South East Community Care Access Centre and Hospital Executive Forum (SECHEF)
Development of a Sustainable Integrated Model of Hospital Care
Phase 1 Recommendations Report

June 24, 2015
Letter of Transmittal

June 24, 2015

Board members:

We are pleased to present to you the Phase 1 Recommendations Report, representing the culmination of the work of Phase 1 of the Health Care Tomorrow – Hospital Services project. This report summarizes the opportunities/options/recommendations that have been developed by the Working Groups over the past five months.

We – as seven hospitals, the South East Community Care Access Centre (CCAC), the South East Local Health Integration Network (LHIN) and the Faculty of Health Sciences, Queen’s University – have been working together as part of the Health Care Tomorrow – Hospital Services project since June 2014, and have witnessed the significant and inspiring efforts of our staff to explore and identify opportunities to make our hospital system better for the patients we serve. In our opinion, the result is a thoughtful, patient-centred path forward that will guide significant transformation for our region.

We are currently faced by significant challenges, including:

- An aging population;
- Patients with an increasing number of chronic diseases;
- Fiscal constraints on all government funded health care programs, and in particular hospitals;
- An aging workforce and increasing competition for health professionals when they are needed most; and,
- An expected net negative financial impact due to health system funding reform.

We believe that the opportunities put forward by the Working Groups, as articulated in this report, establishes a sound footing to address these challenges. Overall, we believe that the opportunities for collaboration and integration of services identified by the Working Groups will lead to a sustainable hospital system for the individuals who live within the South East region. We believe that a more collaborative and integrated approach to hospital care will improve access to local services, improve the quality of care we provide, and will better position us, as a system of hospitals, to take advantage of the emerging changes to the hospital funding formula. All of this positions us to improve care for patients and families in our region.

We, as the SECHEF CEOs, representing the seven hospitals, the South East CCAC and the Faculty of Health Sciences, Queen’s University, enthusiastically approve the attached report and recommend it to the governing bodies of the hospitals within the South East LHIN for approval.

We believe that the direction to engage in collaborative efforts amongst the healthcare providers in the South East LHIN has been established by the Boards through the resolution passed in October 2014 that committed each organization to following:

- Support for the guiding principles of the project;
- Full participation in the project and agreement to provide appropriate and sufficient in-kind resources to support the completion of the project; and,
- Open and honest communication with partner hospitals regarding any decisions the organization may make related to specific project proposals, made through SECHEF, and the associated rationale for such decisions.
We appreciate the tone for collaboration that you have set as Directors and we believe that you will continue to value the important work that lays ahead as we continue to work together to further explore the opportunities presented in this report, to build towards a more collaborative and integrated system for our patients – all towards achieving our vision of, improved access to high quality care through the development of a sustainable system of integrated care.

By way of this letter, we as SECHEF CEOs recommend to the Directors of the organizations participating in Health Care Tomorrow – Hospital Services project the approval of the recommendations presented within the Phase 1 Recommendations Report, leading to Phase 2 of this project.

Signed,

Wayne Coveyduck, President & CEO, Lennox and Addington County General Hospital Signed electronically – June 22, 2015

Mary Clare Egberts, President & CEO, Quinte Health Care Signed electronically – June 22, 2015

Beverley McFarlane, Perth and Smiths Falls District Hospital Signed electronically – June 22, 2015

Dr. David Pichora, CEO, Hotel Dieu Hospital Signed electronically – June 22, 2015

Jacqueline Redmond, CEO of South East CCAC Signed electronically – June 22, 2015

Dr. Richard Reznick, Dean, Faculty of Health Sciences, Queen's University Signed electronically – June 22, 2015

Cathy Szabo, President & CEO, Providence Care Signed electronically – June 22, 2015

Leslee Thompson, President & CEO, Kingston General Hospital Signed electronically – June 22, 2015

Tony Weeks, President & CEO, Brockville General Hospital Signed electronically – June 22, 2015

Paul Huras, CEO, South East LHIN Signed electronically – June 22, 2015
Purpose of this Report

The Phase 1 Recommendations Report summarizes the opportunities/options/recommendations that have been developed by the Working Groups, and subsequently approved by the SECHEF CEOs, during Phase 1 of the Health Care Tomorrow – Hospital Services project. The opportunities/options/recommendations contained within this report are directional in nature.

Any findings that articulate financial savings identify the potential opportunity for savings that will need to be validated in a subsequent phase, upon approval of the report and its recommendations. The work completed to date includes an articulation of the opportunities available to the hospitals in the South East LHIN that would contribute to achieving the vision of improved access to high quality care through the development of a sustainable system of integrated care.

The recommendations presented within the report would proceed to Phase 2 of the project only after approval by the Hospital Boards, and subsequently the South East LHIN Board.

By way of this report, Hospital Boards are being asked to consider approval of the recommendations presented within the Phase 1 Recommendations Report. Such approval will lead to the “Design” phase of work (Phase 2), which includes the next level of analysis, design and potential implementation planning, including stakeholder engagement and opportunity analysis.

The approval of the Phase 1 Recommendations report does not mean approval to move to implementation.

As context only – the outcome of Phase 2, after detailed design would articulate the role each hospital will have in the South East region. Phase 2 would result in a clear decision-point for potential implementation, for consideration and approval by the hospital Boards.

Disclaimer

The identification of potential savings and investment costs, have been calculated to identify the potential order-of-magnitude opportunity, and to provide input to help prioritize where the greatest opportunities may exist. Further work is required in Phase 2 to validate these figures through detailed design and due diligence. The identification of savings across each of the Working Groups has been calculated as follows:

- Business Functions Working Groups developed ‘strategic’ business cases to determine the order-of-magnitude opportunity through the development of shared service models;
- Diagnostics & Therapeutics Working Groups were asked to identify opportunities for savings; however, these have not been financially confirmed. A high-level estimate for each area was provided based on input from each Working Group.
- Clinical Working Groups received analysis from KPMG/PSG that examined the potential gross savings based on expected performance compared to provincial averages. All potential savings are assumed to offset required investments and reinvestment in clinical care.

These high-level order-of-magnitude estimates provide the direction of savings and can be used to prioritize future design activities. In many cases, conservative estimates have been used that point to the potential for higher savings.
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Executive Summary

The Hospitals in the South East LHIN face a number of issues so significant, that they cannot be solved in isolation. The hospitals have come together to resolve these issues to improve access to high quality care through the development of a sustainable system of integrated care.

This report is the culmination of Phase 1 activities that sought to identify the case for change, to understand the scope and scale of the challenges that the South East LHIN hospitals face, and to identify opportunities for the optimal deployment of resources that will lead to a sustainable system of integrated care.

Case for Transformation

For its dollar, Canada is not achieving value for its healthcare system that other countries around the world have achieved. Canada is a high spender (Organisation for Economic Co-operation and Development, OECD, 2014) with lower outcomes as recently reported by the Commonwealth Fund who ranked Canada 11th, out of 12 countries surveyed (Davis et. al, Commonwealth Fund, 2014).

Comparisons of healthcare spending indicate the South East LHIN is a high spender when compared to other LHINs. Expected limitations on health system funding over the next ten years creates an unsustainable situation, as stated below:

- Healthcare has changed, as have the needs of patients: the hospitals in the South East LHIN are not designed for the patients of today;
- We expect lower funding growth in the next ten years, than we’ve seen in the past ten years that will not keep pace with population growth; and,
- If nothing changes, in ten, or even five years, we will see a very constrained environment that will make it difficult to provide quality patient care.

The analysis that KPMG/PSG conducted revealed a $120 million funding gap in ten years, due to population growth and aging if no changes are made to the way services are currently provided. In addition, the constraints of Health System Funding Reform (HSFR) will increasingly impact the hospitals in the South East LHIN. This year (2014-15), hospitals in the South East LHIN experienced a $6.5 million reduction in funding through the application of the Health Based Allocation Model (HBAM) as a consequence of the hospitals, collectively, performing at a higher than expected cost. Hospitals expect that the continued application of HBAM will further reduce revenues in the future.

In the South East LHIN, we have the ability and the intellect to address these pressures and to improve access to high quality care. The question is, do we have the will to change?

To help solve these issues the hospitals have come together to develop a regional hospital system. This will enable the hospitals in the region to act as a true system in the eyes of patients, rather than a collection of independent hospitals.

We have a clear opportunity to gain from this transformation, to take a considered approach to design a system that is fit for purpose, provides higher quality care at lower cost and addresses the needs of the patients. A system that not only addresses the treatment of patients but also the treatments.

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1 This projection excludes inflation.
Opportunities for Change

The opportunities and recommendations identified below have been developed with input from hundreds of stakeholders, including providers and patients alike. The process has relied on the following:

- Data analysis that identified some of the greatest challenges and areas of opportunity;
- Input from local experts, clinicians, providers and professionals that led and participated in the Working Groups and stakeholder engagement;
- Learnings from other jurisdictions that have already succeeded, and leading practices;
- Input and advice from patients and families; and,
- Engagement of the community.

This report signifies the end of Phase 1 of the Health Care Tomorrow – Hospital Services project that has been focused on the identification of opportunities to achieve the vision and improve service delivery for patients.

It is the recommendation of SECHEF CEOs that the Hospital Boards, and subsequently the South East LHIN Board, approve the recommendations as articulated in this report and proceed to Phase 2.

The opportunities and recommendations provided in this report identify improvements in service delivery that are to be confirmed and validated in Phase 2, a ‘Design’ phase that will follow upon approval of this report and result in a request to Hospital Boards for potential implementation approval.

The risks of not proceeding in concert are significant. Each hospital would have to act individually to resolve the issues identified above – leading to increased fragmentation of service, service reduction and the loss of opportunities that would come from working together. Not proceeding in concert would also diminish, or eliminate, the potential gains to other partners in the region.

While participants involved in this process expressed a great willingness and desire to see system change, there was also a level of skepticism expressed towards collaboration given previous unsuccessful attempts to implement system wide change. Failure to act at this time may require an extended period of time before these efforts can be tried again and the loss of a significant opportunity.

The hospitals in the South East LHIN have a significant opportunity to improve service delivery that will result in improved quality, access and patient experience as well as lower costs. Initial financial benefits have been estimated, as associated with the proposed opportunities for collaboration and integration.

While this study was not an operational review, financial impact was considered as a criteria to assess the opportunities, to help achieve sustainability, recognizing that savings will be required to support future population growth and aging. The savings identified in this report should be taken into context:

- Savings identified are directional, order-of-magnitude estimates;
- Most of the savings will be realized in the long term and will require some up-front-investments; the full suite of which still need to be considered and calculated in Phase 2;
- Savings identified will be achieved after implementation starts in Phase 3, the next phase of work (Phase 2) is design and due diligence, resulting in decisions to implement, which means that year 1 for savings considerations
is year 1 for implementation, and that gains by individual hospitals could be achieved in the timeframe between now and the start of implementation;

- While a financial analysis of each hospital was not part of the scope of this project, each hospital is not starting at the same fiscal position; this means that some part of the identified “savings” in this report may be required to fill efficiency or fiscal gaps;

- Hospitals in the South East LHIN will continue to face increasing pressures: the hospitals, collectively, within the South East LHIN are inefficient when compared to provincial peers; this will result in a reduction in revenue through HBAM; hospitals, collectively, will face inflationary pressures on cost and increasing demand through demographic changes; and,

- Hospitals in the short-term will still need to balance their budgets, take efforts to improve their individual efficiency and make investments to build capacity to invest in the future together.

Table 1 on the next page presents the high-level projected cash flows over the next six years and beyond for savings and investments related to Business Function and Diagnostics & Therapeutics opportunities. Future state annual ongoing savings have been identified at approximately $29 million\(^2\). This represents ongoing savings that could be achieved once all opportunities have been implemented. Known investments over that period amount to approximately $15 million\(^3\) (this does not include capital investments required for Hospital Information Systems, Laboratory and Diagnostics, which will be estimated in Phase 2, pending Board approval). This results in total net cumulative savings of approximately $52 million over five years. For detail on financial estimates, see notes to financials in the footnotes below.

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\(^2\) Savings potential includes an order-of-magnitude opportunity identified by shared services business cases for Information Services, Human Resources, Facilities/Support Services and Finance; and an estimate of savings that could potentially be achieved from regional Laboratory (15%), regional Diagnostic Imaging (10%) and regional Pharmacy (5%). These figures are directional and will need to be validated in Phase 2.

\(^3\) One-time investments include costs of a shared enterprise resource system for Human Resources and Finance, severance costs for all four business functions as defined in the business cases, and project implementation cost estimates. Any investment costs for clinical services (i.e., central intake and scheduling system) was assumed to come out of any clinical savings identified. These costs need to be identified as part of the next phase of work. Costs of the Hospital Information System have been excluded at this stage as significant work remains to identify costs, potential savings, benefits and alternatives that will be conducted in the next phase of work. Additional work is required to confirm the investments and potential costs associated with termination of existing regional Laboratory, Diagnostic Imaging and Pharmacy systems.

Health Care Tomorrow – Hospital Services Planning
Phase 1 Recommendations Report (FINAL)
Table 1: High-level projected cash flows over the next six years and beyond for savings and investments related to Business Function and Diagnostics & Therapeutics opportunities

*all figures represent 000’s

<table>
<thead>
<tr>
<th>Work stream</th>
<th>Opportunity</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6+</th>
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<tbody>
<tr>
<td>Business Functions</td>
<td>Develop a regional shared service to support Finance, Human Resources, Facilities/Support Services and Information Services</td>
<td>Investments</td>
<td>($7,000)</td>
<td>($4,500)</td>
<td>($500)</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$11,000</td>
<td>$12,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$12,000</td>
<td>$16,000</td>
</tr>
<tr>
<td>Diagnostics &amp; Therapeutics</td>
<td>Develop a Regional System for Laboratory, Diagnostic Imaging and Pharmacy</td>
<td>Investments</td>
<td>($500)</td>
<td>($500)</td>
<td>($1,000)</td>
<td>($1,000)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Savings</td>
<td></td>
<td></td>
<td></td>
<td>$6,000</td>
<td>$13,000</td>
</tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>$13,000</td>
<td>$13,000</td>
</tr>
<tr>
<td>Investments</td>
<td></td>
<td>($7,500)</td>
<td>($5,000)</td>
<td>($1,500)</td>
<td>($1,500)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$17,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>Cumulative Net</td>
<td></td>
<td>($7,500)</td>
<td>($12,500)</td>
<td>$3,000</td>
<td>$26,500</td>
<td>$51,500</td>
<td>$80,500</td>
</tr>
</tbody>
</table>

Based on leading benchmarks, the savings estimates are conservative, but may be offset by additional investment costs that will be identified in Phase 2 (see note 2 on previous page). In addition, it was calculated that ongoing annual gross savings of approximately $38.5 million could be achieved through the clinical opportunities. Further analysis is required in the design phase to validate this potential and identify required investments. In addition, any clinical efficiencies identified will likely be required to offset inflation and any negative impact of the funding formula.

The proposed opportunities for collaboration and integration of services across the seven hospitals have the potential to create a sustainable system of integrated care within the South East region that is positioned to succeed through the broader health system transformation, and to deliver increased quality and access to services across the region. This transformation cannot be achieved in isolation, requiring collaboration and further integration with the community and primary care sectors through the other streams of work as part of the Health Care Tomorrow suite of
initiatives. These recommendations provide the South East LHIN with the opportunity to catch-up with other leading health systems that have developed more regional integrated health systems and have seen improved quality and patient experience at lower costs. These include the ranks of Kaiser Permanente, Intermountain Healthcare, Geisinger, Coxa Hospital in Finland, Canterbury New Zealand, and Jonkoping in Sweden to name a few.

Overall, the strength of this value proposition is not in the short-term, but rather in the longer-term in which the hospitals are able to position themselves to better serve the South East region, create a shared vision for a transformed local health care system, address fiscal challenges together, and take advantage of the fast changing health care environment.

Tables 2 and 3, below, present a summarized list of opportunities and recommendations for next steps in Phase 2.

- The first seven opportunities are the responsibility of the hospitals in the South East LHIN. **These are the opportunities that the Hospital Boards are being asked to approve to move forward to Phase 2.**
- The subsequent three opportunities require partnership and collaboration with community partners via a shared accountability, or accountability of the community sector. **It is the collective Hospital’s recommendation to the South East LHIN to take on the responsibility to move these forward.**

**Table 2: Summarized list of opportunities and recommendations for next steps in Phase 2 (responsibility of hospitals)**

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Recommendations for Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop a regional shared service to support Finance, Human Resources,</td>
<td>That the Hospital Boards approve moving forward to Phase 2,</td>
</tr>
<tr>
<td>Facilities/Support Services and Information Services</td>
<td>which would include detailed design, due diligence and potential transition planning.</td>
</tr>
<tr>
<td>2. Develop a regional laboratory system to serve all the hospitals in the</td>
<td>That the Hospital Boards approve moving forward to Phase 2,</td>
</tr>
<tr>
<td>South East LHIN</td>
<td>which would include detailed design, due diligence and potential transition planning.</td>
</tr>
<tr>
<td>3. Develop a regional Diagnostic Imaging system to serve all the hospitals</td>
<td>That the Hospital Boards approve moving forward to Phase 2,</td>
</tr>
<tr>
<td>in the South East LHIN</td>
<td>which would include detailed design, due diligence and potential transition planning.</td>
</tr>
<tr>
<td>4. Develop a regional Pharmacy system to serve all the hospitals in the</td>
<td>That the Hospital Boards approve moving forward to Phase 2,</td>
</tr>
<tr>
<td>South East LHIN</td>
<td>which would include detailed design, due diligence and potential transition planning.</td>
</tr>
<tr>
<td>5. Develop a regional system of care for highly specialized services (tertiary/quaternary services) and planned care (elective)</td>
<td>That the Hospital Boards approve moving forward to Phase 2,</td>
</tr>
<tr>
<td></td>
<td>which would include detailed design, due diligence and potential transition planning.</td>
</tr>
<tr>
<td>6. Develop a regional system of care for urgent/emergent care to focus on</td>
<td>That the Hospital Boards approve moving forward to Phase 2,</td>
</tr>
<tr>
<td>process improvement and excellence that is evidence-based through an</td>
<td>which would include detailed design, due diligence and potential transition planning.</td>
</tr>
<tr>
<td>Emergency</td>
<td></td>
</tr>
</tbody>
</table>
Opportunity | Recommendations for Phase 2
--- | ---
Department/Urgent Care community of practice | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning; and would include working collaboratively with cross-sectoral partners in that design.

7. Expand/standardize seniors care strategies across all South East LHIN hospitals, including primary, secondary and tertiary care, with regional specialization of Behavioral supports and geriatric medicine/inter-professional resources | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning; and would include working collaboratively with cross-sectoral partners in that design.

Table 3: Summarized list of opportunities and recommendations for next steps in Phase 2 (Opportunities requiring community collaboration and partnership – to be recommended to the South East LHIN to take on the responsibility to move these forward.)

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Recommendations for Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Build capacity in community support services and optimize community resources to prevent unnecessary use of hospitals</td>
<td>That the Hospital Boards approve working collaboratively with the South East LHIN and community partners to help define the scope of a community capacity review.</td>
</tr>
<tr>
<td>2. Development of an ED Avoidance Strategy that include Enhanced Emergency Medical Services (EMS) Services and Care at Home and the Community</td>
<td>That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning; and would include working collaboratively with cross-sectoral partners in that design.</td>
</tr>
<tr>
<td>3. Improve service delivery and the integration of care for complex patients/frail elderly through the development of automated, Integrated Coordinated Care Plans</td>
<td>That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning; and would include working collaboratively with cross-sectoral partners in that design.</td>
</tr>
</tbody>
</table>

Moving Forward

A proposed sequence of activities has been developed on page 43. This proposal will depend on the capacity and investments available to the hospitals in the South East LHIN to proceed in Phase 2. A key proposal in moving forward is the development of a 90-day plan that will become a measure stick for progress. At the end of that plan, we anticipate that significant progress will be made and we will be able to present Hospital Boards with evidence on the design and due diligence on many of the activities planned for the next phase of work.

In summary, the activities that have been prioritized are both early opportunities identified by the Working Groups and key enablers that a significant number of Working Groups identified as necessary to integrate service delivery. Following these foundational activities, high priority activities will be sequenced as capacity allows. These activities are described further below:

Activities that should be started immediately, following Board approval:

- Development of a service governance model and design for a renewed shared service entity to house business function shared services;
- Launching a Request for Information (RFI) for Facilities/Shared Services;
- Identifying the cost-benefit for Hospital Information System (HIS) options that include status quo, independent hospital investment, a new shared HIS, independent HIS investment with connectivity across the region, taking into consideration all costs, benefits and risks;
- Design and due diligence of all business functions (Human Resources, Finance, Information Services, Facilities/Support Services); and,
- Business case development, design, due diligence for a Regional Laboratory System.

Priority Phase 2 activities that will follow, once capacity allows:
- Business case, design and due diligence for centralized intake and scheduling, an enabler identified by many of the Clinical Working Groups;
- Acute services redesign, which will include identify the acute roles and accountabilities for each hospital in the region in a regional, integrated system for elective, urgent/emergent and tertiary/quaternary services;
- Establishing a regional Emergency Department Council responsible for regional standardization and process improvements; and,
- Establishing a Regional Council for Complex Care/Frail Elderly patients to develop a regional system of care that includes standardization and access to geriatric assessment clinics, acute elderly units, and centres of excellence, followed by the development of integrated, coordinated care plans.

In addition, two important enablers identified by the Working Groups were the need for Clinical Leadership and oversight, and design and implementation using a rigorous Change Management approach. These have been designed into the Phase 2 activities.

It is envisioned that a series of activities will conclude in December 2015, after the 90-day plan to seek Board approval, followed by another decision point in March 2016. These staggered decision points will require ongoing Board engagement at key points to enable progress to continue and proceed to implementation where the business case demonstrates value.

Notes to financials:
The identification of potential savings and investment costs, have been calculated to identify the potential order-of-magnitude opportunity, and to provide input to help prioritize where the greatest opportunities may exist. Further work is required in Phase 2 to validate these figures through detailed design and due diligence. The identification of savings across each of the Working Groups has been calculated as follows:
- Business Functions Working Groups developed ‘strategic’ business cases to determine the order-of-magnitude opportunity through the development of shared service models;
- Diagnostics & Therapeutics Working Groups were asked to identify opportunities for savings; however, these have not been financially confirmed. A high-level estimate for each area was provided based on input from each Working Group.
Clinical Working Groups received analysis from KPMG/PSG that examined the potential gross savings based on expected performance compared to provincial averages. All potential savings are assumed to offset required investments and reinvestment in clinical care.

