Even though we have experienced considerable growth, it has not always resulted in improvements to how people experience their health care or the outcomes expected by that care. A primary reason for this is new health care resources are often aligned to service structures and delivery models that were created many, many years ago and no longer adequately serve our population. Over time, the health care system has become extremely complicated and difficult to navigate by users and providers of services. We have been continually adding services to a foundation that is based on historical approaches as opposed to current needs and best practices. Hence, it is imperative that over the next 12 years, we address the fundamental elements that need to be reconstructed to ensure that we have an "Integrated Health System of Care" built for 2022. Great care must be taken and effort made to ensure that accessible, quality and integrated services exist and will be there for SouthWest LHIN residents, their children and their grandchildren.

SouthWest LHIN: Integrated Health Service Plan 2010-2013. Providers across health sectors face the following challenges:

- Inequitable distribution of health services across the LHIN pose access challenges for residents, particularly those in rural communities
- Current funding and operating models reinforce a provider-focused versus person-centered approach to health service delivery costs
- Lack of integration across sectors and of health service providers inhibits the seamless movement of individuals and families across the continuum of care
- The health profile of the SouthWest LHIN necessitates more appropriate, integrated screening and early identification of health risk factors and conditions
- Lack of integrated technology platforms across the LHIN inhibit information-sharing among health service providers across sectors and geography
- Capacity limitations make it difficult to meet the increased demand for health services
- Limited availability of health human resources make it difficult to meet the current and anticipated health service demand. These issues must be addressed to improve the health system and ensure its sustainability in the future.

To access the full Southwest LHIN integrated service plan, please click on the link below.

http://www.southwestlhin.on.ca/uploadedFiles/Public_Community/Integrated_Health_Service_Plan/2009_IHSP/SWLHIN_IHSP_F2_ExecSummary.pdf

Meeting the challenge

Transformational Strategy: Implement Vision 2013
******* www.hpha.ca *******

4. Technology

Combining medical technology and the human touch, HPHA diagnoses, treats, and administers care around the clock, responding to the needs of thousands of people—from newborns to the terminally ill.

In the rapidly changing healthcare industry, technological advances have made many new procedures and methods of diagnosis and treatment possible. Clinical developments, such as infection control, less invasive surgical techniques, advances in diagnostic technology and procedures continue to improve the quality of care. The HPHA has an ongoing renewal process for medical and general equipment

Additionally, the ability to access clinical information in a timely manner and reduce opportunities for potential error in information sharing and transfer is a key opportunity and outcome for HPHA's ongoing commitment to creating and providing its care givers with a patient electronic health record. The electronic health record allows interprofessional teams to align practices and care plans for individual patients, increasing practitioner access to information and ensuring that patients are therefore cared by the most informed care provider as possible. In response, the HPHA has created an Electronic Health Record roadmap to assist with guiding the organization's efforts in moving forward with information technology investments.

Meeting the challenge

Medical Technology:

- ✓ **Ongoing refresh of medical and general equipment**
- ✓ **Implementation of a Magnetic Resonance Imager (MRI)**
- ✓ **Voice recognition technology**
- ✓ **Information Technology**
- ✓ **Creation and implementation of an Electronic Health Record roadmap**

5. Risk Management

Risks existing within the healthcare environment are complex and growing in nature and impact. Integrated risk management looks at all business operations, not just risks associated only with clinical activities, or risks associated only with non clinical activities.

Risk management emanates from the sense that a logical, consistent and disciplined approach to an organization's uncertainties will allow it to deal with them prudently and productively, avoiding unnecessary waste of resources. Risk management is an inherent part of good management. It requires an approach *integrated with corporate strategy* that outlines exposures, issues, and potential problem areas. Integrated risk management creates a system to identify in a systemic way, important gaps, variations and exposures that allows an organization to anticipate, avoid and mitigate their possible impacts.

Risk is:

- About the future
- Based on the notion of probability of an event happening
- Assessed in the intensity or impact of that event
- Based on the above assessments, compared and prioritized
- About mitigating, managing and controlling risk

Integrated Risk Management is:

- A process
- Effected by people
- Applied in a strategic setting
- Applied across the entire organization
- Designed to identify potential events
- Manages risks with risk appetite
- Provides reasonable assurance
- Supports achievement of objectives

The HPHA performs a variety of risk management activities on a frequent basis in an attempt to mitigate, manage and control risks in its day to day operating environment. The risk analysis, monitoring and control must be integrated with strategic and operating priorities and monitored at all levels of the organization, including the board, senior executive and management.