These high-level order-of-magnitude estimates provide the direction of savings and can be used to prioritize future design activities. In many cases, conservative estimates have been used that point to the potential for higher savings.

1. Business Function investments include severance costs and ongoing project management and change management that would be part of an overall shared service implementation. These costs also include the full projected cost of an Enterprise Business System for Finance and Human Resources. One system would also provide the potential for further efficiencies across Human Resources and Finance. These costs have not considered ongoing costs required to support current Finance and Human Resource systems and will be considered in Phase 2 design work.

2. Diagnostic and Therapeutic investments exclude any investments in Information Services. These will be identified in Phase 2, pending Board approval. Working Groups identified the benefits of shared information services (i.e., Laboratory Information Systems, shared Picture Archiving and Communications System (PACs) for Diagnostic Imaging and shared Pharmacy system). There is the potential to take advantage of Provincial Laboratory and PACS systems that may reduce these costs that will be considered in the design phase. The regional Pharmacy system would be included in a shared HIS, as would a regional Radiology Information System (RIS) were this investment to proceed.

3. Additional analysis is required to identify the costs and benefits of a Health Information System (HIS) solution. There are currently four options that will be assessed in Phase 2: status quo, independent hospitals investment, shared regional HIS, individual investments with connectivity (i.e., Health Information Access Layer, HIAL). The savings identified from Information Services is the savings attributed to a shared service model with some consolidation of the Information Services across the region, excluding the Health Information System. The additional, strategic Information Services savings, include the Information Services savings for a regional shared Health Information System. Additional work is required to identify the clinical efficiency that could be gained through a regional shared Health Information System. It should also be noted that an option to connect the individual Health Information System’s in the region, would also require investments to upgrade current Health Information System’s to enable automation and connectivity.
1.0 Introduction

1.1 Background

The Local Context

Residents in the South East are served at eleven hospital sites operated by seven corporations spanning the geography of the South East LHIN. The hospitals face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability, including:

- An aging population, with the proportion of those over age 65 becoming one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition for health professionals when they are needed most;
- An expected net negative financial impact due to health system funding reform intended to improve quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care for many services.

All hospitals in the South East LHIN and the South East CCAC have continually worked to manage within a balanced budget through focusing on internal efficiencies. Hospital members have also worked together to implement a regional shared services entity which has delivered ongoing savings in procurement and supply chain. Further, providers have been making significant progress in a number of important areas to improve the system for patients, including:

- Addictions and Mental Health – through the Addictions and Mental Health Redesign, which aims to redesign addictions and mental health services in the South East region to ensure patients receive the right care at the right time in the right place, enhance capacity of providers and the system, and reduce stigma.
- Primary Care – through the Health Links initiative, which brings local health care providers together and ensures that people with complex needs are at the centre of their care.
- Clinical Services Redesign – through the Clinical Services Roadmap (CSR) initiative, which is designed to find better ways of providing improved access to care for residents across this region; to cut down on the red tape patients have to deal with in moving from one caregiver to another; and to ensure that hospitals and the Community Care Access Centre can integrate their services to fill the gaps and deliver a more seamless continuum of care region-wide.

While much has been achieved to continue to serve the needs of patients across the South East LHIN, the scale of the issue facing the hospitals requires a re-examination and redesign of hospital and related community care.

The Provincial Context

The aging population and fiscal challenges require changes to how health care is delivered. To respond, the provincial government released Ontario’s Action Plan for Health Care (2012). Of particular importance is the Plan’s focus on integration, noting that “if we are to meet the needs of a growing population with multiple, complex and chronic conditions, our health care system must be even better coordinated, with seamless levels of care.” (p. 12) The Ministry of Health and Long-Term Care (MOHLTC) continues to emphasize integration for better quality, better access and better value. A number of initiatives have been rolled out provincially to incent integration between health service
providers such as new funding models, Health Links (to better support patients with complex conditions) and the Home First initiative (to provide care in the right place).

Furthermore, Health System Funding Reform (HSFR) is creating an increasingly challenging environment as hospital reimbursement shifts from a significant reliance on global budgets and allocations to one where hospitals are reimbursed for the amount (and eventually the quality) of service provided. This has had the effect of increasing (to a degree) the competitive environment between hospitals for patients, funding, capital and health human resources. The new funding models will benefit organizations that are able to adjust their operations to achieve high quality, efficient care and have established effective partnerships with other providers in the system, such as primary care, long-term care, rehabilitation services, etc.

In February 2015 the MOHLTC released Patients First: Action Plan for Health Care, the next phase of Ontario’s Action Plan for Health Care. It exemplifies the commitment to put people and patients at the centre of the system by focusing on putting patients’ needs first. It builds on that commitment and sets the framework for the next phase of healthcare system transformation. The plan focuses on four core principles:

- Access: Improve access – providing faster access to the right care.
- Connect: Connect services – delivering better coordinated and integrated care in the community, closer to home.
- Inform: Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.
- Protect: Protect our universal public health care system – making evidence based decisions on value and quality, to sustain the system for generations to come.

The Next Step

The next step in the journey to improving healthcare across the South East LHIN is to look at hospital services. As such, hospital and system leaders within the South East LHIN – represented by the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) – are working together to explore the future of hospital services across the South East region through Health Care Tomorrow – Hospital Services project.

The project is led through the South East CCAC and Hospital Executive Committee (SECHEF). This body acted as the Steering Committee for Phase 1 and is expected to have oversight of all future redesign recommendations. The Hospital Boards have been actively involved and will be asked to consider for approval recommendations put forth to them, and subsequently to the South East LHIN Board.
1.2 Health Care Tomorrow – Hospital Services Project Scope and Approach

Scope

The Health Care Tomorrow – Hospital Services project brings together the seven hospitals in the South East LHIN, the South East CCAC, the South East LHIN, Queen’s University Faculty of Health Sciences, key stakeholders including staff, community partners, patients and citizens to reimagine patient care in the region. The scope of the project is focused on reviewing how current hospital services should be provided, with the vision to improve access to high quality care through the development of a sustainable system of integrated care.

While the focus of the Health Care Tomorrow – Hospital Services project is on the provision of integrated hospital care across the South East LHIN, the planning recognizes that hospitals do not operate in isolation from other important elements of the health care system. As such, appropriate engagement and consideration is needed to ensure the hospitals deliver appropriate care that recognizes the interconnectedness of health care beyond hospitals. In recent years, there has been significant progress in important areas to improve our health care system for patients, including Addictions and Mental Health Redesign and Health Links.

The Health Care Tomorrow – Hospital Services project builds on the Clinical Services Roadmap (CSR) initiative that has been focused on improving patient care particularly with respect to patient access and transition points, patient flow across the region, and to some extent, patient flow across sectors in seven specific clinical areas of care. CSR was a set of initiatives that were identified through the development of the Integrated Health Services Plan (IHSP) 2. The initiatives sought to build capacity and integrate service delivery to solve very specific problems (i.e., Patient Flow and Alternate Level of Care). The Health Care Tomorrow – Hospitals Services project, Phase 1, seeks to engage a wide range of system stakeholders to establish a vision and, from that vision, the opportunities that exist across the clinical spectrum to improve access to high quality care through a more integrated, regional system of care.

The ultimate purpose of the Health Care Tomorrow – Hospital Services project is to support South East LHIN Hospitals, South East CCAC and the South East Local Health Integration Network (LHIN) in determining the role each provider will adopt to improve access to high quality care within the current and projected financial environments. This role will include new accountabilities at a system level including the integration of services across the region. The outcome will be an improved system than exists today that will serve the needs of residents in the South East LHIN into the foreseeable future.

The objective of Phase 1 of this project, which this report represents, is to develop a set of directional recommendations to enable the hospitals to work more as a regional system of care integrated with other elements of the healthcare system.

VISION:

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’
Approach

On July 17, 2013, SECHEF CEOs supported the development a Request for Services (RFS), which sought to contract an external agency with experience in system and process redesign. On June 15, 2014 the SECHEF CEOs contracted KPMG to begin work on Phases 0 and 1 of the Health Care Tomorrow – Hospital Service project.

KPMG has supported Phase 0 and Phase 1 through the provision of project management, change management and facilitation services, as well as strategic advice. In addition, KPMG has assisted in refining and articulating the need for change.

Please refer to Appendix A for the Project Charter for Phases 0 and 1.

Guiding Principles

The Health Care Tomorrow – Hospital Services project has been guided by the following principles:

 A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
 Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
 Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
 Inclusive engagement with patients and residents to inform processes;
 Inclusive engagement with Francophone and Indigenous communities to inform processes;
 Engagement via an appreciative inquiry approach;
 Options will be developed based on evidence and leading practice models;
 Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
 Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
 Realistic activities and timelines.

Methodology

The Health Care Tomorrow – Hospital Services project has been structured as a four phase initiative (starting at Phase 0 and going to Phase 3, with required approval points at the end of Phases 1, 2 and 3 in order to move to the subsequent phase). The table on the next page outlines the key activities for each of the phases of the project to provide context to the overall planning effort.

This report marks the end of Phase 1, pending approval from the Hospital Boards and the South East LHIN Board.
Phase 0: Planning
- Project Plan development
- Consult stakeholders on project scope, planning principles and approach
- Develop supporting project management tools using methodologies for communications, stakeholder engagement, change management and risk management

Phase 1: Build Case for Change and Identify Opportunities for Regional Collaboration
- Implement Project Plan; including continuous management, reporting and evaluation of change management, risk management and stakeholder engagement and communication plans
- Visioning Session with key stakeholders to launch Phase 1 (October 30, 2014)
- Develop the case and vision for change (including confirmation of the needs of the population and the quality of services provided, and confirmed the post mitigation net hospital funding impact)
- Review current individual hospital strategies for administrative efficiencies
- Stakeholder engagement; including governance engagement
- Leading practice review
- Identification of opportunities for regional collaboration and integration, through facilitated Working Group process

Phase 2: Analysis, Design and Implementation Planning
- Further analysis, design and potential implementation planning on approved opportunities and options
- Further validation of opportunities and options with key stakeholder groups, including community members
- Facilitate discussion of potential new roles
- Continue to implement change management, risk management and stakeholder engagement and communication plans

Phase 3: Implementation
- Potential implementation of approved opportunities and options
- Consultation with key stakeholder groups, including community members
- Design and facilitate a process to determine and validate recommended roles for each organization
- Continue to implement change management, risk management and stakeholder engagement and communication plans
Since June 2014, the seven hospitals, the South East CCAC, the South East LHIN and the Faculty of Health Sciences, Queen’s University have been engaged in Phases 0 and 1 of the project. The diagram on page 23 describes the key activities of Phase 0 and Phase 1, and how it fits in with Phases 2 and 3.

The approach to build the case for change and identify opportunities for regional collaboration is based on five key inputs.

1. **Data analysis**
   
   Significant data analysis and modeling was undertaken to validate the case for transformation and to determine the projected needs of the population. Data was a key piece of evidence upon which the opportunities for regional collaboration and integration were developed.

2. **Local expert advice**

   Those who work in the system have the knowledge and experience to inform what the future of health services needs to look like. Through the four-session Working Group structure, key local experts were engaged to identify opportunities for regional collaboration and integration in the three key focus areas (Business Functions, Diagnostics & Therapeutics and Clinical). Over 150 local experts were engaged in this process and included representation from groups including (but not limited to) physicians, program managers, patients, etc.

3. **External advice from other jurisdictions**

   A jurisdictional review of leading regional models of integrated care was conducted to inform the identification of opportunities for regional collaboration and integration. This included leading regional models provincially, nationally and globally. For example, international experts from the United States, the United Kingdom and the Netherlands were consulted to provide input and guidance on regional models for integrated care.

4. **Patients and families**

   A Regional Patient Advisory Council was formed to bring together patients and family members to discuss and test ideas related to the future of hospital services across the South East region. The Council consists of 24 representatives from across the South East region, including Francophone representation. Through their involvement in the Council, as well as some members’ involvement as active contributing members on the Diagnostics & Therapeutics and Clinical Working Groups, they ensured that the voice of the patient was considered throughout all planning discussions.

5. **Community input**

   Twelve community engagement ‘open house’ sessions took place throughout May and June across the South East region to provide the opportunity for community representatives, health service providers, and patients to learn more about the planning and provide feedback that was considered by the SECHEF CEOs in their decision-making. An online survey was also launched in as an outlet to provide feedback.
Engaging Key Stakeholders: Identifying Opportunities for Regional Collaboration

The SECHEF CEOs committed to a robust engagement strategy to ensure key stakeholders contributed to the identification of opportunities for regional collaboration.

As such, Phase 1 included the establishment of Working Groups to identify opportunities for regional collaboration, towards the vision to improve access to high quality care through the development of a sustainable system of integrated care. To do this, the Working Groups had four in person sessions, each with the following focus:

Session 1: Visioning
Session 2: Opportunity identification
Session 3: Opportunity assessment
Session 4: Finalize future state model

A total of eleven Working Groups were created, including:

- **4 Business Functions** – Human Resources, Finance, Facilities/Support Services, Information Services
- **3 Diagnostics & Therapeutics** – Laboratory, Pharmacy, Diagnostic Imaging
- **4 Clinical** – Chronic Complex/Frail Elderly Care, Elective Services, Tertiary/Quaternary Services, Urgent/Emergent Services

In addition to the Working Group sessions, the Co-Leads of each of the Working Groups along with SECHEF CEO Leads met regularly between Working Group sessions to align on direction for the Working Groups towards the overall vision.

There were also a number of additional Working Groups and advisory groups that were integral to supporting Phase 1, including:

- Regional Patient Advisory Group
- Communications Working Group
- Change Management Leadership Group
- Physician Change Management Working Group
- Technical Advisory Group

Please refer to Appendix B for the Terms of Reference and Listing of Participants that were involved in Phase 1.
Community Engagement

In addition to the robust engagement of providers and patients through the Working Group process, a focused effort was made to engage the broader community to ensure their voice was heard and their feedback considered in the identification of opportunities for regional collaboration.

Throughout May and June, a concerted effort was made to engage as broadly as possible and hear ideas from residents in the South East region. The objective of the engagement was to inform and consult with community stakeholders and the general public about their beliefs for a sustainable health care system. The engagement provided an opportunity for community representatives, health service providers, and patients to learn more about the project and provide feedback that will be considered by the SECHEF CEOs. All Hospital staff members were also encouraged to take part in the community engagement activities.

The engagement included the launch of a survey at the end of April 2015 and a series of ‘open house’ sessions that occurred during the same time period. Through print and radio advertising, and extensive media pick-up across the South East LHIN, the survey garnered 1,723 respondents – an excellent response rate based on previous engagement outcomes. Of those surveys that were initiated, 1,535 were completed in full, allowing for a thorough analysis. In addition, twelve community engagement ‘open house’ sessions took place across the South East region in the following communities: Bancroft, Picton, Brockville, Trenton, Napanee, Kingston, Perth, Smiths Falls, Brighton, Belleville, Sharbot Lake and Westport. Further engagement was supported through discussions with local dignitaries, sub regional community symposia and advisory councils.

Those individuals who participated in the survey and/or ‘open houses’ had an opportunity to share their perspectives on healthcare including their priorities and experiences.

The survey and ‘open house’ sessions were also supported by a web-based portal at [www.healthcaretomorrow.ca](http://www.healthcaretomorrow.ca), by which those seeking further information on the Health Care Tomorrow – Hospital Services project, as well as other South East LHIN activities, could locate the required information. The portal was also the primary access point for the French-based survey.

Please refer to Appendix C for the Stakeholder Engagement Summary which provides a summary of the stakeholder engagement feedback gathered through Phases 0 and 1, as well as the feedback from the community engagement activities.

It is estimated that the voices of over 2,000 internal and external stakeholders contributed to Phase 1 of the project.

Overall, the internal and external engagement process has provided tremendous value to the SECHEF CEOs and Working Groups in the identification of opportunities.
**Decision-making Criteria**

SECHEF CEOs have committed to the following criteria to guide the work of the Heath Care Tomorrow - Hospital Services project and to inform decision-makers:

1. **Access** – South East LHIN residents should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes, regardless of where they live.

2. **Patient experience** – Healthcare providers should offer services in a way that is sensitive to an individual’s needs and preferences based on patient and family centred care philosophy, and creates a smooth transition between services.

3. **Quality (outcomes/effectiveness)** – South East LHIN residents should receive care that works and is based on the best available scientific information.

4. **Cost (efficiency)** – Healthcare providers should continually look for ways to eliminate inefficiencies, and provide care that is in the most appropriate setting, at the right place, at the right time.

5. **Academic mission** – The healthcare system in the South East LHIN is integral to a vibrant and thriving teaching and research community. The teaching community, made up of multiple university and college partners, helps to prepare students of all disciplines to graduate with skills needed for our Health Care Tomorrow environment. The research community informs improvements and innovations to care across the system through supportive partnerships with the School of Health Sciences, as well as Nursing, and Allied Health professionals.

The criteria are intended for use in the development and evaluation of Clinical and Diagnostic & Therapeutics opportunities/options/recommendations. The criteria are meant to:

- Provide guidance to Boards, SECHEF CEOs and Working Groups on important features of a future state health care system;
- Ensure alignment to Ontario’s quality framework;
- Inform the design of new models by stimulating consideration for improvements within and between providers;
- Support evaluation of opportunities and options recognizing that the evaluation will be a combination of qualitative and quantitative assessments;
- Support transparent decision-making that recognizes that in particular circumstances consideration of criteria will likely result in criteria being in conflict and requiring tradeoffs; and,
- Support the assessment of the impact of opportunities, options and recommendations in the final report.

The initial framework and definitions are based on the Health Quality Ontario (HQO) framework. Patients, through the Regional Patient Advisory Council, were asked to provide feedback on the criteria by defining what each criterion means from a patient perspective. Working Groups provided feedback on the criteria through an exercise at their Working Group sessions. Finally, SECHEF CEOs provided feedback on the framework and its application.

Please refer to Appendix D for the Decision-making Criteria Summary, which outlines the decision-making criteria definitions and the feedback provided by the Working Groups and Regional Patient Advisory Council.

The criteria are intended to be considered as ‘guide posts’ to assist participants in their evaluation of opportunities/options/recommendations and to assist with the explanation of why some options were approved over others.
Key activities

- Project Plan development
- Consult stakeholders on project scope, planning principles and approach
- Develop supporting project management tools using methodologies for communications, stakeholder engagement, change management and risk management

Key activities

- Implement Project Plan; including continuous management, reporting and evaluation of change management, risk management and stakeholder engagement and communication plans
- Visioning Session with key stakeholders to launch Phase 1
- Develop the case and vision for change (including confirmation of the needs of the population and the quality of services provided, and confirmed the post mitigation net hospital funding impact)
- Review current individual hospital strategies for administrative efficiencies
- Stakeholder engagement; including governance engagement
- Leading practice review
- Identification of opportunities for regional collaboration and integration, through facilitated Working Group process

Should the SECHEF CEOs, hospital Boards and South East LHIN approve the opportunities/options/recommendations at the end of Phase 1, this will signal movement into Phase 2 of the project (focused on further analysis, design and implementation planning).

At the end of Phase 2 (note: the work streams within Phase 2 will not all follow the same timelines, some may complete Phase 2 planning earlier than others – see Phase 2 sequencing on page 22), the SECHEF CEOs, hospital Boards and South LHIN Board will be presented a detailed recommendation with a request for approval to implement specific options (Phase 3).
1.3 Structure of this report

This Phase 1 Recommendations Report provides a summary of the work of Phase 1 of the Health Care Tomorrow – Hospital Services project. Specifically, the report outlines the case for change and summarizes the opportunities for regional collaboration and integration, as identified by the Working Groups focused on three streams of work – Business Functions, Diagnostics & Therapeutics and Clinical.

The potential opportunities identified by the Working Groups are organized into themes to describe the potential value that collaboration and integration opportunities could deliver to patients and the communities.

Exploring potential collaboration and integration opportunities also requires consideration of the critical enablers that must be in place to successfully support these activities. To this end, the report describes not only the investments required, but also key organizational transition risks and considerations.

Overall, the report is structured with the following sections:

1. Introduction
2. The Case for Transformation
3. Opportunities for a High-Performance Health System in the South East
4. Considerations for Next Steps
5. Value Proposition
6. Recommendation

An appendix is also included:

- **Appendix A**: Project Charter
- **Appendix B**: Terms of Reference and Listing of Participants
- **Appendix C**: Stakeholder Engagement Summary and Community Engagement Feedback Report
- **Appendix D**: Decision-making Criteria Summary
- **Appendix E**: Technical Data Analysis
- **Appendix F**: Visioning Day Summary
- **Appendix G**: Change Management Plan
- **Appendix H**: Decision-making and Dispute Resolution Process
2.0 The Case for Transformation

Overall, the need to transform healthcare in the South East region is driven by the following three factors:

- Canada is falling behind the world in providing healthcare, and is quickly moving to last place.
- Although each Health Service Provider and hospital should be proud of the services they have provided to their patients in the past, today’s system is not meeting the needs of our current patients.
- The South East region can expect much slower growth in healthcare funding over the next ten years compared to the last ten years.

In the South East LHIN overall, the hospitals as a whole are spending more money on clinical services than provincial peers, according to the funding formula. This challenge increases each year as others across the Province continue to improve their performance year over year as well. As such, the hospitals within the South East LHIN have an efficiency imperative to address the funding formula shortfall, as well as year over year gaps for unfunded inflation. The savings to address these pressures will not be available for capital or other clinical investments – additional savings will be required.

We have in the South East LHIN, the ability and the intellect to address these pressures and to improve access to high quality care.

The question is do we have the will to change?

2.1 The Patient Perspective: Focusing on Treatments and Treatment

“...I have to admit I am very pleased with the emergency services I received two years ago. I also realize the great efforts of the medical clinic and my doctor to minimize delays. We must maintain this level of service within the fiscal realities, while keeping the patient as a priority."

“...It’s not about whether the hospital is a good hospital, or the physician is a good physician, it’s about the experience."

“...There is so much inconsistency with regard to the information, medical treatment, and patient support that is provided, both from location to location and from care provider to care provider within a single location."

The vision of the Health Care Tomorrow – Hospital Services project is to improve access to high quality care through the development of a sustainable system of integrated care. With this, the ultimate goal is to improve patient care and the patient experience.
Through the dedicated involvement of 24 patients and family members, who participated on the Regional Patient Advisory Council (RPAC), an invaluable perspective on the patient experience was gained – including a perspective on the current challenges faced by patients within the system, as well as insights into how the system can be improved.

The following patient stories articulate some of the patient stories that were shared by RPAC members.

**Patient Stories**

An RPAC member shared a personal account of his and his wife’s experience with the health care system in the South East. His wife, who suffers from several chronic conditions was set to undergo surgery in 2011. However, she was also scheduled for an important appointment the following week and the required diagnostic test, an MRI, prior to the appointment. He and his wife experienced frustration and stress when the providers in the system did not communicate properly in order to facilitate both of these important procedures. Several complications later, his wife’s surgery was delayed and her appointment and MRI were almost missed. In addition, opportunities to combine diagnostic tests (i.e., two MRIs that could have been done together) were missed. Overall, he stressed the importance of communication and coordination between providers in the system in order to both improve efficiency and patient and family experience.

An RPAC member shared the experience when her husband was experiencing chest pains and was taken to the emergency room. Admitted quickly, he saw five different healthcare providers – two in the Emergency Department, one in the Intensive Care Unit, his primary care provider in the community, and a physician at the Heart Institute, where he was ultimately referred. Throughout this process, he and his wife wondered which provider would be accountable if an adverse health event happened before he saw his primary care physician.

Another Francophone RPAC member described an experience he had, both in and out of the Emergency Department, when he experienced a blood clot in his lung. He saw several different providers, underwent several different tests, and was given several different instructions for next steps and follow-up care. Although fully bilingual, he had difficulty understanding the entire process, especially due to the stress that arose due to acute illness. Only when his daughter joined him to ask questions and advocate for him in English did the process become clear to him. She was able to describe the process, next steps, and the seriousness of his situation in his language.

Through these, and the many other patient experiences that were shared by RPAC members, the following challenges were identified:

- Struggles navigating care
- Poorly handled transitions between providers
- Lack of clear and consistent communication from providers (including considerations for unique needs, i.e., disabilities and language requirements)
- Long wait times
- Cancelled surgeries
- Patient surge/gridlock

**How can we do better? How one is Treated compared to the Treatments Received ...**

An RPAC member articulately spoke to the importance of the need to think about “treatment” of the individual, rather than just “treatments”. She stressed the importance of considering how patients are treated and the quality of the
care, rather than just the medical treatments. To this point, from a patient perspective, **accessibility, communications** and **choice** are key.

Overall, the RPAC spent time articulating the key elements of the ‘ideal patient experience’, from the perspective of ‘people factors’ and ‘system factors’.

<table>
<thead>
<tr>
<th>People factors of the ideal patient experience</th>
<th>System factors of the ideal patient experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Strong two way communication between providers and patients/caregivers/family</td>
<td>• Seamless communication between all providers (i.e., hospitals, primary care, CCACs, etc.)</td>
</tr>
<tr>
<td>• Continuity and consistency of providers</td>
<td>• Information and links to community resources</td>
</tr>
<tr>
<td>• Considerate and respectful of each patient/family’s unique needs and involves them in the design of the care plan</td>
<td>• Seamless and timely access to care, transition and follow up</td>
</tr>
<tr>
<td>• Support and advocacy</td>
<td>• Seamless access to patient information between providers</td>
</tr>
<tr>
<td>• Confidence in staff and quality of care</td>
<td>• Accessible care locations and/or remote options (i.e., telemedicine, remote technology, etc.)</td>
</tr>
</tbody>
</table>

Overall, from the patient’s perspective, change is necessary. Status quo is not an option, and continuing to work in silos is not good for patient care. In order to effectively address the challenges facing the system and preventing better patient care, and to move towards the ideal patient experience, **hospitals must work better together**.

RPAC members have been involved in many of the Diagnostics & Therapeutics and Clinical Working Groups and were integral to informing the opportunities from a patient perspective – bringing forward their own experiences as a patient or family member, and those of the broader RPAC.

Throughout the process, the broader RPAC reviewed the work of the Working Groups and provided valuable considerations and input that was further considered by the Working Groups. Specific considerations from the patient’s perspective are noted within the Diagnostics & Therapeutics and Clinical sections of this report.
2.2 Community Engagement Feedback

A focused effort was made to engage the broader community to ensure their voice was heard and their feedback considered in the identification of opportunities for regional collaboration.

All responses from the community engagement ‘open houses’ and surveys were analyzed using an industry standard analytical tool and reviewed to ensure the tool was appropriately reflecting the nature of the responses. The analysis revealed three predominant themes, outlined in Table 4 below. In reviewing the comparison between providers and the public there was only slight variation in the themes.

Table 4: Community Engagement Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Provider</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access (i.e., wait times in the Emergency Department)</td>
<td>Access (i.e., wait times in the Emergency Department, for diagnostics)</td>
</tr>
<tr>
<td>2</td>
<td>Quality of care (i.e., staffing challenges, better communication)</td>
<td>Quality of care (i.e., show compassion, respect patients, involve families)</td>
</tr>
<tr>
<td>3</td>
<td>System integration (i.e., better linkages with primary care, improved communication providing more timely updates on patients)</td>
<td>Provision of care (i.e., improved communication between providers, cleanliness of site)</td>
</tr>
</tbody>
</table>

In the theme related to access, the provider responses focused on wait times and improving access to services in the Emergency Department. There were also suggestions that wait times could be lowered by improving access via 24 hour non-urgent care centres. The patient focused comments for access, as expected, included commentary to improve their wait times in the Emergency Department, and more timely access to diagnostic services like MRI and CT scans.

Quality of care varied between the two types of respondents. The provider responses focused on issues around staffing including interpersonal relationships but also the issue of communication among the various providers. The patient focus reflected on staff skills related to compassion and respect towards patients, with a request to include the patient and family in discussions concerning their care.

The more significant variation in themes between the two groupings was in the final theme. Providers indicated a desire for more system integration, including better linkages with primary care and improved communication across services. Patient responses focused on improved communication between providers but also reflected concerns that should services integrate that they may not be as available to their community as they are now. Other impacts on patient impressions related to recent hospital stays included items such as food quality and cleanliness, which would have improved their experience.

The ‘open house’ sessions were provided as opportunities to reach out to more communities that may support the attendance of additional subgroups in the LHIN. These sessions were supported by various members of SECHEF who also participated in informing and gathering feedback. This format provided the chance for the public to present ideas, to share opinions and to discuss concerns. The items brought forward were collected and thematically assigned as follows:

- Access to a physician or primary care provider
- Retain 24 hour emergency services in local communities/close to home
- There is a need for in-patient beds close to home
- There is a willingness to travel for specialized procedures
- Community support services are essential in rural areas
- Many voiced concerns over changes in community supports offered by the Community Care Access Centre
- In general, there appears to be a lack of understanding or clarity about the types of services available in their local communities or hospital.

The feedback that was received through the community engagement activities was presented to the Working Groups for their consideration in their final opportunities/options/recommendations, as well as to the SECHEF CEOs for their consideration in final decision-making.

Please refer to **Appendix C** for the Stakeholder Engagement Summary which provides a summary of the stakeholder engagement feedback gathered through Phases 0 and 1, as well as the feedback from the community engagement activities.
2.3 Current State of Health Services

The hospitals in the South East LHIN comprise seven hospital corporations across 13 sites. Together the hospitals serve a population of 492,956 (Statistics Canada, 2015) in the South East LHIN proper and cover a range of urban and rural settings stretching from across the region. The City of Kingston with a population of 159,561 (Statistics Canada, 2015) is the urban centre of the region, with the second largest city of Belleville at 92,540. The majority of the population lives in a rural setting outside these urban centres.

A current state picture of the assets and high level activity of the hospitals in the South East LHIN is described in Table 5, below:

Table 5: Current state picture of the assets and high level activity of the hospitals in the South East LHIN

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Description</th>
<th>Beds</th>
<th>OR Rooms (availability differs by time of day and week)</th>
<th>CT Scan / MRI (Funded Hours differs by site)</th>
<th>ED Visits (High Acuity, CTAS 1, 2, 3)</th>
<th>ED Visits (Low Acuity, CTAS 4, 5)</th>
<th>Inpatient Admissions 2013/14</th>
<th>Day Surgery Procedures 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brockville General Hospital</td>
<td>Community hospital, providing Acute care, Complex Care, Rehabilitation, Palliative Care and Mental Health.</td>
<td>143</td>
<td>5</td>
<td>CT</td>
<td>17,224</td>
<td>8,404</td>
<td>4,676</td>
<td>11,050</td>
</tr>
<tr>
<td>Hotel Dieu Hospital</td>
<td>Academic Ambulatory care hospital.</td>
<td>6</td>
<td>6</td>
<td>CT</td>
<td>13,321</td>
<td>35,210</td>
<td>179</td>
<td>14,083</td>
</tr>
<tr>
<td>Kingston General Hospital</td>
<td>Academic hospital, providing complex-acute and specialty care, and home to the Cancer Center of South Eastern Ontario.</td>
<td>442</td>
<td>11</td>
<td>CT (2) MRI</td>
<td>40,404</td>
<td>13,495</td>
<td>21,378</td>
<td>5,432</td>
</tr>
<tr>
<td>Lennox &amp; Addington County General Hospital</td>
<td>Community hospital providing Acute care, Palliative Care and Long-term Convalescent Care.</td>
<td>52</td>
<td>3</td>
<td></td>
<td>10,655</td>
<td>13,171</td>
<td>1,281</td>
<td>2,584</td>
</tr>
<tr>
<td>Perth &amp; Smiths Falls District Hospital</td>
<td>Community hospital providing Acute care, Palliative Care and Rehabilitation.</td>
<td>85</td>
<td>4</td>
<td>CT</td>
<td>14,497</td>
<td>28,951</td>
<td>3,519</td>
<td>6,353</td>
</tr>
<tr>
<td>Quinte Health Care</td>
<td>Community hospital providing Acute Care, Rehabilitation, Complex Care and Mental Health.</td>
<td>237</td>
<td>9</td>
<td>CT (2) MRI</td>
<td>59,651</td>
<td>36,782</td>
<td>11,818</td>
<td>21,871</td>
</tr>
<tr>
<td>Providence Care</td>
<td>Post-acute hospital providing Rehabilitation, Complex Care, Palliative Care, Long-term Care, Mental Health and Community Services.</td>
<td>266</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: Hospital Capacity Survey, 2015
A more detailed review of hospital capacity and service delivery is provided in Appendix E (Technical Data Analysis). Table 6, below, provides a snapshot of where residents in the South East LHIN receive hospital care from both the hospitals in the South East LHIN and those outside the LHIN.

**Table 6: South East LHIN resident hospital use, by care type**

<table>
<thead>
<tr>
<th>Provider Share of South East LHIN Resident Hospital Use</th>
<th>Acute</th>
<th>Day Surgery</th>
<th>Emergency Department</th>
<th>CCC</th>
<th>Rehab</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston General</td>
<td>48%</td>
<td>9%</td>
<td>17%</td>
<td></td>
<td></td>
<td>7%</td>
</tr>
<tr>
<td>Hotel Dieu</td>
<td>0.1%</td>
<td>20%</td>
<td>16%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quinte</td>
<td>20%</td>
<td>32%</td>
<td>30%</td>
<td>41%</td>
<td>31%</td>
<td>7%</td>
</tr>
<tr>
<td>Perth &amp; Smiths Falls</td>
<td>8%</td>
<td>8%</td>
<td>13%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lennox &amp; Addington</td>
<td>4%</td>
<td>4%</td>
<td>8%</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brockville General</td>
<td>8%</td>
<td>15%</td>
<td>8%</td>
<td>17%</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>Providence</td>
<td></td>
<td></td>
<td></td>
<td>32%</td>
<td>48%</td>
<td>54%</td>
</tr>
<tr>
<td>The Royal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>South East Total</td>
<td>87%</td>
<td>87%</td>
<td>92%</td>
<td>93%</td>
<td>86%</td>
<td>84%</td>
</tr>
<tr>
<td>Champlain</td>
<td>6%</td>
<td>6%</td>
<td>4%</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Central East</td>
<td>3%</td>
<td>5%</td>
<td>3%</td>
<td>0.1%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Toronto Central</td>
<td>3%</td>
<td>1%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Other LHINs</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0.4%</td>
<td>2%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Data Source: DAD, NACRS, CCRS, NRS, OMHRS, LTC-RAI, 2013/14

In total, 87% of the acute services provided to residents within the South East LHIN are provided by South East LHIN hospitals. This is higher for emergency services at 92%, and complex care at 93%. Services received outside the LHIN can be a consequence of boundary conditions, whereby proximity to other LHIN boundaries and health service providers in those LHINs provides for natural referral and patient flow, or for highly complex services that may not be available in the LHIN. As described in Appendix E, some residents may leave the LHIN as a result of high wait times for service, which may provide some evidence that services in these areas are not serving the population need.

While this provides a picture of where patients receive care and patient flow across the hospital system, the patient stories and perspectives articulated in Section 2.1 highlight some of the challenges patients experience in navigating care across this network of hospitals.

Hospitals for the most part have worked in isolation. Healthcare leaders believe that by building stronger relationships, providers will behave more as an integrated set of entities in order to improve access, patient experience and outcomes of care. The next section presents the case for transformation from a population and funding perspective.
2.4 Case for Transformation

The hospitals in the South East LHIN face a number of challenges that will impact their sustainability and capability to continue to provide excellent patient care to the residents of the region. In addition to the challenges described through the patient perspective in Section 2.1, additional factors include:

1. Demographic shifts that will change the share and make-up of the population;
2. Changes to the way hospitals are funded by the Ministry of Health and Long-term Care; and,
3. A current patient care model that relies heavily on institutional-based care (i.e., hospitals, long-term care homes).

Demographic Shift

The population of the South East LHIN is projected to grow by approximately 5% in the next ten years (Ministry of Finance, 2013/14 – 2023/24 projections), as shown in Figure 1 to the right. This is less than half the projected growth of the Province as a whole at approximately 11%.

This slower than provincial average population growth may have important revenue implications for the South East LHIN’s hospitals. The Ministry of Health and Long-term Care is implementing its Health Based Allocation Model (HBAM) as part of its Health System Funding Reform (HSFR) strategy. Since HBAM allocates a portion of the provincial hospital budget based on relative population growth and aging, South East LHIN hospitals are likely to see their shares of available HBAM funding fall over time. Making no or minimal increases to the Provincial hospital budget and increasing funding for community based services are cornerstones of the HSFR strategy. South East LHIN hospitals may have HBAM funding reductions until the Ministry of Health and Long-term Care increases the provincial hospital budget.

Over the next ten years the seniors population (those aged 65 and over), is projected to grow by 35%. This will create a significant change in the make-up of the population. It will also increase hospital service utilization, particularly increasing demand for services associated with seniors, such as those to treat strokes, cancer, chronic and multiple chronic diseases such as chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes, and Alzheimers and dementia. This is significant because current methods for treating this patient population are inefficient compared to the rest of the Province. This is discussed in more detail below.

Although the senior’s population is projected to grow by 35% over the next ten years, this is slower growth than the rest of the Province. As shown in Figure 2 below, the Provincial senior’s population is growing by 45% over the next ten years, with the highest growth LHIN, Mississauga Halton, growing 60%. Again, the Province has indicated an overall
A slower-growing envelope of funding for healthcare and near-zero growth in hospital funding. Regions with faster growing populations, and faster growing senior’s populations will be the recipients of an increasing share of that funding.

Within the South East LHIN, the demographics of the population will also shift over the next ten years. The central regions of the South East LHIN will see higher rates of growth, particularly in and around Kingston, while eastern (including Brockville, Perth and Smiths Falls) and western portions (including Belleville, Bancroft, Trenton and Napanee) of the region will see slower rates of growth, growing less than 10%. This implies a need to reallocate resources within the LHIN to keep pace with population change.

Figures 3 and 4 below show the expected growth in hospital utilization by sub-region in the LHIN. The effects of an aging population will create variations in the service needs of the population across the LHIN over the next ten years.
Hospital Funding

Canada is typically in the top quartile of healthcare spending when compared to the Organisation for Economic Co-operation and Development (OECD) countries on a per capita basis (OECD, 2014). There is widespread acknowledgement that the outcomes Canada achieves are not commensurate with this high level of spending. Countries that spend less (i.e., United Kingdom, Australia and Sweden) achieve greater outcomes than Canada. The Commonwealth Fund in its latest comparative report of eleven international healthcare systems ranked Canada second last behind the United States, comparing quality, access, efficiency, equity, population health and spending (Davis et al, Commonwealth Fund, 2014).

In Ontario, healthcare consumes 41% of the Provincial budget with projections that vary between 60 to 80% in the long term. In response, the Ministry of Health and Long-term Care has taken steps to improving quality of care and bending the cost curve, moving to align payment with outcomes, decisions based upon best available evidence, thereby increasing the value of our healthcare system.

In April 2012, the Ministry of Health and Long-term Care began changing the way it funded hospitals. The Ministry of Health and Long-term Care began implementing its Health System Funding Reform (HSFR) strategy to transition from a predominately global funding model towards patient-based funding. HSFR includes new funding models: Quality-based Procedures (QBPs) and the Health-based Allocation Model (HBAM). By April 2014, QBPs were expected to comprise 30% of hospital funding, HBAM 40% and the remaining 30% is global or block funding.

QBPs are volume-based funding whereby hospitals are paid a fixed price for specific procedures or diagnoses. Since 2012, the Province has been increasing the number of procedures funded using this model. Hospitals are paid a fixed price for each QBP up to an agreed limit as agreed in their Hospitals Service Accountability Agreement (HSAA). Procedures in excess of the HSAA agreed volumes are funded by the other resources of the hospital. Hospitals who can provide QBP services at or less than the price will do well under the QBP funding stream; other hospitals will have to adjust by reducing their costs or exiting the QBP market.

HBAM allocates funding to hospitals based on expected service volumes and expected unit costs. In HBAM, a hospital's activity is adjusted for the age, forecast growth and aging, socio-economic status, and rural geography of its population to determine its expected services. Unit costs are a function of hospital characteristics, including size, geographic isolation, teaching intensity, and clinical specialization. Cost efficient hospitals (i.e., those whose unit costs are less than expected) serving fast growing and aging populations will see their shares of available HBAM funding increase. Cost inefficient hospitals serving relatively slow growing and aging populations will see their share of HBAM funding fall over time. Since South East LHIN hospitals serve populations growing slower than the provincial average, their best strategy to avoid funding cuts is to improve their cost efficiency, including reducing expenses where possible. Reducing admissions and shortening lengths of stay per admission are among the tactics South East LHIN hospitals will have to examine.

HSFR has been introduced gradually over time to allow hospitals time to adjust to the changes. Mitigation factors were applied to the funding model to dampen the financial consequences of the new approach to funding on hospitals and to give the hospitals an opportunity to adjust their operation. In the first year since mitigation factors were removed, South East LHIN hospitals collectively lost approximately $6.5 million in funding. As the number of QBPs increases and the portion of funding from global budgets decreases, this impact is likely to increase until (maybe) the hospitals in the South East LHIN become more efficient. Analysis identified an inefficiency of approximately $30.4 million compared to operating efficiency expected through HBAM funding.
Overall, this means that, year over year, hospitals will be required to match any funding formula loss. As such, savings identified are not savings that can be invested elsewhere – they will be efficiency savings that hospitals are required to make to keep up with HBAM requirements. Hospitals must in fact find ways to generate surpluses in order to build up funds for capital investment in Information Technology and other investments.

**Current Service Delivery Model**

The provision of patient care in the South East LHIN is highly institutional when compared to health service providers in other parts of the Province. This means patients use the Emergency Department more, are more likely to be admitted when they show up at the Emergency Department, are more likely to stay longer as an inpatient, and are more likely to be admitted to Long-term care and stay in Long-term care longer than similar patients across the Province. These higher rates of utilization increase costs and do not necessarily increase quality, patient experience and access.

A detailed data analysis was performed of the current service delivery model, compared to other LHIN jurisdictions. The following was identified. Please refer to Appendix E (Technical Data Analysis) for detailed data analysis.

- There are significant opportunities to improve readmission rates and wait times.
- There is a need to examine whether the observed high post-procedural complication rates are the result of attentive documentation and reporting practice or imply opportunities to improve patient safety.
- The South East LHIN is the second highest spender per capita for hospitals, and second highest for Long-term Care.
- The South East LHIN is this highest spending per capita for Home Care services and the lowest for community support services such as assisted living, seniors day programs, meals on wheels, respite care. These spending figures are adjusted for age to compare similar populations.
- The sub-LHIN planning regions (as depicted in Figure 3) in the South East have high acute expenses per person when compared to other sub-LHIN planning regions in the Province. Again these figures are adjusted for age to compare similar populations.
- Residents in the South East used the hospitals in the LHIN for 50% (101,394) more Emergency Department visits that expected in 2013/14. The rate of low acuity visits was driving most of this increase at 71,363 more than expected.
- Potentially avoidable and admissions accounted for a high proportion of South East LHIN hospital use. Potentially avoidable admissions including Ambulatory Care Sensitive Conditions (ACSC) accounted for the use of 75 beds in the South East that could have been used otherwise for acute patients, or would have resulted in savings of approximately $17.3 million if they were not used at all.
- In ten years, the South East LHIN will require 278 more beds or 20% more than is in use today, if nothing changed and current approaches to care continued. This would require significant funding that is not available, amounting to approximately $120 million over ten years if no changes are made in the way clinical services are provided. This provides a clear opportunity to improve service delivery by becoming a low cost provider to enable a sustainable healthcare system that is available to serve the needs of the future population.

Overall, patients in the South East visit hospital more often, are more likely to be admitted and stay longer than residents in other parts of the Province. There are a number of factors that could contribute to this high usage of the hospital system. The system as it is, was not designed for the patient population we see today, with significantly higher rates of chronic disease. As demonstrated, this issue will only grow in the decades to come. Patients in many parts of the South East LHIN rely on the Emergency Department for primary care and treatment for their chronic disease.
In addition, the hospitals and broader health system have not always worked in concert, making it difficult for patients to move around the system efficiently, as demonstrated in the patient stories articulated in section 2.1. Lastly, this could be a feature of a misallocation of resources between the community and hospital sector, where patients can be as effectively and more efficiently cared for at home.