Meeting the challenge

Risk Management activities and structures in the HPHA include:

- HPHA Pandemic Plan
- Monthly Operational Analysis Report meetings with Program Directors and Managers to review program performance based on identified metrics
- Emergency preparedness policies
- Performance Monitoring Reports at the corporate and operational levels with prescribing monitoring and reporting schedules
- Quality Improvement Plan
- Clinical and Non-Clinical policies and procedures to guide practice for safe, proactive operations
- Clinical competencies identified for regulated healthcare professionals
- Leadership competencies identified
- Health and Safety Management Systems initiatives to align patient and staff safety activities. Safety Rounds on each clinical unit and monthly Patient Safety Walk Arounds
- Participation in Accreditation Canada Process

Operational Priority:
Quality and Safety; To provide safe high quality patient care
Goal: Improve risk management analysis organization wide
Objective: Develop a risk management framework by June 2012

Operational Priority:
Workplace Health; To create a preferred place to work, volunteer and provide care
Goal: Enhance the Alliances culture of a safe and healthy workplace

The HPHA has partnered with the Health and Safety Association for Government Services in the development of an Alliance-Wide Health and Safety Management System (HSMS). It is the Alliance's expectation that this system will align patient safety and staff safety activities allowing the organization to create a wide-ranging and robust "safety culture". To date, the Alliance has conducted a comprehensive and thorough Alliance-wide Hazard Identification and Risk Assessment and is embarking on the Risk Management and Control, and Evaluation and Corrective Action phases of the project. The implementation of an HSMS will help mitigate risks to employees, patients and the public.

3. **Emergency & Pandemic Planning:**

Health care organizations have been planning for the risk of a possible pandemic for a number of years. The health systems preparedness was put to the test with the worldwide spread of the H1N1 influenza virus. In June 2009, the World Health Organization raised the pandemic alert level to a "Level Six" indicating that there was sustained spread in communities in more than one area of the world. Faced with increased emergency department volumes and patient activity, hospitals worked very closely with community health agencies to help manage such surges. Although the severity of illness associated with H1N1 was milder than expected and activity in Ontario has been less severe than predicted, continued diligence and planning are essential.

Meeting the challenge

- HPHA has a comprehensive Pandemic Plan which is reviewed at a minimum of annually and revised more frequently as indicated. The HPHA actively participates with the Huron and Perth Public Health Units with respect to pandemic planning

6. Patient Satisfaction and Expectations

A balanced scorecard approach to assessing activities and outcomes is undertaken by most Ontario hospitals. The HPHA Performance Monitoring Report (PMR) is organized under the four operating priorities of Quality and Safety, Patient Access, Fiscal Health and Workplace Health. Patient Satisfaction is included as an Organizational Outcome Measure on the

Quality and Safety quadrant and reports the NRC Picker results concerning if an individual having had the experience of an acute hospital admission or an ER visit would recommend the hospital to family or a friend. Patient satisfaction is a priority at HPHA. Patient satisfaction rates are regularly reviewed at a macro level by the Board of Directors as a part of the HPHA Performance Monitoring Report. Managers and directors closely monitor department and unit specific rates on a more frequent and detailed basis.

Meeting the challenge

- Patient Comment forms which are available through the four sites in inpatient and outpatient areas; these comment sheets are reviewed by the Vice President Clinical Programs and the Program Director/Manager for the clinical area and receive further circulation and attention as needed.
- HPHA has policies regarding Patient Relations, Patients' Rights and Responsibilities and the Patient Declaration of Values. ***Link to web site?***
- HPHA engaged "Juice" to launch an organization-wide cultural engagement initiative based on respect and effective communication.

7. Patient Flow

Patient flow refers to the movement of patients from the front doors of a hospital, through the Emergency Department or from Admitting, to an inpatient bed and through discharge or from attendance for an outpatient procedure or appointment.