In Summary – The Case for Transformation

In summary, there are two major factors behind the case for transformation, and ultimately driving the Health Care Tomorrow – Hospital Services project. These include:

1. **Constrained financial resources** – the changing funding formula and fiscal restraint are significant contributors to the need for a more sustainable way to deliver high quality care within the South East LHIN.

2. **Increasing demand** – an aging population is creating an increased demand for services in the South East region and contributing to the estimated shortfall in funding available. All told, this will amount to a gap of approximately $120 million if no changes are made to the way services are provided.

The hospitals in the South East LHIN have a significant opportunity to improve service delivery that will result in improved quality, access and patient experience, as well as lower costs. The case for transformation is clear – if no changes are made to improve patient experience, quality, access and costs, the system will continue to experience many of the challenges it faces today in an extreme fashion.

The Working Groups have done significant work to identify opportunities to respond to these challenges.
2.5 Vision for a High-Performing Health System in the South East

The hospitals in the South East LHIN have an incredible opportunity to change the way healthcare is provided across the region. As demonstrated by the Case for Transformation, there is a clear case and opportunity to improve care for patients and residents that will improve the sustainability of the system and create a more effective and efficient system. At the beginning of Phase 1 of the Health Care Tomorrow – Hospital Services project, the hospitals sought to understand the key issues and challenges patients have experienced transitioning across the system, and to gather input on a future vision for healthcare in the region.

Through a Visioning Day, held in October 2014, over 200 stakeholders came together to imagine what the healthcare system in the South East region could look like to support a more integrated system of care. The detailed output of the Visioning Day is provided in Appendix F (Visioning Day Summary) that outlines the key issues and challenges, the strengths, new and emerging initiatives that could be built upon to improve the system. Participants identified what a high performing health system would look like in the South East, including the following:

A high-performing health system in the South East...

- Works with patients as partners to empower them to help them manage their health;
- Continuously identifies and adopts innovative and evidence-based models of care;
- Is accessible to patients and easy to navigate;
- Is accountable and outcome-oriented;
- Communicates and shares information;
- Is governed collaboratively to enable system thinking;
- Has clearly developed and understood roles; and,
- Is a true system (providing integrated, seamless care across the continuum).

This is the benchmark against which the hospitals in the South East LHIN will be measured as they set out to redesign a sustainable integrated health system that is accessible and provides high quality care.
3.0 Opportunities for a High-Performing Health System in the South East

3.1 Overview of Opportunities

Over 100 opportunities were discussed by the Working Groups. Overall, 10 opportunities were prioritized by the Working Groups, with the focus to improve access to high quality care through the development of a sustainable system of integrated care.

The opportunities focus on a balance of integrating service delivery across the region, and enabling a more cost-effective system so that current and future patients’ needs can be met. The opportunities include the development of a shared service entity to serve the region through shared business functions; developing a regional approach to diagnostics and therapeutics (i.e., Laboratory), and improving service delivery amongst clinical services that would see a regional, integrated approach, that improves access and patient flow between hospitals, and between the hospitals and community and primary care.

While each opportunity does not individually serve to address both challenges of constrained financial resources and increasing demand, they collectively serve to improve service delivery that will result in improved quality, access and patient experience, as well as lower costs for a more sustainable system of care.

Across all of the opportunities, there were a number of important elements that emerged that support an overall regional model of care for the South East region. The following enablers were identified that were common features across the Working Groups:

- **Regional clinical leadership, oversight and accountability** is a key factor for the success of all proposed regional models;
- An **integrated information system** is a critical enabler – options considered include: health integration access layer approach and common Health Information System (including common Picture Archiving and Communications System (PACs));
- Proposed regional models follow the common principle of consolidation of expertise and redistribution of knowledge – including consolidated services (concentrated specialized services, Centre of Excellence) and regional services.

Specifically, for Diagnostics & Therapeutics and Clinical:

- Consideration of **centralized scheduling and intake** to address access, navigation and capacity management; and,
- Identification of the need for **better integration with primary care** – opportunities include: integrated care pathways and standardization of care.

Other key enablers include:

- **Access to 24/7 diagnostic services**;
- **Transportation** to support mobility across the region;
- **Decision-support**; and,
- **Common credentialing**.

Figure 5, on the next page, provides an overview of the high-level opportunities identified by the Working Groups and how the identified linkages and enablers begin to form a conceptual model for what a regional model could look like. Each opportunity is described in further detail within this section.
Figure 5: Overview of the high-level opportunities identified by the Working Groups
Assessment of Opportunities

In addition to evaluating the opportunities against the decision-making criteria (see Section 1.2 and Appendix D), the Working Groups also assessed the complexity to implement the opportunities, where complexity was influenced by the availability and size of funding or investments required, political, people or technological changes required, or the length of time to implement an opportunity.

The ratings against the criteria and the complexity were used to inform a relative ranking of the impact and complexity of all opportunities, conducted by SECHEF CEOs, as depicted in Figure 6, on page 42. It is important to note that the impact and complexity scores noted within this report may not match exactly to the ratings provided by the Working Groups since they were considered relative to all opportunities.

With a significant number of opportunities identified within each of the eleven Working Groups, it is important to consider how these opportunities may be sequenced in possible implementation. While potential implementation of these opportunities is a Phase 3 activity, there are important phasing considerations which help to understand the current work.

Many opportunities will provide financial benefits in the relative short term, while others will require more significant investments prior to showing financial benefit. While some activities may appear to be low impact/easy to implement, these activities may provide foundational activities that can achieve early savings to support ongoing investment. At a high-level, a proposed prioritization of opportunities shows how these opportunities can be considered over a short, medium and long-term phasing.

With each of these opportunities there is a natural series of steps where some steps are easier to achieve than others, and within Phase 2 activities, some activities, particularly amongst the more transformational opportunities could be started immediately.

The activities in the lower left quadrant of the matrix on page 42 are those activities that were deemed to be relatively easier to implement. These pieces are foundational and can support ongoing transformation of some of the more strategic pieces, particularly by freeing up savings for continued investment in future work. These include the following:

- Shared Service in Human Resources (Transactional);
- Shared Service in Finance (Transactional);
- Shared Service in Information Services (Transactional);
- Development of a Clinical Advisory/Leadership Group to steward early clinical wins; and,
- Emergency Medical Services (EMS) Enhanced Services.

The activities in the upper left quadrant on page 42 are those activities that are typically considered Early Opportunities and are high impact and easier to implement. These included the following:

- Regional Laboratory System;
- Regional Pharmacy System;
- Shared Service in Facilities/Support Services;
- Regional Diagnostic Imaging Leadership; and,
- Standardized regional approach to serving complex chronic/frail elderly, such as Senior Friendly Hospitals Strategy.
The opportunities identified in the upper right quadrant on page 42, are those that are typically considered **Transformational**, and were considered relatively higher impact, and more complex to implement. These included the following:

- Regional system of Tertiary/Quaternary Care;
- Regional system of Elective care;
- Regional model of Urgent/Emergent care to focus on process improvement and excellence that is evidence-based;
- Integrated (automated) care plans for complex chronic/frail elderly;
- Increased capacity in community support services and optimization of community resources;
- Shared Service in Human Resources (strategic);
- Shared Service in Finance (strategic);
- Shared Service in Information Services (strategic investment);
- Emergency Department Avoidance Strategy;
- Regional Diagnostic Imaging system.
Figure 6: Proposed prioritization of potential Phase 2 activities
Figure 7: Proposed sequencing of potential Phase 2 activities

- August 2015: Hospital Boards Approval, Establish Project Management Council, Establish Clinical Leadership Council, Develop 90-day plan.
- September 2015: SE LHIN Board Approval, PMG/CLC Plan Approval.
- October 2015: Launch change management audit.
- November 2015: Monthly CLC Meetings.
- December 2015: Ongoing Project Management.
- January 2015: Ongoing Change Management.
- February 2015: Ongoing Change Management.
- March 2015: Ongoing Change Management.

- Hospital-Led Initiatives:
  - Hospital Information System Option Cost-Benefit Analysis.
  - RFP to Facilities / Support Services.
  - Develop Service Governance Model for Shared Services.
  - Shared Service design and due diligence for Transactional HR, Finance, IS, Facilities / Support Services.
  - Design and due diligence for regional Laboratory model.
  - Central Intake and Scheduling design and due diligence.
  - Acute Services Redesign: System design for Elective, Tertiary, Urgent / Emergency services.
  - Establish Regional ED Council.
  - Develop Plan for Regional Urgent / Emergent Council to focus on process improvements.
  - Establish Regional Complex Care / Frail Elderly Council.
  - Design for standardization of complex care / frail elderly services that include senior friendly hospitals, OAHU clinics, ACE units and establishing Centres of Excellence.
  - Design and due diligence for automated, integrated coordinated care plans.

- Cross-sectoral Collaborative Initiatives:
  - Collaborate on capability of community capacity review with SE LHIN and Community Partners.
  - Report back and decision on next steps.
  - Connect with EAMS, SE LHIN, MOHLTC and municipal on expansion of community paramedic programs.
  - Report back and decision on next steps.

Note: Regional Diagnostic Imaging, Regional Pharmacy, and Strategic Shared Services for HR, IS & Finance moved to next Phase of work.
Proposed Sequencing

The figure on page 43 identifies a proposed sequencing for Phase 2 activities. This proposal will depend on the capacity and investments available to the hospitals in the South East LHIN to proceed in Phase 2. A key proposal in moving forward is the development of a 90-day plan that will become a measure stick for progress. At the end of that plan, we anticipate that significant progress will be made and we will be able to present Hospital Boards with evidence on the design and due diligence on many of the activities planned for the next phase of work.

The activities that have been prioritized are both early opportunities identified by the Working Groups and key enablers that a significant number of Working Groups identified as necessary to integrate service delivery. Following these foundational activities, high priority activities will be sequenced as capacity allows. These activities are described further below:

Activities that should be started immediately, following Board approval:

- Development of a service governance model and design for a renewed shared service entity to house business function shared services;
- Launching a Request for Information (RFI) for Facilities/Shared Services;
- Identifying the cost-benefit for Hospital Information System (HIS) options that include status quo, independent hospital investment, a new shared HIS, independent HIS investment with connectivity across the region, taking into consideration all costs, benefits and risks;
- Design and due diligence of all business functions (Human Resources, Finance, Information Services, Facilities/Support Services); and,
- Business case development, design, due diligence for a Regional Laboratory System.

Priority Phase 2 activities that will follow, once capacity allows:

- Business case, design and due diligence for centralized intake and scheduling, an enabler identified by many of the Clinical Working Groups;
- Acute services redesign, which will include identify the acute roles and accountabilities for each hospital in the region in a regional, integrated system for elective, urgent/emergent and tertiary/quaternary services;
- Establishing a Regional Emergency Department Council responsible for regional standardization and process improvements; and,
- Establishing a Regional Council for Complex Care/Frail Elderly patients to develop a regional system of care that includes standardization and access to geriatric assessment clinics, acute elderly units, and centres of excellence, followed by the development of integrated, coordinated care plans.

In addition, two important enablers identified by the Working Groups was the need for Clinical Leadership and oversight, and design and implementation using a rigorous Change Management approach. These have been designed into the Phase 2 activities.

It is envisioned that a series of activities will conclude in December 2015, after the 90-day plan to seek Board approval, followed by another decision point in March 2016. These staggered decision points will require ongoing Board
engagement at key points to enable progress to continue and proceed to implementation where the business case demonstrates value.
3.2 Business Functions

On November 19, 2014, the SECEHF CEOs in the South East LHIN approved the following vision ("Vision 2020"): 

*By 2020 a shared service organization will be fully implemented supporting the provision of all business functions; provided the business case demonstrates adequate value.*

Given this direction, four Working Groups were established to identify opportunities for regional collaboration and integration of business functions in support of this vision, with the ultimate objective to improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

These four Working Groups included the following:

- Facilities/Support Services
- Finance
- Human Resources
- Information Services

Overall, each of the four Working Groups identified proposed opportunities to share services across the region. The Working Groups were in agreement with the following opportunity: **To develop a Shared Service across the South East LHIN to support Finance, Human Resources, Facilities/Support Services and Information Services.**

All of the Working Groups identified significant benefits to regional collaboration and the shared services model for Business Functions services among the seven hospitals. These include:

- Optimization of processes – elimination of duplication and standardization of policies and procedures
- Excellence in transactional services – becoming as efficient and effective as possible
- Consolidation and scale will allow for various leading practices to become standards across the South East LHIN

There is strong evidence and precedence across all business functions for shared service models in other jurisdictions. A summary of successful healthcare shared services across Canada and beyond are demonstrated in the graphic on page 48. These examples provide significant benefit with typical returns in the range of 10% to 25%, including models for Facilities (i.e., supply chain, purchasing, linen, etc.), Finance (i.e., accounts receivable and accounts payable, etc.), Human Resources (i.e., payroll, employee records, payroll, etc.) and Information Services (i.e., data centres, data management, service desks, etc.). Evidence supports the benefits identified by the Working Groups including: increased scale/scope and the achievement of efficiencies, stronger negotiating positions, optimization of business processes, potential for improved management and improvement in quality and delivery of service and cost savings. Results achieved are typically dependent on the rigor of the approach taken to implement.

Overall a shared service model across the South East LHIN to support Finance, Human Resources, Facilities/Support Services and Information Services would provide significant financial benefit, which would contribute to addressing the current fiscal challenges facing the South East LHIN. The financial savings are summarized below:

- Ongoing (annual) savings: representing approximately $15.8 million

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4 This represents the combined savings estimated for Human Resources, Information Services without HIS investment, Finance and the mid-point of the range of savings estimated for Facilities / Support Services.
One-time investments: approximately $11.5 million\(^5\)

This is a conservative estimate as benchmarking against South East LHIN Hospital peers pointed to higher possibilities.

In addition to cost savings articulated above, the proposed shared services model will result in savings from service improvements (i.e., process efficiencies and standardization) and savings from cost avoidance related to regional approaches to capital planning.

Each Working Group recommends to SECHEF CEOs, and subsequently Hospital Boards and the South East LHIN Board, that the business cases be approved to move to the “Design” phase of work, to move forward with the next level of analysis, including further development of the financials and delivery models, as well as development of a potential transition approach.

Each of the Working Groups developed a vision for their service area, towards the ultimate Vision 2020, as outlined below:

- **Finance**
  High quality, low cost provider of transactional financial services, analytical support and corporate administrative services.

- **Information Services**
  Integrated Information Services that enable patient care, business operations and academics to help deliver the right information to the right people at the right time to create an unparalleled patient experience.

- **Human Resources**
  To deliver a high performing, cost-effective human resources service that facilitates a resilient and engaged workforce in support of excellent patient care and the mission of each hospital.

- **Facilities/Support Services**
  Provide value to customers by facilitating innovative and integrated solutions for facilities management and support services.

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\(^5\) Investment costs includes order-of-magnitude cost estimates for an enterprise business system for Human Resources and Finance, severance costs, and project implementation costs.
The Working Groups were informed by success in shared services in other jurisdictions listed in Figure 8, below.

**Figure 8: Healthcare Shared Service Organizations and services offered**

<table>
<thead>
<tr>
<th>Healthcare Shared Service Agencies</th>
<th>Facilities</th>
<th>Finance</th>
<th>Human Resources</th>
<th>Health IT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Supply chain</td>
<td>Sourcing</td>
<td>Contract Mgmt</td>
<td>Purchasing</td>
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<tr>
<td>Health Shared Service BC</td>
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<td>3SHealth, Sask</td>
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<td>Plexusus, Toronto</td>
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<td>Mohawk, Hamilton</td>
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<td>Shared Service West, Oakville</td>
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<td>Transform, Chatham</td>
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<td>FacilicorpNB</td>
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<td>John Hopkins University and Medicine</td>
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The details that are provided below provide a high-level summary of the opportunities and potential benefits that were identified by each of the Working Groups.

**Facilities**

The Facilities/Support Services Working Group considered a range of models across each of the services that include the following:

- Shared Management Model;
- Contracted Management Model; and,
- Contracted Management and Staff Model.

The future state model being proposed includes a mix of these models and includes the following:

- Development of a shared service model for all facilities/support service Directors and Managers (non-union), driving process efficiencies and standardization across the region;
- Development of a pool of shared, specialized building maintenance staff that would serve the needs of the region, including shared maintenance helpdesk and dispatch centre;
- All current and future contracted services to be managed through the facilities/support services shared service with ongoing opportunities to consolidate to regional contracts; and,
- Exploration and validation of the opportunity for further contracted management and staffing for all services, further driving efficiencies.

**Summary of benefits:**
The estimated cost savings of this model is in the range of 7 – 15%, representing approximately $3.85 million to $8.25 million.

Further gains are possible by achieving the top quartile in performance compared against provincial South East LHIN hospital peers with potential savings of 18.3%, which would include further process efficiencies and standardization.

Further gains are possible through supply and equipment rationalization, as well as utility spending opportunities that can be further examined in Phase 2.

**Finance**
The future state model being proposed by the Finance Working Group includes:
- Consolidation of human resources;
- Rationalization due to scale, including reduced supervision (broader scope of influence) and productivity increases (inputs/transaction); and,
- Optimization of processes, including elimination of duplication and implementation of best practices.

Each major system and function was evaluated for opportunities and options to improve service delivery and achieve financial efficiencies. Opportunities and options identified by the Working Group include:
- Procurement and supply chain – the co-location of accounts payable with the purchasing staff (currently located at member hospitals) would create additional efficiencies not yet realized through current procurement shared service through 3SO.
- Payables/payments – provision of services to all hospitals through shared services organization.
- Accounts Receivable (AR) OHIP and Non OHIP Billing – numerous processes are currently manual and could be automated by sharing best practices in processes among member hospitals and consolidating onto a singular financial (AR/OHIP) platform.
- Standardization of collections/cashier/patient trust accounting among all hospitals.
- Single fixed assets platform to support the following functions for all hospitals: accounting/depreciation, budget planning and control, fund accounting, foundation and research entities (NOTE: some Foundations may have arrangements that would preclude them from joining the shared service).
- Consolidation of resources and standardization of processes related to general ledger functions, including: management reporting, journal entries, external audit and internal audit, external report (Ministry of Health and Long-term Care and other), variance analysis.
Consolidation of resources and standardization of processes related to treasury management, including: bank services/contracts and cash flow.

Consolidation of resources and standardization of processes related to risk management, including: legal services and insurance.

Consolidation of resources and standardization of processes related to decision support.

Consolidation of case costing functions.

Sharing of regional resources related to capital planning and development.

**Summary of benefits:**
The estimated annual ongoing savings of this model is approximately $1.9 million, or 31.3% of current spend.

In addition to cost savings articulated above, the proposed shared services model will result in savings from service improvements (i.e., process efficiencies and standardization) and savings from cost avoidance related to regional approaches to capital planning.

**Human Resources**

In support of vision 2020, the future state Human Resources delivery model recommends that all functions that can be delivered through a shared services model, will be delivered through a shared services model.

The future state model identifies a total of 19 opportunities to share services across the region, including:

1. Scheduling and Payroll
2. Workforce Planning/Analytics
3. Employee Recruitment
4. Benefits Administration
5. Onboarding
6. Contract Services (non 3SO)
7. Employee Records
8. Help Desk/Employee Service Centre
9. Human Resources Information System
10. Compensation and Rewards
11. Talent Management
12. Learning and Development, including Learning Management System
13. Organizational Development
14. Employee/Labour Relations
15. Disability Management
16. Wellness
17. Employee Health
18. Employee Safety
19. Attendance Management

**Summary of benefits:**
The estimated annual ongoing savings is 10.6% of current spend or approximately $1.1 million.

In addition to cost savings articulated above, the proposed shared services model will result in savings from service improvements (i.e., process efficiencies and standardization) and savings from cost avoidance related to regional approaches to capital planning. Additional value added benefits of the proposed model include: regional workforce planning, regional talent management and regional access to best practice services in wellness, learning programs and enhanced expertise.
The Information Services Working Group proposed two options that would create different levels of savings based on the investments required.

1. The first option is the development of a centralized Centre of Excellence while recognizing that some services are required on site to support technology, staff and patients. The future state model creates the opportunity to leverage buying power and eliminate the duplication that exists in the current approaches taken within a single organizational structure. Gains can be made by gradually adopting shared systems and increasing levels of shared staff. Savings would be achieved by consolidation of information technology infrastructure and data center operations, and service deck. Total gross savings for this option was estimated at approximately $2.7 million.

2. The second option would build on the Centre of Excellence approach in Option 1, however would establish a single strategic approach to Information Technology through the adoption of a single Hospital Information System that would allow for further standardization to enable services to achieve clinical and operational savings through process automation on a single technology platform. This would allow for further consolidation of application development and maintenance, coding and abstracting, clinical paper processes, transcription/distribution, and registration and scheduling. Total gross savings for this option was estimated at approximately $6.6 million. This option would respond to the strategic needs identified by the Working Groups.

The options could be implemented in sequence, with an established shared Information Services team gradually consolidating information systems and delivery, while a decision is made on an HIS solution.

A priority activity in Phase 2 should be a cost-benefit analysis of the options for an HIS solution. Four options to be considered include the following:

- Status quo;
- Individual hospital HIS investments;
- A shared regional HIS;
- Individual hospital HIS investments with connectivity (e.g. through Health Information Access Layer, HIAL).

All costs, benefits and risks of each option should be considered. Information Systems were identified as an enabler by all Working Groups; as such, this activity should receive priority to enable the development of an investment strategy to lay the foundation for integrated service delivery across the South East LHIN.

In addition, a proposed investment for a regional Enterprise Business System has been proposed to enable shared Finance and Human Resource functions. The investment for this system has been estimated at $8.5 million that includes licensing and implementation. These costs have been included in the investments required for Human Resource and Finance Business Functions. Development of the Enterprise Business System would be in addition to the core Information Technology opportunity identified in Option 1 above.

**Summary of benefits:**

The business case contemplates both the savings opportunities through regionalization of Information Services and the investment required to enable the priorities of the other Work Groups.
The estimated savings of Option 1 is approximately $2.7 million or 8.4% of current spend. Additional analysis will be conducted in the next phase of work to identify options and savings associated with a single/shared Hospital Information System and alternatives that may include regional connecting middleware or a provincially funded HIAL (Health Information Access Layer). It is estimated that an additional $3.9 million in savings could be achieve in Information Services spend through Option 2 which would include a single/shared HIS.

The estimated investment to enable the requirements of the Business Function Working Groups (to support the opportunities for Finance, and Human Resources) is estimated at $8.5 million for capital, licensing and project management and potential implementation. This investment is the estimated cost of a regional Enterprise Business System that would enable additional savings in both Human Resources and Finance through shared resourcing.

A key consideration in the assessment of the benefits of a regional approach to Information Technology investment is the fact that each hospital will be required to make significant investments in Information Technology as individual organizations that will exceed what is necessary for investment as a region.

Considerations for Sequencing

With a significant number of opportunities identified within each of the four Working Groups, it is important to consider how these opportunities may be sequenced in possible implementation. While potential implementation of these opportunities is a Phase 3 activity, there are important phasing considerations which help to understand the current work.

Many of the opportunities that have been identified will provide financial benefits in the relative short term, while others will require more significant investments prior to showing financial benefit. While some activities may appear to be low impact/easy is complexity, these activities may provide foundational activities that can achieve early savings to support ongoing investment. At a high-level, a proposed prioritization of opportunities, shown in Figure 9 below, shows how these opportunities can be considered over a short, medium and long-term phasing.

**Figure 9: Proposed prioritization of Business Functions opportunities**
Notes:

1. Annual ongoing savings of approximately $6.1 million represents the mid-point of the gross savings identified by the Facilities/Support Services Working Group of between approximately $3.8 million and $8.2 million.
2. One-time investments include severance costs and ongoing project management and change management and would be part of an overall shared service implementation.
3. One-time investments for Finance and Human Resources include severance, and a combined investment of $8.5 million in an Enterprise Business System to support all hospitals in the South East LHIN. One system would also provide for the potential for further efficiencies across Human Resources and Finance.
4. Ongoing savings for Strategic IT represents the “IT Department” savings of implementing Option 2 identified above, which includes a shared HIS. Further efficiencies in Clinical and Diagnostics & Therapeutics areas are possible. This assessment would be required in Phase 2.
5. The investment in strategic IT, for a shared HIS is currently estimated at $120 million, including project management capital investments and implementation costs. Traditionally, funding for these costs are sourced from capital budgets, using in-house resources (i.e., education departments, change management, IT and Quality Improvement teams), and benefit realization by replacing manual or other processes. This investment could be partially offset against clinical and diagnostic efficiencies not represented in the ongoing savings for Strategic IT. It is important to note that the investment of $120 million needs to be compared to the cost that is required to upgrade the current information systems at each hospital, regardless of whether the hospitals move forward with an integrated system – it is not a net new investment.

Transformation of 3SO and Service Governance Considerations

It was recognized that expanding the scope of shared services across the region would require a transformation of 3SO, the current hospital-owned shared service agency that was developed to handle procurement and supply chain. Rebuilding 3SO to handle the increase in capacity and capability to support all four business functions will require considerable thought and redesign.

An important element to any shared service model is a robust service governance model. A service governance model provides a vehicle through which the hospitals maintain input, control and oversight over each of the services provided by the shared service entity to enable desired outcomes. Service governance can be defined by an operational governance structure where each service is governed by service committees. These service committees have members from each of the hospitals and serve to provide advice regarding issues, apply in-depth knowledge to support performance and objectives of the service, and provide oversight of service performance. They do not operate the business, but advise as per the appropriate committee terms of reference.

In any future state model, each service would be constructed based on a set of service management principles that may include: consistent performance management, common communications and reporting channels, common global templates and documentation standards and common tools. This enables a performance-based culture for the shared service where performance is tracked quantitatively and qualitatively against the right key performance indicators.

As part of the Phase 1 work, the Business Functions Working Groups did not consider options for shared service governance. Pending approval of the Phase 1 Recommendations Report, the service governance model will be designed and brought back to SECHEF CEOs and the Hospital Boards for approval. The service governance approach
will enable the potential implementation of the business function shared services into an integrated shared service entity that is performance-based and will meet the needs of the hospitals for the cost-effective delivery of each business function.

Recognizing this as an important element of any shared service model, SECHEF CEOs had a preliminary discussion regarding principles/factors for success related to service governance. Another important concept related to a potential shared services model is gain-sharing. SECHEF CEOs discussed the following principles/factors for success related to service governance and gain sharing. These are to be considered further pending a decision from hospital Boards regarding whether to move forward with further design of a shared service model.

- Respect the current mandate and deliverables of the current Shared Service Organization (SSO), as we plan for the future SSO
- Organizational readiness for current SSO
- Build confidence to move to Phase 2
- Getting the ‘right’ Board composition over the short, mid, and long-term
- Clarity around roles of service level committees at the SSO, and at the hospital level
- Commitment by hospital partners to a ‘common’ strategy, with flexibility to address legitimate hospital specific needs
- Commitment by hospital partners for a period of time to allow for assessment of SSO performance and consideration of future directions
- Clarity around gain-sharing
- Recognition that investments need to be made in order to realize benefits; this should be considered with respect to gain-sharing
- Overall, same or lower cost for all hospital partners
- Clear understanding of the current state (baseline) against the performance of the future SSO

The principles on service governance are intended to support the development of a strong shared service entity to support all the shared service needs of the hospitals in the South East LHIN, as defined in the working papers of the Business Functions Working Groups. It was further agreed that all hospitals would be required to participate in all service offerings, identified in the design phase, for a period of five years. This should be enabled by the development of gain sharing principles. At the end of the five-year period, if performance measures are not being met, a process should be developed whereby hospitals have the option to opt-out of services provided by the shared service entity. This process should include a transparent process whereby hospitals are required to bring lower-cost options back to service oversight committees as part of the service governance structure for consideration.
3.1 Clinical

Four Clinical Working Groups were established to identify the opportunities to improve service delivery. Participants came together with a clear sense of urgency to address the patient and provider experience, access and care quality issues they felt commonly challenged by in the current system. They considered evidence-based approaches to improving service delivery and expressed many anecdotal experiences that supported their common sense that they could and must do better. There was early expression of commitment to use leading practices to shape opportunities, to review clinical services and processes across organizations to explore potential savings and improved outcomes, and to identify gaps in the system to determine priorities and set direction for moving forward.

The four Working Groups were established to identify opportunities for regional collaboration and integration of clinical services, with the objective to improve access to high quality care through the development of a sustainable system of integrated care.

The four Working Groups included the following:

- Complex Chronic/Frail Elderly
- Elective Services
- Tertiary/Quaternary Services
- Urgent/Emergent Services

Overall, each of the four Working Groups identified proposed opportunities for collaboration and integration of clinical services across the region. As demonstrated in the case for transformation, there is a clear population need for hospital services into the future. The exercise of the Clinical Working Groups was not focused predominantly on removing costs, rather identifying ways to improve outcomes, access and patient and provider experience, while maintaining and building on the resources we already have. What this will look like in the future, is a system that serves more patients more effectively by working together to more efficiently use the resources we currently have.

To achieve this, the following opportunities have been recommended by the Working Groups:

- Develop a regional system of care for highly specialized services (tertiary/quaternary services) and planned care (elective)
- Develop a regional system of care for urgent/emergent care to focus on process improvement and excellence that is evidence-based through an Emergency Department/Urgent Care community of practice
- Development of an Emergency Department Avoidance Strategy that include Enhanced Emergency Medical Services (EMS) Services and Care at Home and the Community
- Optimize community resources to prevent unnecessary use of hospitals
- Standardize the approach to serve the needs of complex chronic/frail elderly patients that includes rapid assessment and disposition in Emergency Department, mobility in hospital, geriatric ambulatory and acute care specialization
- Improve service delivery and the integration of care for complex patients/frail elderly through the development of Integrated Care Plans for Complex Patients/Frail Elderly

Common to all of these opportunities, are the need for the following regional elements:

- Regional clinical and operational leadership, oversight and accountability
- Integrated information system
- **Consolidation of expertise and redistribution of knowledge** – including consolidated services (concentrated specialized services, Centre of Excellence) and regional services
- **Centralized scheduling and intake** to address access, navigation and capacity management
- **Improved integration with community and primary care** – including: integrated care pathways and standardization of care
- **Access to 24/7 diagnostic services**
- **Transportation** to support mobility across the region
- **Decision-support**
- **Common credentialing**

All of the Working Groups identified significant benefits to regional collaboration and integration of some clinical services among the seven hospitals. These include:

- Improved patient experience and satisfaction – timely and seamless access
- Improved quality of care and outcomes – reduced risk, increased safety of care
- Improved and standardized access to appropriate services – better alignment of needs with resources
- Improved service coordination and navigation
- Standardized evidence-based care models across region reduce variation in service, quality and access
- Improved capacity (clinicians) for specialized knowledge and skill; advanced clinical expertise
- Increased educational and research opportunities
- More efficient utilization of hospital resources – reduced duplication
- Reduced costs through consolidation of services and development of Centers of Excellence
- Cost avoidance as a result of more proactive care

There is a significant body of evidence, and precedence that supports the opportunities that have been put forward by the Working Groups. Not only internationally, but within Ontario, hospitals have utilized integration to improve service delivery and patient flow. In a region in Finland, similar in size to the South East LHIN, the providers and municipality partnered to form a joint venture to create a single orthopaedic surgical centre to process all hip and knee replacements for the region. This high volume center decreased costs, and improved quality and became a national referral centre for higher complexity revisions. Through developing a regional approach across all areas, efficiencies can be gained that will enable improved access, outcomes and patient experience.

Each Working Group recommends to SECHF CEOs, and subsequently Hospital Boards and the South East LHIN Board, that the opportunities/options/recommendations be approved to move to the “Design” phase of work, which includes the next level of analysis, design and potential implementation planning, including stakeholder engagement and opportunity analysis.
Complex Chronic/Frail Elderly Care

The Complex Chronic/Frail Elderly Working Group was established due to the significant impact complex patients have on the healthcare system. These patients, when compared to other regions in Ontario, are cared for in a highly institutionalized manner. This means they visit the Emergency Department more, and when they visit they have a higher propensity to be admitted to hospital, and when they are admitted, they stay in-hospital longer. They are also more likely to be admitted to Long-term care and stay in Long-term care longer than in other LHINs. Analysis of the usage of the hospital system has also identified that the top 1% of patients use 51% of the hospital resources, and the top 5% of patients use 81% of the hospital resources. These patients are a key driver of hospital utilization. Amongst the top 1%, 69% have four or more chronic diseases, and 75% of them are aged 60 and above.

The Working Group identified some of the following key challenges in addressing the needs of this patient population:

- Lack of integration, even within the hospital for patients managing multiple chronic conditions.
- High rates of hospitalization that include high rates of emergency usage and acute inpatient stays.
- Patients with multiple complex conditions experience difficulties due to the resources or lack of resources available to them once they are hospitalized, which, in turn, contributes to the number of Alternate Level of Care (ALC) days.
- Lack of community resources to manage isolation.
- Lack of access to multi-disciplinary specialists in the community.

The Working Group recommends a regional system of integrated care for the Complex Chronic/Frail Elderly populations, supporting by the following opportunities:

**Opportunity 1: Build Capacity in Community Support Services and optimize the use of Community resources**

- Build capacity in core Community Support Services, such as Assisted Living, geriatric day centres, Meals on Wheels, and the Seniors Managing Independent Living Easily (SMILE) program (the SMILE program is intended to support frail seniors with multiple unmet needs who will end up in crisis if they can’t access additional service. The program serves only those seniors who, due to increasing frailty, are at risk of losing their independence and who require significant support with functional activities of daily living).
- Optimize the use of community resources to enable patients to age in place.
- Central access number to coordinate and manage all services.

**Opportunity 2: Expansion/standardization of seniors’ strategies across all South East LHIN hospitals – primary, secondary and tertiary, with regional specialization of behavioral supports and geriatric medicine/inter-professional resources**

- Optimize hospital services to better meet needs of the Complex Chronic/Frail Elderly population and a standardized approach to care to include: intake screening, complex care plans connected with community, updated at time of intake and discharge, Acute Care for the Elderly (ACE) units or teams accessible through hospital, senior friendly hospital best practice initiatives, Geriatric Assessment and Intervention Network (GAIN) Clinics, inter-professional case management and central access number.
- Develop a Centre of Excellence/Community of Practice for geriatric care that builds off the current geriatric program as a hub that reaches out to provide the knowledge level to additional users in community centres.
Use the current geriatric program as a hub that reaches out to provide the knowledge level to additional users in the community.

- Develop specialty clinics (i.e., Seniors day rehabilitation)
- Centralized intake to ensure optimal placement of patients.
- Behavioral supports expertise – clinical inter-professional consultants as well as regional beds at Providence Care and Quinte Health Care.

**Opportunity 3: Increase use of automated, integrated Coordinated Care Plans**

- Build on coordinated care plans developed by Health Links to increase the catchment to include all complex chronic/frail elderly population.
- Care plans will be the standard method for communicating and coordinating care amongst the Hospital, Primary Care Providers and community partners.
- Care plans should be automated to improve coordination, simplicity and integration amongst hospital, community and primary care partners.
- All complex chronic/frail elderly patients who visit the hospital who do not already have a care plan will have one developed before/upon discharge.

**Summary of benefits:**

*From the patient’s perspective, regional system of integrated care for Complex Chronic/Frail Elderly care would mean...*

- Patients will be in the right care, at the right time, in the right place, meaning:
  - Patients will be cared for in the community and by primary care, reducing reliance on the Emergency Department
  - When they visit the Emergency Department, they will be quickly assessed and brought to the most appropriate setting, even if that is their home
  - Patients will have the resources they need to keep them healthy in their home
  - Patients will have a care team around them and will know who to call when they are ill
  - Patients will spend less time in the acute setting where they can become disoriented, and their condition can deteriorate

**Elective Services**

The Elective Working Group was established due to the high volume of primary/secondary planned/scheduled activity across the hospitals in the South East LHIN. There were 72,926 elective procedures across the South East LHIN hospitals in FY 2013/14. Demand for elective services will contribute to a 22% increase in adult surgical inpatient beds over the next ten years if no changes are made to the way services are provided.

Some of the current key challenges identified by the Working Group in addressing this activity include the following:

- Wait times are long for both medical and surgical procedures but not all elective procedures are measured;
- Wait time discrepancies exist within the region;
- There is a cumbersome, non-centralized, resource intensive (not patient-centred) referral process;
Access to rehabilitation in the community, transitions to community care, access to post-acute care are not standardized;

- Ineffective scheduling of providers not just patients; and,
- Lack of effective rapid assessment and triage resource.

Overall, the Working Group recommends a regional system of care for planned care (elective) that is characterized by the following elements:

1. Regional operational oversight
2. Centralized LHIN-wide referral, scheduling and tracking
3. Common robust quality standards and accountability
4. Choice (including most timely access and closest access)
5. Timely and relevant information that speeds up the pre-assessment phase
6. Careful triage – patients with higher risk may be triaged to a tertiary care site
7. Integrated care bundle including pre-procedure instructions to ensure adequate preparation and adequate follow-up care
8. Post-procedure care is integrated – patient knows by whom, and when results will be communicated where necessary, and any follow-up arrangements.
9. Population-based planning (i.e., supply meets demand)
10. Regional service plan
11. Transfer and repatriation protocols
12. State of the art of care
13. Clearly articulated roles for hospitals, and role of community care
14. Consolidation of procedures where evidence indicates improved efficiency and outcomes
15. 24 hour service coverage
16. 24 hour access to supporting service, post-procedure on-call care.
17. Regional medical/health human resource and recruitment plan
18. Regional common credentialing.

Based on these elements of a regional system of care for planned care (elective), the Working Group identified the following opportunities for the development of regional systems of care:

- Gynecology
- General Surgery
- Orthopaedics – Hips/Knees
- Endoscopy
- Arthroscopy
- Obstetrics
- Pediatrics
- Ophthalmology
- Urology
- Transfusion
- Chemotherapy

**NOTE: Further validation of the opportunities for priority procedures is required in Phase 2, prior to moving forward with any opportunities. For example, it is recognized that a level of evidence for obstetrics (regarding the relationship between high volume and quality outcomes) differs from other opportunities and this needs to be validated in Phase 2.**

The Working Groups also developed the following criteria to assist in the prioritization of the potential programs in Phase 2, pending approval of the Phase 1 Recommendations Report.
Quality Based Procedures (QBPs) – start with procedures that are currently QBPs.
Wait times – precedence should be given to those procedures with higher wait times.
High volume/critical mass – precedence should be given to those with higher volumes.
Amenable to reduce variation with standardized care – evidence provides guidance on improved outcomes and volume.
Highly elective – start with those procedures that are not urgent or emergent and truly elective.

Summary of benefits:

From the patient’s perspective, a regional system of care for planned care (elective) would mean...

- Improved wait times and choice for faster versus closer service
- Improved outcomes leading to improved recovery times and quality of life, and less repeat visits to the hospital
- Improved service coordination between hospitals, smooth transitions between sites, reduced duplication
- Improved service coordination between primary care and the hospital

Tertiary/Quaternary Services

The Tertiary/Quaternary Working Group was established due to the high rate of patient flow across hospitals in the South East LHIN to access tertiary care. The majority of residents in the South East LHIN access tertiary level services at either Kingston General Hospital or Quinte Health Care. In FY 2013/14, for tertiary level services, 60% of General Medicine, 56% of General Surgery, 78% of Orthopaedics and 98% of Stroke were cared for at Kingston General Hospital. Quinte Health Care saw 3% of General Medicine, and 8% of Orthopaedics.

In addition, high rates of patients leave the South East LHIN for tertiary level services that include 36% for General Medicine, 43% for General Surgery, 44% for Cardiac Medicine, 67% for Vascular Surgery, and 60% for Paediatrics.

The Working Group identified the following issues related to accessing tertiary level services:

- Lack of care pathways/protocols;
- No single coordinated referral system;
- No standardized triaging/diagnoses process;
- Patient transportation – lack of options, time to transport between centres (i.e., transferring a patient from a community hospital to a tertiary centre takes a long time);
- Lack of integrated information technology platform; and,
- Lack of accountability and overarching authority in the system.

The Tertiary/Quaternary Working Group proposed a regional system of Tertiary/Quaternary care that would serve the needs of the patients across the South East LHIN to include the following characteristics:

- Consolidation and redistribution of tertiary and primary/secondary care at core specialty centres;
- 24/7 access to tertiary/quaternary care;
- Strong academic mission;
- Regional centres of excellence established;
- Institutional role changes to support the new model;
- Improved use of telemedicine/e-consult to facilitate consultation; and,
- Centralized referral system.

**Summary of benefits:**

**From the patient’s perspective, regional system of Tertiary/ Quaternary care would mean...**

- Improved patient experience through more seamless and timely access to care
- Improved outcomes leading to improved recovery times and quality of life, and less repeat visits to the hospital
- Improved service coordination between hospitals, smooth transitions between sites, reduced duplication
- Improved service coordination between primary care and the hospital

**Urgent/Emergent Services**

The Urgent/Emergent Working Group was established to address the complex issue of the use of the hospital system for urgent/emergent care. For many patients the Emergency Department is a central community resource and the gateway to the hospital. In FY 2013/14, hospitals in the South East LHIN saw 50% more Emergency Department visits than the Provincial average, or approximately 100,000 visits; and 90% more CTAS1⁶ 4/5 (Low-acuity Emergency Department) visits than the Provincial average. In addition there were high rates of Ambulatory Care Sensitive Conditions being seen in the Emergency Department than the Provincial average. These cases are typically unnecessary use of hospital resources, if they are receiving adequate care in the community. In addition, patients that do seek care in the Emergency Department have a high propensity to be admitted.

The Working Group identified the following current issues related to the needs of urgent/emergent patients:

- Public and providers unclear as to what they need and what resources are available;
- Unbalanced utilization of primary care;
- Staff and patient satisfaction;
- Access to primary care/community services after hours;
- Measuring quality of care;
- Access to bilingual services in hospitals;
- Consistency/continuity between providers;
- Access to diagnostic services particularly for primary care physicians;
- Availability of community services/resources (especially after hours);
- Seasonal surges in the Emergency Department;
- Outbreaks (in community or Long-term Care);
- Reliance on Emergency Department for access to specialists or investigations; and,
- Rural areas may not have access to services outside the Emergency Department and hospital.

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⁶ CTAS: Canadian Triage Acuity Scale, a method used in Canadian Hospitals to Triage patients when they arrive at the ED. 1 is high, should be seen by a physician immediately; 5 is low, patients need to be seen within 120 minutes, 80% of the time.
Through the development of a regional system of integrated care, the Working Group identified the following opportunities:

**Opportunity 1: Regional model for Urgent/Emergent Care to focus on process improvement and excellence that is evidence-based through Emergency Department/Urgent Care Centre**

- Put in place South East Urgent/Emergent Care Council for oversight as an accountable collaboration
- To operate as three programs: East (Brockville General Hospital and Perth and Smiths Falls District Hospital), Central (Kingston General Hospital, Hotel Dieu Hospital and Lennox and Addington County General Hospital), and West (Quinte Health Care), linked to SECHF and to the rest of the healthcare system, accountable to the South East Urgent/Emergent Care Council.
- Example initiatives could include:
  - Access to enhanced Allied Health services in Emergency Department/Urgent Care Centre
  - First contact decision-maker in Emergency Department/Urgent Care Centre
  - Rapid access to specialists through common scheduling system or process for immediate access or planned referrals

**Opportunity 2: Emergency Medical Services (EMS) Enhanced Services**

- Enhanced EMS services that can see and treat, rather than transport all patients to the Emergency Department. Some patients who call EMS to go to Emergency Department can be managed elsewhere or even in the home though communication with Emergency Department physician support (base hospital); EMS must be able to access primary care/ Emergency Department physician when making their determinations.
- Requires working with community partners that include the South East LHIN, Municipalities, MOHLTC and EMS to build capacity and grow the capability of community paramedicine programs in the region.

**Opportunity 3: Emergency Department Avoidance Strategy**

- Develop a cross-sectoral Emergency Department strategy that would enable the efficient and effective use of hospital and community resources for patients urgent care needs.
- Examples would include the following:
  - Primary care access at home – 24/7 on call providers to support patients/clients in their home
  - Specialty care home visits, i.e., Respiratory Therapist, Hemodialysis, Geriatric psychiatry, CHF, COPD
  - Regional care pathways and care maps
  - Consistent access to 24/7 on-call physician and NP specialist resources
  - Community Care access and navigation
  - Care at Home: Communication through a robust Electronic Medical Record that is viewable by all in the circle of care
  - Diagnostic Services (lab and imaging) available 18h- 24h/7 days per week to providers in the community with timely reporting
Summary of benefits:

From the patient’s perspective, regional system of integrated Urgency/Emergent care would mean...