Internal mechanisms at HPHA which promote effective patient flow include effective communication; comprehensive documentation and access thereto; thorough and effective discharge planning; mechanisms to effectively utilize resources and decrease wait times; systems which promote consistent evidence based care such as care maps, order sets and medical directives pre-admit procedures; EDM tracker boards; Surge Capacity protocols; bed management protocols; overcapacity protocols; viewing the Alliance inpatient beds as HPHA resources thus facilitating movement between sites as indicated and appropriate; effective outpatient and community based programs to facilitate appropriate continuity of recovery following hospital discharge (e.g. Community Stroke Rehab Team); partnerships with community providers; management of Alternate level of Care days and conservable days; and engagement in such resources as Home at Last. Effective patient flow is also dependent upon such mechanisms as adequate and effective signage; the presence of volunteers and well- informed staff to direct patients and families to their destination; adequate and accessible parking; and adoption of the principles of the SWLHIN Seniors Friendly Hospitals initiative.

Meeting the challenge

- HPHA strives to remove bottlenecks affecting patient flow and thus joined the provincial FLO Collaborative in the fall of 2009. The aim of the FLO Collaborative is to improve the timeliness and effectiveness of patient transitions from acute care hospital to subsequent care destinations for all medicine patients and ensure early discharge planning for all medicine patients. The FLO Collaborative was piloted in two medical units with "bullet rounds" (Stratford and St. Marys sites) with early results indicating a decrease in admitted patients waiting in ER for a medical bed, and a significant decrease in calls to the Administrator–on-Call after hours to resolve bed crises. The FLO Collaborative will be rolled out to all HPHA inpatient units by March 2012. An ER FLO team at the Stratford site was implemented May 2011 to assess additional ways to fast track medical patients
- In mid-2009, the SWLHIN CEOs identified a need to more effectively respond to the needs of critically ill patients and ensure access to proper resources and levels of care. The SWLHIN Patient Access and Flow initiative was launched and involved the participation of all hospitals in the LHIN as well as the Southwest Community Care Access Centre (CCAC) and Criticall. This initiative has had significant success in implementing algorithms for access care for critically ill patients and for the repatriation of patients. Common forms and protocols have been implemented. The initiative has not only resulted in improved patient flow but also a greater appreciation of partners' resources and capacities and enhanced cooperation across providers. The Patient Access and Flow Initiative has garnered significant interest from adjacent LHINs.

- Bullet Rounds
- Patient Access and Flow algorithms and common forms
- Interprofessional Documentation
- EHR Roadmap
- Wait Times
- Order Sets
- Surge Capacity Management
- Overflow Capacity Management

Reference List

1. Canadian Institute for Health Information; Health Indicators 2010
2. Community Picture Summary - Perth County - March 2011 (PDF)
3. Health Behaviours and Lifestyle Practices in Southwest Ontario: Results from the Canadian Community Health Survey (2000/2001) August 2004 (PDF)
4. A Healthy Communities Partnership - Perth County - A Community Picture Report 2011 (PDF)
5. D'Amour, D., Oandasan, I. "Interprofessionality: an emerging concept" Journal of Interprofessional Care, Supplement 1: 8 – 20, May 2005 pp 15-18.
6. HPHA Functional Plan 2006
7. HPHA Performance Monitoring Reports 2010
8. http://www.huroncounty.ca/health/reports_index.php
9. http://www.12.statcan.ca/english/census06/data/profiles/community/Details/Page.cfm?Lan
10. KPMG. (2008). MoHLTC-LHIN Effectiveness Review: Final Report. Toronto, ON: KPMG.
11. Ministry of Health and Long-Term Care (MoHLTC). (2009). Results-based Plan Briefing Book 2009-2010. Toronto, ON: MoHLTC.
12. Ontario Ministry of Health & Long Term Care "Local health System Integration Act, 2006" Available online at:
13. http://www.health.gov.on.ca/english/public/legislation/lhins/hu_lhins.html Last accessed Jan 7, 2010.
14. Ontario Minister of Finance. Fall Economic Statement (2009, October 22).
15. Safer Healthcare Now! website: http://www.saferhealthcarenow.ca/ Last accessed April 26, 2007.
16. SWLHIN Environmental Scan 2006
17. SWLHIN Health System Design Blueprint – Vision 2022