- Patients experience shorter wait times in the Emergency Department
- Patients who use the Emergency Department and need to be admitted, are admitted quickly and to the most appropriate setting
- Patients have access to a range of care options that may prevent them from having to access the Emergency Department and can be cared for in their home or in their Long-term Care home
- Patients who require urgent diagnostic results, are seen and treated by their primary care provider, and no longer sent to the Emergency Department
- Patients who require specialist consultation are seen in the community so they don’t have to travel to hospital
- When patients leave the Emergency Department, they have a number to call for follow-up questions, preventing repeat visits to the Emergency Department or the specialist

Overall Value Proposition of a Regional Model of Clinical Care across the South East LHIN

The development of a regional model of care across the hospitals that is integrated with community and primary care will provide a robust platform for service improvements. These improvements will enable more efficient use of the available resources in the South East LHIN that will lead to more effective service delivery. These improvements are required to sustain the health system that exists today for current and future populations.

Overall, the opportunities will:

- Make better use of existing resources
- Maintain or improve service
- Improve capacity within the system
- Improve responsiveness to the growing demand for service
- Improve the patient experience

Considerations for Sequencing

With a significant number of opportunities identified within each of the four Working Groups, it is important to consider how these opportunities may be sequenced in possible implementation, noting that potential implementation of these opportunities is a Phase 3 activity. Figure 10, on the next page, outlines at a high-level how the opportunities may be sequenced to ensure success through realistic timelines and consideration of resource requirements.
Figure 10: Proposed prioritization of Clinical opportunities

**Short-term**
- Early Clinical Wins (i.e., Clinical Advisory Group)
- EMS Enhanced Services
- Standardized regional approach to serving CC/FE (Senior Friendly Hospitals)

**Medium-term**
- Regional system of T/Q care
- Regional system of Elective care
- Regional model of U/E care to focus on process improvement and excellence that is evidence-based

**Long-term**
- ED Avoidance Strategy
- Integrated Care Plans for CC/FE
- Optimization of community resources to prevent unnecessary use of hospitals
3.2 Diagnostics & Therapeutics

Three Working Groups were established to identify opportunities for regional collaboration and integration of services, with the objective to *improve access to high quality care through the development of a sustainable system of integrated care.*

These three Working Groups included the following:

- Diagnostic Imaging
- Laboratory
- Pharmacy

Overall, each of the three Working Groups identified proposed opportunities for collaboration and integration of diagnostics and therapeutics services across the region.

The following opportunities were have been recommended by the Working Groups:

- Develop a regional Diagnostic Imaging system to serve all the hospitals in the South East LHIN
- Develop a regional Laboratory system to serve all the hospitals in the South East LHIN
- Develop a regional Pharmacy system to serve all the hospitals in the South East LHIN

Common to all of these opportunities, are the need for the following regional elements:

- Regional clinical leadership, oversight and accountability
- Integrated information system

All of the Working Groups identified significant benefits to regional collaboration and integration of diagnostics and therapeutics services across the seven hospitals. These include:

- Improved patient experience and satisfaction
- Improved quality of care
- Improved and standardized access to appropriate services
- Improved service coordination and navigation
- Standardized evidence-based care models across the region that reduce variation in service, quality and access
- Improved capacity for specialized knowledge and skill; advanced clinical expertise
- Increased educational and research opportunities
- More efficient utilization of hospital resources – reduced duplication
- Reduced costs through consolidation of services

Across each of the Diagnostics & Therapeutics Working Groups there is evidence for improved service delivery through the opportunities they have identified. Examples of regional models and collaborative, even in Ontario have been effective at helping hospitals improve efficiency, outcomes and the flow of information. These regional models have also enabled access to higher levels of specialization that may not have been available previously, made available by creating economies of scale. Evidence supports the benefits identified by the Working Groups including: increased scale/scope and the achievement of efficiencies (i.e., improved utilization), stronger negotiating positions,
optimization of clinical and business processes (i.e., centralized intake and scheduling), potential for improved management and improvement in quality and delivery of service.

In addition to the benefits outlined above, potential savings have been identified:

- Ongoing savings: representing approximately $13 million
- One-time investments: $TBD

Each Working Group recommends to SECHEF CEOs, and subsequently Hospital Boards and the South East LHIN Board, that the opportunities/options/recommendations be approved to move to the “Design” phase of work, which includes the next level of analysis, design and potential implementation planning, including stakeholder engagement and opportunity analysis.

Diagnostic Imaging

Diagnostic Imaging exams for FY 2013/14 totaled 425,892 across all modalities across all South East LHIN hospitals. Total expenses across all sites for FY 2013/14 amounted to approximately $72.3 million. Diagnostic Imaging represents significant spend and activity in the South East LHIN with a significant flow of patients across sites to access higher levels of scans including CT Scans and MRIs.

The Working Group identified the following challenges that currently exist within the system:

- Diagnostic Imaging is the highest capital intense service in most hospitals within a competitive capital funding environment;
- Although Diagnostic Imaging is highly structured under the Canadian Association of Radiologists, Accreditation Canada, Ministry of Labour compliance standards, there is opportunity for standardization and Quality Assurance/Diagnostic Imaging, Coordinated Quality Improvement Plans across hospitals that would yield efficiencies;
- Inappropriate utilization of Advanced Diagnostic Imaging Procedures: CT, MRI;
- There is a disparity amongst Diagnostic Imaging technology, equipment, systems, software, which poses challenges for information sharing, integrated planning and data management systems; and,
- Seamless and timely access to Diagnostic Imaging service may be difficult due to geographic locations.

The Diagnostic Imaging Working Group proposed a regional system of Diagnostic Imaging services that would serve the needs of the patients across the South East LHIN to include the following characteristics:

- Regional leadership – medical/administrative leadership team with oversight and accountability
- Centralized intake/scheduling for Diagnostic Imaging services
- Consolidation of Diagnostic Imaging services (i.e., Nuclear Medicine, Interventional Radiology)
- Regional Diagnostic Imaging information system

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7 One-time investments will be costed in Phase 2, and would include primarily ongoing project management and change management ($1 million - $3 million) depending on the scope of the regional model, and information technology which may be included in the Hospital Information System, or the availability of provincially funded systems to support information sharing (i.e., regional PACS, OLIS etc.)
Standardization of policies, procedures, protocols
Common credentialing
Shared human resource planning
Regional capital strategy

**Summary of benefits:**
- Reduced duplication of services
- Improved utilization – more appropriate testing
- Reduced wait times and care closer to home where possible
- Potential cost savings due to bulk purchasing of equipment
- Shared workload for radiologists across the region and coverage
- Improved research and teaching due to a regional approach

**Potential Savings:**

Diagnostics & Therapeutics Working Groups were asked what changes could be made if they had to achieve 10% in savings. These opportunities are presented above. Further analysis and costing of these opportunities is required in Phase 2.

If savings of 10% could be achieved, this would result in approximately $6 million in savings. This represents 10% of current hospital spend in Diagnostic Imaging for compensation, supplies and sundry, and excludes equipment/capital expenditures. The Working Group identified that this level of savings may be possible through the initiatives identified, however more detail would be required in Phase 2 to confirm the opportunity. Achieving this level of savings would require investment (i.e., shared Picture Archiving and Communications System (PACs), etc.)

In addition to cost savings articulated above, the proposed opportunities will result in savings from service improvements (i.e., process efficiencies and standardization) and savings from cost avoidance related to regional approaches to capital planning including savings on future contract rationalization and bulk purchasing.

**Laboratory**

Laboratory tests for FY 2013/14 totaled 3,996,000 across all South East LHIN hospitals. Total expenses across all sites for FY 2013/14 amounted to approximately $42 million. As such, Laboratory represents significant spend and activity in the South East LHIN.

The Working Group identified some of the following challenges that currently exist within the system:
- Lack of competitive costing, given more challenges with funding reform;
- Lack of transport system for region – now a mix of taxis, and other “couriers”;
- Lack of shared capital planning (12 years ago the South East LHIN moved towards standardized equipment; however since then issues with capital availability/cash flow locally have led to different platforms/versions);
- Lack of common platform, used to fullest extent for the whole process;
- Lack of utilization management to avoid unnecessary tests and related costs;
- Providers and patients need easy access to results and respectful treatment in acquiring this information; and,
Lack of use of telepathology.

The Laboratory Working Group proposed a regional system of Laboratory services that would serve the needs of the patients across the South East LHIN enabled by the following elements:

- Strong regional leadership and governance
- Standard processes, policies and procedures
- Regional capital planning, including common equipment platform
- Regional transportation system (of specimens)
- Regional approach for siting of lab testing to improve efficiencies
- Regional laboratory information system
- Regional document control system
- Standard order sets
- Regional utilization and quality management
- Community laboratory testing models to increase access [including options: performing lab tests within community (i.e., CCAC), private labs, after hours within hospital, mobile (i.e., care at home), and regional phlebotomy team].
- Regional physician model
- Regional workforce
- Auto-verification
- Regional Transportation system
- Regional approach for siting of lab testing to improve efficiencies

The Working Group has proposed two regional model options, for further exploration in Phase 2:

1. **Create a South East LHIN Regional Model**
   - South East LHIN hospitals to come together to create a new regional laboratory model, including a hiring of leadership and sourcing of infrastructure.

2. **Join EORLA Regional Model**
   - South East LHIN hospitals to join Eastern Ontario Regional Laboratory Association (EORLA). South East LHIN hospitals would like to explore the potential of joining EORLA as long as we have a significant regional laboratory presence in the South East LHIN and retain expertise and capacity in the South East LHIN.

**Summary of benefits:**

- Reduced duplication of services due to information sharing and access
- Improved turnaround times, quicker results
- Improved utilization of existing resources
- Standardization across the region
- Cost savings
Potential Savings:

Option 1: A high-level MIS analysis of costs in 2013/14 suggests that top quartile performance could provide savings of approximately $6.3 million (+/- 15% range)

Option 2: A preliminary comparison of South East LHIN labs with EORLA’s pricing for similar sites suggests a potential savings of approximately $6.4 million to $8.5 million (in the range of 15-20%) is possible based on economies of scale and automation.

Pharmacy

Total non-drug Pharmacy expenses (i.e., compensation, supplies, equipment) totaled approximately $15 million across all hospitals in the South East LHIN in FY 2013/14. Total expenditures on drugs amounted to approximately $42.3 million representing significant spend and activity in the South East LHIN.

The Working Group identified some of the following challenges that currently exist within the system:

- Siloed services (by hospital);
- Lack of information system integration to facilitate sharing of patient information during transitions of care;
- Inadequate resources in some hospital sites to perform clinical work;
- General fear of a Kingston General Hospital hegemony;
- Fear of loss of identity;
- Worry about losing systems that work; and,
- Challenges seeing how geography and current budget constraint could be overcome.

The Pharmacy Working Group proposed a regional system of Pharmacy services that would serve the needs of the patients across the South East LHIN, enabled by the following elements:

- Common Formulary and Regional Pharmaceutical & Therapeutics (P&T) Committee
- Integrated regional pharmacy information system (i.e., one system vs. many systems that communicate)
- Regional education/training/professional development for pharmacists and pharmacy technicians
- Regional human resources strategy
- Regional capital strategy – staged replacement of standardized equipment (i.e., medical carts)
- Regional pharmacy governance
  - Two models proposed:
    1. Confederation of Pharmacy Leads if seven entities exist in the future
    2. Preferred model (allows timely decision-making): Single Pharmacy Lead (i.e., Vice President) for single hospital governance model, should be content expert (i.e., Pharmacist)
- Linkages to other regions

Summary of benefits:

- A consistent approach to pharmaceutical treatment, better access and consistent use of drugs
Improved access to pharmacists across the region
Improved coverage for pharmacists and human resource planning
Reduced duplication and improved medication reconciliation
Improved patient safety
Enhanced research and a better dataset for research
Cost savings from reduced duplication

Potential savings:
Diagnostics & Therapeutics Working Groups were asked what changes could be made if they had to achieve 10% in savings. The Pharmacy Working Group identified the initiatives noted above, however cautioned that they already operate as lean departments and already take advantage of bulk drug purchasing, limiting the cost savings potential of a regional pharmacy system. Further analysis and costing of this opportunity is required in Phase 2. If regional pharmacy could save even 5% of savings, this would result in potential savings opportunity of $750,000. This represents 5% of the non-drug spend in Pharmacy across the hospitals in the South East LHIN for 2013/14. Similar to clinical services, the Working Group recommended that any savings identified be reinvested for service improvements in Pharmacy.

Overall Value Proposition of a Regional Model of Diagnostics & Therapeutics care across the South East LHIN

The development of regional models across the Diagnostics & Therapeutics programs in the hospitals would contribute to a more integrated system of clinical care for the patients in the South East LHIN. These improvements will enable more efficient use of the available resources in the LHIN that will lead to more effective service delivery. Patients would have their CT scan or their Laboratory result provided in the “system”, knowing that regardless of where they had their test, it would be provided to the right standard, and would be available to clinicians across the system, regardless of site. Patients would also be able to have their CT scan or MRI at the nearest or fastest location. These improvements are required to sustain the health system that exists today for current and future populations.

Overall, the opportunities will:
- Make better use of existing resources
- Maintain or improve service
- Improve capacity within the system
- Improve responsiveness to the growing demand for service
- Improve the patient experience

Considerations for Sequencing

With a significant number of opportunities identified within each of the three Working Groups, it is important to consider how these opportunities ought to be sequenced during possible implementation. While potential implementation of these opportunities is a Phase 3 activity, there are important phasing considerations which help to understand the current work. Figure 11, on the next page, outlines at a high-level how the opportunities may be sequenced to ensure success through realistic timelines and consideration of resource requirements.
Figure 11: Proposed prioritization of Diagnostics & Therapeutics opportunities

- **Short-term**
  - Regional Laboratory System
  - Regional Pharmacy System

- **Medium-term**
  - Regional DI Leadership

- **Long-term**
  - Regional DI System
4.0 Considerations for Next Steps

4.1 Phase 1 Transition Period and Phase 2 Activities and Resource Requirements

This report represents the culmination of the work of Phase 1, outlining the opportunities, options and recommendations that have been put forward to the SECHF CEOs from each of the Working Groups. This report has been approved by all SECHF CEOs to go forward to their respective Hospital Boards for approval consideration, signaling movement into Phase 2.

There are a number of key project Working Groups and Advisory Groups that will need to continue through a ‘Transition Period’ – this Transition Period is defined as the period of June 30 (end of the KPMG contract) to September (post Hospital Board and South East LHIN approval to proceed to Phase 2).

SECHF CEOs are currently discussing the potential Project Governance structures, approaches and resourcing, to support the Transition Period and potential Phase 2 activities.

4.2 Enablers for Phase 2

Across all of the Working Groups a set of clear, common enablers emerged that would help support the successful implementation and outcomes of each of the opportunities identified by the Working Groups. These enablers are described as follows:

1. **Program Governance and System Leadership**: All Working Groups identified the benefit to having a shared leadership model and governance at a program level to drive accountability and decision-making. It will be important in Phase 2 to give consideration of how the hospital Boards delegate responsibility to a regional governance model whereby they are ultimately accountable for quality and safety, but still provide a structure that has the authority to make decisions on behalf of all hospitals.

2. **Integrated Hospital Information Systems**: All Working Groups identified the benefit, and stressed a significant need to be able to efficiently share information across hospitals. This included the need for a common Hospital Information System, Picture Archiving and Communications System (PACs), or Finance System, as examples. It is critical to identify a solution to enable information sharing across the hospitals when patients are flowing across the system. For Business Functions, a common Information Technology platform was seen as an enabler to develop a shared service to enable a shared resource pool that was serving the needs of multiple hospitals.

3. **Centralized Intake and Scheduling**: A common enabler identified by the Working Groups was a shared centralized intake and scheduling function. This would act as a centralized access point for patients, creating one central point of referral and would enable coordinated scheduling across the system. This would also enable central coordination of wait times, improving patient experience and access to services. The benefit of this function would support the hospitals in the coordination of service delivery across the region.

4. **Improved integration with community and primary care**: Many Working Groups identified better integration with community and primary care as an enabler to improve service efficiency, access and patient experience. Leading practices have demonstrated the benefits to the health system of a strong primary care system at its core.
Integration with community and primary care is essential to increase the efficiency of hand-offs and transitions, and will be essential to support a growing response to keeping people healthy at home longer, and treating them in their home when they do become ill.

5. **Transportation:** There was a significant amount of discussion on transportation as an enabler for a more efficient regional system. Certainly any movement of services or support services will require patients and services to be transported around the system. Transportation should be considered in any subsequent design phase as the roles of each hospital are defined and the travel patterns of patients and services are determined. Particular attention needs to be paid to transportation needs of those with low income and those with special needs (i.e., disability).

6. **The Role of the Faculty of Health Sciences:** The Queen’s University Faculty of Health Sciences has an important role to play to enable the movement of professionals, research and education across the system. It is also an enabler to support the provision of highly specialized services. Thirdly, it has a role to play in bringing evidence to the table on leading clinical models, and care pathways.

7. **Regional Physician Credentialing and Alternate Reimbursement Models:** Regional physician credentialing would enable the flow of physicians across the system where they are needed. For example, regional credentialing of Radiologists would enable LHIN-wide coverage regardless of where the Radiologists are located. Alternate Reimbursement Models were also identified as an enabler in the development of a LHIN-wide network or system for education, research and patient care.

8. **Change Management:** There is a need for a robust Change Management strategy to support staff and key stakeholders through any potential changes, and further discussion on potential changes. Within Phase 1, two Change Management groups were formed – Change Management Leadership Group the Physician Change Management Working Group. The Change Management Leadership Group was focused on supporting the current change management requirements of the Health Care Tomorrow – Hospital Services planning, including support of the physician engagement strategy at each hospital and support of broader stakeholder groups’ change management needs. The Physician Change Management Working Group was focused to support the current change management requirements of physicians in the Health Care Tomorrow – Hospital Services planning, including support of the physician engagement strategy. These two key groups should continue to exist and support the change management requirements for the duration of the project and should continue to build on the tools and strategies that have been developed to date. Please refer to Appendix G for the Change Management Plan developed in Phase 1, intended to support Phase 2 activities, as well as the Change Management dashboard which supports Phase 1 activities and is intended to continue to support Phase 2 tactics.

### 4.3 System Barriers

In the next phase of work, consideration should be given to some of the system barriers or challenges that will make it difficult to create a regional integrated system of care. These barriers include the following:

- **Independent Nature of Hospital Governance:** As discussed above, regional program governance was identified as an enabler to creating a regional system of care. Hospital Boards will have to give some consideration how they can delegate responsibility to a regional governance structure(s) designed to enable the objectives identified in the report to succeed. Advisory councils may not be sufficient to allow for the implementation of goals and that alternate models need to be carefully considered.
Funding Formula: There may be considerations that will need to be explored to understand the implications of system redesign on the allocation of resources. For example, HBAM incentivizes efficiency and throughput, so systems will need to be designed to enable optimization of these features. While the funding formula was created to help develop a more competitive environment, particular for the provision of QBPs, there may be alternatives that could be considered during the Design Phase such as joint ventures, pooled funding amongst others.

Physician Remuneration: Physician compensation is an important issue that was often deferred during the discussions in this phase of work. It will need to be considered in the next phase of work as any design has the potential to impact physician remuneration. Physicians have and should continue to be an important part of the discussion in the redesign of the hospitals into a health system.

Policy/Legislative: In many instances the system solutions may require broad system changes that may include changes to policy or legislation to create the winning conditions for success. These include changes to scope of practice, for example with advanced care paramedics, in any see and treat protocols, current legislation requires they transport every patient call to the Emergency Department. Through changes to policy or legislation, system solutions could provide simple answers to enable change.

4.4 Human Resources

In the case that hospitals move forward through to implementation following Phase 2, pending Board approvals, this scale of change will require well developed human resource strategies.

The Human Resources Working Group, working with the Change Management Leadership Group, has developed preliminary Human Resources principles that may be used in the case that a decision is made to proceed with Phase 2, and potentially, Phase 3. These are outlined below.

Service Considerations
- Consider all people, including: patients, clients and families, employees (both unionized and non-unionized), physicians, volunteers and students
- Manage any potential transitions to ensure the least amount of disruption to patient/client service
- Treat all impacted people across the region in a fair and respectful manner with transparent processes
- Ensure that those that are affected by changes be notified first

Human Resource Transition Principles
- Transparency – Open communications with respect to the Human Resource practices and strategies and ensure clear, coordinated and consistent communication protocols and messages are in place
- Consistency – Model best staffing practices and ensure fair treatment of employees at all levels
- Compliance – Adhere to collective agreements, memoranda of agreements, employment contracts, relevant legislation and common law principles
- Opportunity – Maximize opportunities for employees for development and growth where possible
- Retention – Promote the retention of key skills and competencies
- Support – Provide a common, regional approach to support any impacted people to ensure successful transitions
(such as Employee Assistance Programs, training, counseling, outplacement assistance)

**Staffing Strategies**
Staffing strategies outline how positions will be filled and what strategies will be used to ensure the staff in the positions have the necessary skills, competencies and supports to work in the new structure.

**Recruitment**
- Recruitment/competition - open competitions will be posted to all internal candidates first and will respect all collective bargaining agreements. In the case that an appropriate candidate is not found, an open competition including posting to candidates external to the region will be held.
- Non-competitive strategies (i.e., temporary assignment/secondment, permanent appointments/waivers) will only be considered under critical circumstances and in accordance with established Human Resource policies and collective agreements, with the approval of SECHEF CEOs.

**Learning and Development (for all employees)**
- Defining core competencies that will enable the system transformation agenda and desired culture shift
- Organizational learning strategies available to all staff to build desired competencies across the region
- Individual learning and development plans to address individual gaps/needs
- Coaching and peer mentoring

**Transitioning Work Activities**
- Activities to operationalize the new organizational model and implement job-related changes must be led by Business Areas with support from Human Resources

**Strategies to Minimize Employee Impacts (attrition and vacancy management)**
As vacancies at [the level determined for each organization, as per guidelines below] are identified, CEOs will bring the vacancy and the plan to address that vacancy to the SECHEF CEO table for discussion. The following possibilities will be considered, effective immediately:
- Sharing positions between organizations (to be considered first)
- Not filling such positions
- Filling vacancies on a temporary basis only so that positions can be reduced as process improvement creates redundancies

<table>
<thead>
<tr>
<th>Organization</th>
<th>Level in consideration for vacancy management strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brockville General Hospital</td>
<td>Manager-level and above (usually three levels below the CEO)</td>
</tr>
<tr>
<td>Hotel Dieu Hospital</td>
<td>Manager-level and above (usually three levels below the CEO)</td>
</tr>
<tr>
<td>Kingston General Hospital</td>
<td>Manager-level and above (usually four levels below the CEO)</td>
</tr>
<tr>
<td>Lennox and Addington County General Hospital</td>
<td>Manager-level and above (usually two levels below the CEO)</td>
</tr>
<tr>
<td>Perth and Smiths Falls General Hospital</td>
<td>Manager-level and above (usually two levels below the CEO)</td>
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<td></td>
<td>Manager-level and above (usually three levels below the CEO)</td>
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<tr>
<td>Providence Care</td>
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<tr>
<td>Quinte Health Care</td>
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</tbody>
</table>
4.5 Considerations for Community Resources

One of the key and critical enablers to a sustainable health care system in the South East is a robust, efficient and effective community and primary care sector that integrates service delivery with the hospitals acting as one system.

Throughout Phase 1 of the Health Care Tomorrow – Hospital Services project, Working Groups identified several initiatives in the community and primary care sector that would help to enable a more sustainable and efficient hospital system. These are summarized below:

1. **Build Capacity in Community Support Services and optimize the use of Community resources**
   - Build capacity in core Community support services, such as Assisted Living, geriatric day centres, Meals on Wheels, and the SMILE program.
   - Optimize the use of community resources to enable patients to age in place, which would include caring for more patients in the community through higher intensity home care and community support services, reducing Long-term Care length of stay and the propensity to admit to Long-term Care.

2. **Emergency Medical Services (EMS) Enhanced Services**
   - Enhanced Emergency Medical Services that can see and treat, rather than transport all patients to the Emergency Department. Requires support of a base hospital physician to support decision-making and protocols.
   - Requires working with community partners that include the South East LHIN, Municipalities, MOHLTC and EMS to build capacity and grow the capability of community paramedicine programs in the region.

3. **Emergency Department Avoidance Strategy**
   - As part of the Urgent/Emergent Working Group opportunities, the community and primary care sector would play a significant role in the support a patient needs in the community as part of a cross-sector Emergency Department Avoidance Strategy. These would include the following:
     - Primary Care and Specialty Care at Home
     - Community Care role in access and navigation
     - Care at Home: Communication through a robust EMR that is viewable by all in the circle of care
     - Diagnostic Services (lab and imaging) available 18h-24h/7 days per week to providers in the community with timely reporting

4. **Integrated Care Pathways**
   - Many Working Groups identified the benefit of developing integrated care pathways between Primary Care and the Hospital sector. Integrated care pathways were fundamental in the transformation of the health care system in Canterbury, New Zealand and demonstrated significant improvements to patient flow, experience and access from Primary Care to secondary and tertiary levels of care, and subsequent follow-up in the community. In addition, the development of integrated and automated care plans between that include the hospitals for a broader subset of the population, building on the work on Health Links would provide significant benefit to patients and outcomes.
This summary of community opportunities has been documented here for the South East LHIN and community providers, many who have been involved in the Health Care Tomorrow – Hospital Services project and provided input into these opportunities. This list serves to summarize the hospitals’ recognition and commitment to continue to work with the community and primary care sectors to improve patient care across the South East LHIN.
5.0 Value Proposition

5.1 Overall Value Proposition Defined

Overall, the opportunities identified by the Working Groups for collaboration and integration of services have the potential to build a sustainable hospital system for the South East region. A more collaborative and integrated approach to hospital care would improve access to local services at best and prevent erosion at worst. Furthermore, by working together, the hospitals may be better positioned to take advantage of the emerging changes to the hospital funding formula.

Many stakeholders hold the view that the opportunities for collaboration in the three areas – Business Functions, Diagnostics & Therapeutics and Clinical – would allow the hospitals to perform better together than what each hospital can achieve independently. The Working Groups have identified opportunities to leverage economies of scale, converge to top quartile performance by understanding and extending each organization’s strengths, and working as a system of providers to deliver higher quality, more accessible and more cost-effective care.

Moving ahead to achieve the vision – *to improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’* – will impact each of the various stakeholder groups differently. Therefore, it is important to articulate any value proposition for possible collaboration and integration from the various stakeholder perspectives.

- Patients and Community
- Health Care System
- Organizational/Financial
- Staff and Physicians

Each perspective is highlighted below with a summary of the key areas of value identified through the Working Group process.

**Patients and Community**

- **Enhanced patient experience** – With a more integrated continuum of services across the hospitals, patients would experience smoother and fewer transitions and hand-offs as they move through the system contributing to better outcomes and higher satisfaction.
- **Enhanced quality of care** – Integrated care, including consolidation and redistribution of services, represents an opportunity to better serve local residents by improving care through increased specialization, better transitions and better sharing of expertise and resources by leveraging the best of all organizations.
- **Easier access to one system** – Currently, many of the hospitals within the South East region serve the same communities with 2 to 249 km distance between sites. A more integrated system of care will reduce the “silos” and the complexity of transitions for patients.
- **Equitable access to care** – An integrated system of clinical care with a shared vision will enable the establishment of regional programs and Centres of Excellence for specialized services, hence providing improved access to care.
Better linkages to community care – A more integrated system of clinical care will facilitate consistent community partnerships to improve care for patients and provide the ability to navigate patients to community services in a more timely and efficient manner.

Health Care System

Alignment with system strategies and directions – Key system strategies, such as Patient’s First Action Plan and Ontario’s Action Plan for Health Care, emphasizes patient-centred care, integration for better quality, better access and better value. Also, with the South East LHIN as a key partner in this planning, there is an alignment to regional directions. A strong hospital system is an essential component of a strong, local health care system.

Stronger system positioning – It is becoming an increasingly competitive environment for patients, funding, capital and health human resources. Currently, many hospitals within the South East region serve the same communities, yet they compete for patients, funds and other resources. As an integrated system, the hospitals can focus on shared opportunities that will benefit their communities and patients.

Organizational/Financial

Financial challenges – All hospitals face difficult economic outlooks in the near future: flat or negative funding; increasing patient volumes and complexity; growing and aging population. A unified hospital system across the region will be better positioned to respond to these challenges.

Economies of scale and operating efficiencies – By working together, the Working Groups have identified significant opportunities for cost savings related to economies of scale and operating efficiencies. Opportunities for shared services, regional approaches to capital planning and standardization of processes are all opportunities which will produce such savings.

Funding gains – By working together to optimize the use of current resources there are opportunities to improve the hospitals’ financial position, including optimizing HBAM funding through improved throughput which could lead to additional funding gains.

Staff and Physicians

Retention and attraction of top talent – The ability to retain and attract top talent can be enhanced through a regional approach to clinical care by providing larger and more specialized programs and services. Increased adoption of leading practices in evidence-based care, as well as enhanced research opportunities through greater volumes, will create further incentives for top talent.

5.2 Summary

Significant opportunities and benefits have been identified to improve access, quality and value. Stakeholder input and the output of the Working Groups have provided concrete ideas that would move towards achieving the vision to improve access to high quality care through the development of a sustainable system of integrated care. These opportunities can be achieved by working collaboratively together. Together the hospitals can position themselves to better respond to the needs of their communities, address fiscal challenges more effectively, and take advantage of the fast changing healthcare environment.
Initial financial benefits have been identified associated with the proposed opportunities for collaboration and integration, albeit not in the short-term.

While this study was not an operational review, financial impact was considered as a criteria to assess the opportunities, to help achieve sustainability, recognizing that savings will be required to support future population growth and aging. The savings identified in this report should be taken into context:

- Savings identified are directional, order-of-magnitude estimates;
- Most of the savings will be realized in the long term and will require some up-front-investments; the full suite of which still need to be considered and calculated in Phase 2;
- Savings identified will be achieved after implementation starts in Phase 3, the next phase of work (Phase 2) is design and due diligence, resulting in decisions to implement, which means that year 1 for savings considerations is year 1 for implementation, and that gains by individual hospitals could be achieved in the timeframe between now and the start of implementation;
- While a financial analysis of each hospital was not part of the scope of this project, each hospital is not starting at the same fiscal position; this means that some part of the identified “savings” in this report may be required to fill efficiency or fiscal gaps;
- Hospitals in the South East LHIN will continue to face increasing pressures: the hospitals, collectively, within the South East LHIN are inefficient when compared to provincial peers; this will result in a reduction in revenue through HBAM; hospitals, collectively, will face inflationary pressures on cost and increasing demand through demographic changes; and,
- Hospitals in the short-term will still need to balance their budgets, take efforts to improve their individual efficiency and make investments to build capacity to invest in the future together.

Table 12, on the next page, presents the high-level projected cash flows over the next six years and beyond for savings and investments related to Business Function and Diagnostics &Therapeutics opportunities. Future state annual ongoing savings have been identified at approximately $29 million. This represents ongoing savings that could be achieved once all opportunities have been implemented. Known investments over that period amount to $15 million (this does not include capital investments required for Hospital Information Systems, Laboratory and Diagnostics,

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8 Savings potential includes an order-of-magnitude opportunity identified by shared services business cases for Information Services, Human Resources, Facilities / Support Services and Finance; and an estimate of savings that could potentially be achieved from regional Laboratory (15%), regional Diagnostic Imaging (10%) and regional Pharmacy (5%). These figures are directional and will need to be validated in Phase 2.

9 One-time investments include costs of a shared enterprise resource system for Human Resources and Finance, severance costs for all four business functions as defined in the business cases, and project implementation cost estimates. Any investment costs for clinical services (i.e., central intake and scheduling system) was assumed to come out of any clinical savings identified. These costs need to be identified as part of the next phase of work. Costs of the Hospital Information System have been excluded at this stage as significant work remains to identify costs, potential savings, benefits and alternatives that will be conducted in the next phase of work. Additional work is required to confirm the investments and potential costs associated with termination of existing regional Laboratory, Diagnostic Imaging and Pharmacy systems.
which will be estimated in Phase 2, pending Board approval). This results in total net cumulative savings of approximately $52 million over five years. For detail on financial estimates, see notes to financials below.

Table 12: High-level projected cash flows over the next six years and beyond for savings and investments related to Business Function and Diagnostics & Therapeutics opportunities

*all figures represent 000’s

<table>
<thead>
<tr>
<th>Work stream</th>
<th>Opportunity</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Year 6+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business Functions</strong></td>
<td>Develop a regional shared service to support Finance, Human Resources, Facilities/ Support Services and Information Services</td>
<td>($7,000)</td>
<td>($4,500)</td>
<td>($500)</td>
<td>($500)</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$11,000</td>
<td>$12,000</td>
<td>$12,000</td>
<td>$16,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostics &amp; Therapeutics</strong></td>
<td>Develop a Regional System for Laboratory, Diagnostic Imaging and Pharmacy</td>
<td>($500)</td>
<td>($500)</td>
<td>($1,000)</td>
<td>($1,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$6,000</td>
<td>$13,000</td>
<td>$13,000</td>
<td>$13,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Investments</strong></td>
<td></td>
<td>($7,500)</td>
<td>($5,000)</td>
<td>($1,500)</td>
<td>($1,500)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$17,000</td>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Cumulative Net</strong></td>
<td></td>
<td>($7,500)</td>
<td>($12,500)</td>
<td>$3,000</td>
<td>$26,500</td>
<td>$51,500</td>
<td>$80,500</td>
</tr>
</tbody>
</table>

Based on leading benchmarks, the savings estimates are conservative, but may be offset by additional investment costs that will be identified in Phase 2 (see note 2 on previous page). In addition, it was calculated that ongoing annual gross savings of approximately $38.5 million could be achieved through the clinical opportunities. Further analysis is required in the design phase to validate this potential and identify required investments. In addition, any clinical efficiencies identified will likely be required to offset inflation and any negative impact of the funding formula.

The proposed opportunities for collaboration and integration of services across the seven hospitals have the potential to create a sustainable system of integrated care within the South East region that is positioned to succeed through the broader health system transformation, and to deliver increased quality and access to services across the region.

Overall, the strength of this value proposition is not in the short-term, but rather in the longer-term in which the hospitals are able to position themselves to better serve the South East region, create a shared vision for a transformed local health care system, address fiscal challenges together, and take advantage of the fast changing health care environment.
Moving Forward

A proposed sequence of activities has been developed on page 43. This proposal will depend on the capacity and investments available to the hospitals in the South east LHIN to proceed in Phase 2. A key proposal in moving forward is the development of a 90-day plan that will become a measure stick for progress. At the end of that plan, we anticipate that significant progress will be made and we will be able to present Hospital Boards with evidence on the design and due diligence on many of the activities planned for the next phase of work.

In summary, the activities that have been prioritized are both early opportunities identified by the Working Groups and key enablers that a significant number of Working Groups identified as necessary to integrate service delivery. Following these foundational activities, high priority activities will be sequenced as capacity allows. These activities are described further below:

Activities that should be started immediately following Board approval:

- Development of a service governance model and design for a renewed shared service entity to house business function shared services;
- Launching a Request for Information (RFI) for Facilities/Shared Services;
- Identifying the cost-benefit for Hospital Information System (HIS) options that include status quo, independent hospital investment, a new shared HIS, independent HIS investment with connectivity across the region, taking into consideration all costs, benefits and risks;
- Design and due diligence of all business functions (Human Resources, Finance, Information Services, Facilities/Support Services); and,
- Business case development, design, due diligence for a Regional Laboratory System.

Priority Phase 2 activities that will follow, once capacity allows:

- Business case, design and due diligence for centralized intake and scheduling, an enabler identified by many of the clinical Working Groups;
- Acute services redesign, which will include identify the acute roles and accountabilities for each hospital in the region in a regional, integrated system for elective, urgent/emergent and tertiary/quaternary services;
- Establishing a Regional Emergency Department Council responsible for regional standardization and process improvements;
- Establishing a Regional Council for Complex Care/Frail Elderly patients to develop a regional system of care that includes standardization and access to geriatric assessment clinics, acute elderly units, and centres of excellence, followed by the development of integrated, coordinated care plans.

In addition, two important enablers identified by the Working Groups was the need for Clinical Leadership and oversight, and design and implementation using a rigorous Change Management approach. These have been designed into the Phase 2 activities.
It is envisioned that a series of activities will conclude in December 2015, after the 90-day plan to seek Board approval, followed by another decision point in March 2016. These staggered decision points will require ongoing Board engagement at key points to enable progress to continue and proceed to implementation where the business case demonstrates value.

There is recognition that the business cases and further analysis of opportunities will need to take into account the impact of the opportunities on HBAM, including consideration of mitigation strategies, where necessary.

Also, as the project progresses, it will need to adapt to, and leverage, new provincial directions that may emerge over the course of potential further design and future phases.

Notes to financials:

The identification of potential savings and investment costs, have been calculated to identify the potential order-of-magnitude opportunity, and to provide input to help prioritize where the greatest opportunities may exist. Further work is required in Phase 2 to validate these figures through detailed design and due diligence. The identification of savings across each of the Working Groups has been calculated as follows:

- Business Functions Working Groups developed ‘strategic’ business cases to determine the order-of-magnitude opportunity through the development of shared service models.
- Diagnostics & Therapeutics Working Groups were asked to identify opportunities for savings; however, these have not been financially confirmed. A high-level estimate for each area was provided based on input from each Working Group.
- Clinical Working Groups received analysis from KPMG/PSG that examined the potential gross savings based on expected performance compared to provincial averages. All potential savings are assumed to offset required investments and reinvestment in clinical care.

These high-level order-of-magnitude estimates provide the direction of savings and can be used to prioritize future design activities. In many cases, conservative estimates have been used that point to the potential for higher savings.

1. Business Function investments include severance costs and ongoing project management and change management that would be part of an overall shared service implementation. These costs also include the full projected cost of an Enterprise Business System for Finance and Human Resources. One system would also provide for the potential for further efficiencies across Human Resources and Finance. These costs have not considered ongoing costs required to support current Finance and Human Resource systems and will be considered in Phase 2 design work.

2. Diagnostic and Therapeutic investments exclude any investments in Information Services. These will be identified in Phase 2. Working groups identified the benefits of shared information services (i.e., Laboratory Information Systems, shared Picture Archiving and Communications System (PACS) for Diagnostic Imaging and shared Pharmacy system). There is the potential to take advantage of Provincial Laboratory and PACS systems that may reduce these costs that will be considered in the design phase. The regional Pharmacy system would be included in a shared Health Information System (HIS), as would a regional Radiology Information System (RIS) were this investment to proceed.
3. Additional analysis is required to identify the costs and benefits of a Health Information System solution. There are currently four options that will be assessed in phase 2: status quo, independent hospitals investment, shared regional Health Information System, individual investments with connectivity (i.e., Health Information Access Layer, HIAL). The savings identified from Information Services is the savings attributed to a shared service model with some consolidation of the information systems across the regional, excluding the Health Information System. The additional, strategic IS savings, include the IS savings for a regional shared Health Information System.

Additional work is required to identify the clinical efficiency that could be gained through a regional shared HIS. It should also be noted that an option to connect the individual Health Information Systems in the region, would also require investments to upgrade current Health Information Systems to enable automation and connectivity.
6.0 Recommendation

This report represents the recommendation of the SECHEF CEOs to the Hospital Boards, and subsequently the South East LHIN Board. As such, the recommendation is articulated in the Board resolution provided below.

Proposed Board Resolution

Whereas,

1. In October 2014, the Board supported, by way of a formal motion, the principles that will guide “Development of a Sustainable Integrated Model of Hospital Care” project.

2. In October 2014, the Board committed, by way of a formal motion, to full participation in the “Development of a Sustainable Integrated Model of Hospital Care” project and will provide appropriate and sufficient in-kind resources to support the completion of the project in a timely manner, while meeting existing obligations as set out within Service Accountability Agreements; and,

3. In October 2014, the Board committed, by way of a formal motion, to open and honest communication with its partner hospitals regarding any decisions the organization may make related to specific “Development of a Sustainable Integrated Model of Hospital Care” project proposals, made through SECHEF, and the associated rationale for such decisions.

4. [Hospital] Board has reviewed the Healthcare Tomorrow – Hospital Services Phase 1 Recommendations Report, informed by the Business Function business cases and outputs of the Clinical and Diagnostics & Therapeutics Working Groups, and understands that the recommendations put forward by each of the Working Groups are directional in nature and have been scoped to provide an order-of-magnitude assessment of the opportunities identified in the table below. [Hospital Board] understands that further verification of total estimated savings and investments are required.

5. The opportunities and recommendations put forward as a result of the Working Groups is as follows. The potential for ongoing savings from these opportunities has been estimated at approximately $29 million. This is an order-of-magnitude estimate that will need to be validated in Phase 2.

   - The seven opportunities listed in the first table below are within the control of the hospitals and are presented to Hospital Boards for consideration of approval to move forward to Phase 2.

   - The subsequent three opportunities require partnership and collaboration with community partners via a shared accountability, or accountability of the community sector. It is the collective Hospital’s recommendation to the South East LHIN to take on the responsibility to move these forward.
<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Recommendations for Phase 2</th>
</tr>
</thead>
</table>
| 1. Develop a regional shared service to support Finance, Human Resources, Facilities/Support Services and Information Services | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:  
- Design of a service governance model and redesign of the shared service entity  
- Further refinement of future state and potential transition leadership models  
- Development of regional service models  
- Launching an RFI for all Facilities/Support Services  
- Assessing how to leverage current IT investments/infrastructure and identification of savings for the proposed Health Information System |
| 2. Develop a regional laboratory system to serve all the hospitals in the South East LHIN. | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:  
- Development of a business case and preferred model for a regional laboratory system |
| 3. Develop a regional Diagnostic Imaging system to serve all the hospitals in the South East LHIN | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:  
- Development of a business case  
- Development of the Terms of Reference for the leadership model |
| 4. Develop a regional Pharmacy system to serve all the hospitals in the South East LHIN | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:  
- Development of a business case  
- Development of the Terms of Reference for the leadership model |
| 5. Develop a regional system of care for highly specialized services (tertiary/quaternary services) and planned care (elective) | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:  
- Establishing of a Clinical Leadership Council to provide oversight of all Phase 2 clinical activities and outcomes  
- Establishing an Expert Advisory Panel to advise on the prioritization of regional programs (see priority list in the |
Opportunity | Recommendations for Phase 2
--- | ---
| Phase 1 Recommendations Report) and consolidation of tertiary services in the South East LHIN and redistribution of primary/secondary care
- Modeling of hospital role scenarios and accountabilities
- Development of a business case with design, investments and savings, and potential implementation planning

6. Develop a regional system of care for urgent/emergent care to focus on process improvement and excellence that is evidence-based through an Emergency Department/Urgent Care community of practice | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:
- Development of a Council Terms of Reference including aims, outcomes and accountabilities
- Development of a detailed 3-year strategy, tactics and work plan
- Development of a business case for Year 1 initiatives including design, investments, savings, and potential implementation planning

7. Expand/standardize seniors care strategies across all South East LHIN hospitals, including primary, secondary and tertiary care, with regional specialization of behavioral supports and geriatric medicine/inter-professional resources | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:
- Establishing complex patients/frail elderly regional council with terms of reference including aims, outcomes and accountabilities
- Designing regional model to include centres of excellence and core services, identifying service gaps and opportunities
- Identifying care pathways and scope of pathway development
- Developing a business case for service needs and gaps and pathway development

Opportunities requiring community collaboration and partnership – recommended to the South East LHIN to take on the responsibility to move these forward.

Opportunity | Recommendations for Phase 2
--- | ---
1. Build capacity in community support services and optimize community resources to prevent unnecessary use of hospitals | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:
| 2. Development of an Emergency Department Avoidance Strategy that include Enhanced Emergency Medical Services (EMS) Services and Care at Home and the Community | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:
- Development of a multi-sectoral Emergency Department avoidance strategy with aims, outcomes and accountabilities
- Development of a multi-year plan
- Development of a business case for Year 1 initiatives including design, investments, savings, and potential implementation planning |

| 3. Improve service delivery and the integration of care for complex chronic/frail elderly through the development of automated, Integrated Coordinated Care Plans | That the Hospital Boards approve moving forward to Phase 2, which would include detailed design, due diligence and potential transition planning. Phase 2 would include the following:
- Development of a detailed design and business case for integrated care plans |

6. The appropriate sequencing of activities will be determined matching priority and capacity to complete next steps. Sequencing will impact the timing of next steps and the order in which activities are planned in the next phase of work.

Therefore, be it resolved,

1. Based on the high-level analysis and assumptions contained in the Healthcare Tomorrow – Hospital Services Phase 1 Recommendations Report, the Board of [Hospital] agrees that the potential benefits presented by each Working Group warrant further detailed analysis and design; and,

2. In support of the collective approval of the SECHEF CEOs, [Hospital Board] approves and provides direction for [Hospital] to support the ongoing Healthcare Tomorrow – Hospital Services planning activities into Phase 2, to move forward with the next level of analysis, including further development of the financials and due diligence and development of service delivery models and transition approach, recognizing that the outcome of Phase 2 will be a decision point for potential implementation.

Please refer to Appendix H for the Decision-making and Dispute Resolution Process.
Appendices

Appendix A: Project Charter
Appendix B: Terms of Reference and Listing of Participants
Appendix C: Stakeholder Engagement Summary and Community Engagement Feedback Report
Appendix D: Decision Making Criteria Summary
Appendix E: Technical Data Analysis
Appendix F: Visioning Day Summary
Appendix G: Change Management Plan
Appendix H: Decision-making and Dispute Resolution Process
Appendix A: Project Charter
Project Charter

1.0 Purpose of this document

This document serves as the charter for the project to develop a sustainable integrated model of hospital care in the South East LHIN, referred to as the “Hospital Sustainability” project. This charter covers all phases of work for the project as defined in section 2.5.

2.0 Project Overview

2.1 Problem Statement

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care for many services.

2.2 Objective

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

2.3 Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

2.4 Principles

The SECHEF Development of a Sustainable Integrated Model of Hospital Care will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
- Inclusive engagement with patients and residents to inform processes;
- Inclusive engagement with Francophone and Indigenous communities to inform processes;
- Engagement via an appreciative inquiry approach;
- Options will be developed based on evidence and leading practice models;
• Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
• Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
• Realistic activities and timelines.

2.5 Key Activities and Deliverables

<table>
<thead>
<tr>
<th>Phase 0</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLAN</td>
<td>UNDERSTAND the current state</td>
<td>DESIGN New Regional Models</td>
<td>BUILD Consensus</td>
</tr>
<tr>
<td>Jun-Sep</td>
<td>Sep-Jun</td>
<td>(TBD)</td>
<td>(TBD)</td>
</tr>
</tbody>
</table>

- Project kick-off meeting with Project Team
- Establish project governance
- Build project Charter
- Interviews with SECHEF leadership
- Conduct targeted interviews will representatives from each provider
- Collect existing data, reports and information on the LHIN
- Develop a preliminary framework for working groups
- Develop a detailed project plan
- Build project support tools
- Consult stakeholders
- Develop a baseline case for change to be built on iteratively throughout the engagement
- Develop shared sense of purpose
  - Interviews with targeted stakeholders
  - Presentation and sign-off by SECHEF Steering Committee on plenary objectives, approach and initial vision and design principles
  - Plenary facilitated visioning session
- Model Current State and Future Outlook
  - Analysis of current state and future impact analysis
- Leading Practice Review
  - Jurisdictional review of effective integrated models of care
- Opportunity Development
  - Working group facilitated sessions to develop shared service options
  - Governance-to-governance facilitated workshop
- Design/Develop Future state regional hospital model in partnership with cross-organizational working groups
- Develop framework to identify hospital roles and accountabilities
- Develop and model scenarios for hospital roles and reconfiguration
- Analyse impact and develop business cases
- Develop Community Engagement Plan
- Conduct broad consultation and awareness campaign to get input/feedback from all relevant stakeholders

Outcomes/Deliverables
- Finalized project Charter
- Finalized project plan
- Finalized project support tools: stakeholder engagement plan, change management plan, communication plan and risk management plan
- System wide plenary session to confirm the vision
- Current state model
- Model of future financial projections
- Leading practice review
- Phase 1 Report containing a prioritized portfolio of options for both clinical and non-clinical service redesign identifying the high level impact
- A framework to identify hospital roles and accountabilities
- Identified roles and accountabilities for each hospital
- A model for integrated health service delivery across the SE LHIN
- Impact and business cases for system redesign

Note: KPMG has been retained to support only Phase 0 and Phase 1.
## 2.6 Scope

| In scope: | • Project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care.  
• Develop detailed work plan for all project phases.  
• Develop the case and vision for change, including:  
  • The needs of the population and the quality of services provided, including cross-border patient flow;  
  • Assessment of the implications of Ontario’s fiscal situation and the Ministry’s Health System Funding Reform strategy for South East LHIN’s hospitals; and,  
  • Identified gaps and opportunities based on leading practice.  
• Review current individual hospital strategies for administrative efficiencies.  
• Review current and potential shared strategies for administrative efficiencies.  
• Develop options for support services reconfiguration (i.e. diagnostics, laboratories).  
• Develop options for clinical service transformation (taking into consideration existing and leading quality frameworks).  
• Prioritize options on the basis of their implications to quality, access, affordability and academic impact.  
• Note: seven hospitals include: Hotel Dieu Hospital, Providence Care, Perth Smiths Falls, Brockville General Hospital, Kingston General Hospital, Quinte Health Care, and Lennox and Addington County General Hospital. |
|---|---|
| Out of scope: | • Long term care, except where related to integration of services with hospitals and potential transfer of services.  
• Primary care, except where related to integration of services with hospitals.  
• Research, except where related to integration of services with hospitals.  
• Community services, not provided by Community Care Access Centre.  
• Review of operations of Community Care Access Centre and Queen’s University. |
3.0 Project Work Plan

The Gantt chart below presents a high-level work plan for this engagement (as at the time of this Project Charter development). A detailed work plan will be developed to integrate and align stakeholder engagement activities. In addition, detailed Phase 1 work plans will be designed for each of the working groups.
4.0 Project Organization

4.1 Project Structure and Governance

Overall Project Structure

Note: See stakeholder engagement plan for full list of stakeholders that will be engaged throughout the project.

NOTE: The Phase 1 Project Management Office was expanded to include two LHIN Project Leads (Darryl Tooley and Elaine Johns), Michael Spinks (South East LHIN), Paul McAuley (Quinte Health Care), Jennifer Goodwin (Providence Care) and Theresa MacBeth (Kingston General Hospital). The South Each LHIN provided project support for Working Group sessions to enable logistics and note taking.
## 4.2 Team Roles and Accountabilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Assigned to</th>
<th>Accountabilities</th>
</tr>
</thead>
</table>
| Steering Committee                           | SECHEF Steering Committee                                                                       | • Provide direction to the process and make key decisions informed by evidence.  
• Identify key risks and mitigation strategies.  
• Champion the project in respective hospitals and communities and escalate issues as required.  
• Work collaboratively with the Project Management Office to resolve issues.  
• Provide final sign-off on all project deliverables.                                                                                     |
| Clinical Advisors                            | SECHEF Clinical Leaders                                                                         | • Provide clinical advice and guidance to the process, through the SECHEF Steering Committee.  
• Champion the project in respective hospitals and communities and escalate issues as required.  
• Work collaboratively with the Project Management Office to resolve issues.                                                                                                            |
| Executive Leads on behalf of Steering Committee | Paul Huras and David Pichora                                                                     | • Act on behalf of the SECHEF Steering Committee to provide accountability and corporate direction for the delivery of the project.  
• Helps resolve project issues (i.e. resources) and escalate issues to SECHEF as required.                                                                                                         |
| Project Management Office                    | Darryl Tooley, Sherry Kennedy, Cynthia Martineau, Caitlin denBoer, Julie Rickard, Drew Baillie, Jessica Logozzo | • Provide direction to the process, manage risks and ensure effective execution of the process and project deliverables.  
• Manage the day to day activities of the project.  
• Manage quality of the deliverables, providing adequate time for meaningful stakeholder input and engagement.                                                                                 |
| LHIN Project Manager                         | Darryl Tooley                                                                                    | • Provide overall accountability for the effective execution of the process and project deliverables.                                                                                                             |
| Communications Lead                          | Caitlin denBoer                                                                                  | • Collaborate with KPMG on the development of a Communications and Stakeholder Engagement Plan.  
• Lead the execution of the Communications Plan, liaising with Hospital Communication Leads to deliver and cascade messaging and communications to their organizations.            |
| Communications Committee                    | Hospital Communication Leads                                                                    | • Provide direction and input on the Communications and Stakeholder Engagement Plan.  
• Execute Communications and Stakeholder Engagement Plan in their respective hospital and communities, keeping stakeholders informed throughout the project.  
• Liaise with respective hospital CEO and executive team to keep them informed throughout the project.                                                                                 |
| Technical Advisory Group                     | Hospital Decision Support Leads                                                                  | • Support hospital data requests as required.  
• Provide input and insight into the understanding of the current state, financial and population projections and the impact of initiatives on their hospitals and communities.  
• Validate the outputs of the data analytics at key points throughout the project.                                                                                                         |
| Working Groups / Expert Advisory Groups      | System thought leaders                                                                           | • Work collaboratively with stakeholders from across the region to provide input on the design of integrated systems of care.                                                                                     |
### Role

<table>
<thead>
<tr>
<th>Role</th>
<th>Assigned to</th>
<th>Accountabilities</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>• Bring their experience and expertise to bear on the design of integrated systems of care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Act as thought leaders to provide input on how integrated systems of care can function in the South East.</td>
</tr>
<tr>
<td>Engagement Partner</td>
<td>Georgina Black</td>
<td>• Overall responsibility for the quality and timeliness of deliverables.</td>
</tr>
<tr>
<td>Project Director</td>
<td>Drew Baillie</td>
<td>• Day-to-day Project Manager and primary client contact.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Manage overall engagement activities; including Risk and Issues Management Plan.</td>
</tr>
</tbody>
</table>

5.0 Project Management Processes

The following project management/communication processes will be in place:

- KPMG will develop a detailed project status report each week (to be sent to the Project Management Office every Thursday) showing progress against the work plan and budget updates;
- KPMG will meet with the Project Management Office each Friday (2:30 – 3:30 PM), as required, to discuss progress on project deliverables and to discuss risks and issues;
- The Project Management Office will brief the Executive Lead regularly at weekly teleconference meetings every Friday (8:00 – 9:00 AM); and,
- The Communications Group (South East LHIN, South East CCAC and Hospital Communications Staff) meet every second week on Thursday (10:00-10:30 AM) and KPMG will be invited when required to discuss sustainability related communications.

6.0 Project Conditions and Controls

6.1 Assumptions

- The engagement start date is June 16, 2014 and end date is June 30, 2015.
- SECHEF meets monthly.
- Ongoing project documents will be provided by KPMG to the South East LHIN with 48 hours lead time for review and feedback. All feedback and approvals will be provided to KPMG within 48 hours. Review of final deliverables will be provided within five working days, or as agreed in advance.
- The Communications Group (South East LHIN, South East CCAC and Hospital Communications Staff) is responsible for the stakeholder engagement and communication strategy and plan (including development of key messaging and tactics and guidance on delivery) with support from KPMG. The South East LHIN is responsible for the execution of the stakeholder engagement and communication strategy and plan (including ongoing communication with hospital communication teams).
- The South East LHIN will manage any additional contracts that are required during the engagement (i.e. video production).
- The South East LHIN will create a Sharepoint site for document sharing with all project participants. KPMG will be responsible for the ongoing management of documents on the site.
- The South East LHIN will host and maintain any website or media that is developed (including uploading of materials). KPMG will assist with the development of content.
- KPMG and partner Preyra Solutions Group will lead and conduct the data analysis. KPMG will work with the South East LHIN enabling support team, who will provide oversight to the data analysis. The South East Technical Advisory Group with representatives from the hospitals and the South East LHIN will validate the outputs.

Assumptions related to Working Group sessions:

- All Working Group sessions will run for a maximum of four (4) hours in length.
- Working Group sessions will be scheduled concurrently over a series of four (days) for each workshop. Thus, a total of 12 sessions will occur (three sessions occurring concurrently over four days – repeated for each of the three workshops).
- The South East LHIN will provide resources to co-facilitate the Working Group sessions.
6.2 Scope Change Management Process

KPMG will adhere to a formal project scope change management process. No changes are to be made to the approved project scope and deliverables without obtaining approval through the formal scope change management process:

- All scope changes will be discussed with the Executive Lead;
- All scope changes will be formally documented in a formal scope change letter, to be reviewed and signed off by the Executive Sponsor and Engagement Partner; and,
- All scope changes will be tracked by the Project Director; to be maintained in a log which will provide an overview and status of each scope change requested.

6.3 Decision-making and issues resolution process

The outcome of this project will be a set of recommendations for system transformation that will contribute to the sustainability of the hospital system in South East LHIN. The recommendations will be developed guided by the principles as established in section 2.4 of this document. A subset of recommendations may be sent to the SE LHIN for review and approval where LHIN approval and support is required. SECHEF will decide on recommendations and advice to the SE LHIN by a process of careful deliberation respecting the wisdom and experience of all SECHEF members. SECHEF will strive for consensus of opinions in its recommendations and advice to the LHIN.

Consensus does not mean unanimity and the following criteria will guide achievement of consensus:

- Consensus strives to synthesize many diverse elements rather than focus on binary options;
- Consensus is about process and is concerned with understanding and mitigating minority objections;
- Consensus appreciates that it is in the organizations’ best interests to understand all of the options, to debate and be open to a new and better option;
- SECHEF will value and respect disagreement to provide a full range of recommendations and advice to the SE LHIN;
- SECHEF members commit to supporting recommendations and advice to the SE LHIN even if they did not support all elements of what is being provided.

Process for developing recommendations

1. A set of system directions and priorities will be established by SECHEF based on a review of the evidence and an established vision;
2. Thought leaders and system experts will be engaged to provide input on how these priorities can be operationalized in the South East;
3. SECHEF will review these inputs and make recommendations to the SE LHIN on the need for system transformation in alignment with the objectives set out in this charter;
4. Decisions on system redesign will be made through consensus with adequate time for discussion and debate after each member’s concerns have been raised and addressed;
5. Project deliverables for contract purposes as agreed with KPMG will be signed off by PMO executive lead(s) after input and discussion by SECHEF steering committee.
### 6.4 Risk and Issues Management Plan

<table>
<thead>
<tr>
<th>Activities</th>
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<tbody>
<tr>
<td>• At the beginning of the engagement, major risks will be identified and</td>
<td>documented for tracking purposes (see Risks and Issues Log). These risks will</td>
</tr>
<tr>
<td>documented for tracking purposes (see Risks and Issues Log). These risks will be identified at the initial Project Kick-off Meeting.</td>
<td></td>
</tr>
<tr>
<td>• As the engagement progresses, the Project Director will log any risks/barriers that may be identified throughout the engagement and will raise these with Project Management Office for resolution.</td>
<td></td>
</tr>
<tr>
<td>• A formal Risks and Issues Log, which will document the details of any risks and issues identified throughout the engagement including associated resolution strategies, will be maintained and communicated to the Project Management Office.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Accountabilities</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>• The Project Director is responsible for the Risk and Issues Management Plan being implemented and for reporting to the Project Management Office as risks and issues arise.</td>
<td></td>
</tr>
<tr>
<td>• The Project Management Office is responsible for communicating potential risks and barriers to the Project Director and for assisting in their resolution.</td>
<td></td>
</tr>
</tbody>
</table>
7.0 Sign Off

Paul Huras, CEO, South East LHIN

_________________________________________________
Dr. David Pichora, President & CEO, Hotel Dieu Hospital

_________________________________________________
Wayne Coveyduck, President & CEO, Lennox and Addington County General Hospital

_________________________________________________
Mary Clare Egberts, President & CEO, Quinte Health Care

_________________________________________________
Beverly McFarlane, Perth and Smiths Falls District Hospital

_________________________________________________
Cathy Szabo, President & CEO, Providence Care

_________________________________________________
Jacqueline Redmond, CEO of South East CCAC

_________________________________________________
Dr. Richard Reznick, Dean, Faculty of Health Sciences, Queen's University

_________________________________________________
Leslee Thompson, President & CEO, Kingston General Hospital

_________________________________________________
Tony Weeks, President & CEO, Brockville General Hospital
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4. Clinical Working Group: Tertiary/Quaternary Care...page 13
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6. Diagnostics & Therapeutics Working Group: Diagnostic Imaging...page 22
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South East Local Health Integration Network (LHIN)

Health Care Tomorrow

Terms of Reference

Regional Patient Advisory Council

1.0 Purpose
The purpose of the Regional Patient Advisory Council is to bring together patients and family members to openly and honestly discuss, suggest and test ideas related to the future of health services across the South East region (within the mandate of the South East Local Health Integration Network). The Regional Patient Advisory council will formulate suggestions to help make the delivery of health services in the South East region more patient-centered.

2.0 Responsibilities
The Regional Patient Advisory Council serves in an advisory capacity, providing open and honest input on matters that impact the experience of patients and their families across the South East region (within the mandate of the South East Local Health Integration Network).

Responsibilities include:

- To share personal experiences in the health system for the purpose of improving the patient and family experience, at a system level, across the South East region.
- To make recommendations regarding the initiatives of the South East LHIN in improving the patient and family experience, at a system level, across the South East region.
- To identify and support opportunities for improvement, at a system level, within the South East region from the patient and family perspective.
- To provide strategic advice and recommendations on proposed strategies to measure, manage and improve the patient experience, at a system level, within the South East region.
- To support wider community consultation and communication around specific South East LHIN-wide health system issues, as requested.
- To actively promote and create new and unique opportunities for open and honest communication, collaboration and partnering among patients, families and staff.
- To provide advice on communication and stakeholder engagement strategies.

3.0 Principles
The Regional Patient Advisory Council will be guided the following principles:

- Advice and input will be open and honest, based in evidence and include personal experiences;
• System-level thinking; and,
• Continued and regular engagement on the initiatives of the South East LHIN in improving the patient and family experience, at a system level.

4.0 Logistics and Process

4.1 Term

Membership will have a renewable three-year term.

Members who miss three consecutive meetings without sending regrets will be approached by the Co-Chairs as to their continued involvement.

Any member of the Council who undertakes legal action against the South East LHIN, or an associated hospital, will step down until there is resolution.

4.2 Meeting Frequency

At the call of the Co-Chairs, as needed based on South East LHIN initiatives and priorities.

4.3 Meeting Agenda Items and Materials

Agenda items and materials minutes will be distributed electronically four days prior to the meeting.

4.4 Decision Making

This is not a decision-making body.
1.0. Context for Health Care Tomorrow

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in improving capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for transformational change. Specifically, to work with all partners in and with the South East LHIN in developing a sustainable integrated model of comprehensive health care, while respecting everyone’s role as part of the integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The SECHEF Development of a Sustainable Integrated Model of Hospital Care will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the all health care providers play in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
- Inclusive engagement with patients and residents to inform processes;
Inclusive engagement with Francophone and Indigenous communities to inform processes;
Engagement via an appreciative inquiry approach;
Options will be developed based on evidence and leading practice models;
Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
Realistic activities and timelines.

2.0. Scope and Role

The Urgent/Emergent Care Working Group is formed of hospital thought leaders, community partners and patients and will meet three to four times to assess, plan and recommend interventions to transform Urgent/Emergent care in Southeastern Ontario into the most effective model that achieves the Health Care Tomorrow goals. As one of the Health Care Tomorrow Working Groups, the Urgent/Emergent Care Working Group will carry out various quantitative and qualitative analyses necessary to support development of a sustainable hospital system in the South East LHIN and support SECHEF in developing well informed recommendations to the respective Boards of Directors and the South East LHIN.

The Urgent/Emergent Care Working Group will focus on the redesign of Urgent/Emergent care with a particular focus on improving access, appropriateness, utilization, and patient flow to Urgent/Emergent care, through the Emergency Departments in the region, and access to Urgent/Emergent diagnostics both through the Emergency Department and hospital-to-hospital transfers. The Working Group will consider regional and system issues that contribute to the high rate of usage of the Emergency Departments, to consider the appropriate utilization of our urgent and emergent services and propose strategies to redesign this patient flow where appropriate. Potential areas for improvement to be considered include but are not limited to: reduce demand, shift settings of care, remove duplication, care pathway redesign and integration of processes including information related processes.

Defining the Issues

Emergency Departments in the South East LHIN see 50% more visits each year than the Ontario age-adjusted average. This contributes to over 100,000 additional visits for a population of approximately 500,000. While the activity may be appropriate and the most cost effective in some instances (e.g. rural hospitals) it is worth a closer examination of this activity. Through stakeholder engagement, a lack of accessibility to urgent (same-day) diagnostics has been suggested as a key issue from both primary care physicians and hospital-to-hospital transfers.

Scope

When we speak of “quality” we define quality according to the Institute of Medicine 6 domains:

Quality care is:
- Patient centered
- Timely
- Safe
- Effective
- Efficient
- Equitable

The Urgent/Emergent Working Group will work in partnership with primary care and community partners to transform the Emergency Care system:

1. **Define** what are the needs for emergency care services for our population now and for the next 20 years, who the patients are that are using the EDs, identify patient demographics and characteristics, reason for visit, time of day and week when they visit the ED etc.

2. **Measure and analyze** the appropriateness of utilization of our EDs. Ask if alternate provisions of care (e.g. primary care etc.) are currently available and adequately supported to provide care in the community (e.g., urgent access to specialists and diagnostics). And likewise determine what services are best provided in our EDs and for whom.

3. Develop a vision for **improved** access to urgent and emergency care and quality of care based on leading practices for both rural and urban centres – consider the issues identified below.

4. Identify current gaps in service and the opportunities for change and continuous improvement.

5. Set out strategies to control the ED quality systems over the long haul so that improvements are sustained and “stick”.

The following early issues were identified in the visioning day and scoping exercise to provide context:

- The public is not aware of the appropriate use of the Emergency Department and alternatives;
- Primary care is not currently set up to divert urgent care patients, although some FHTs have recently started same day service;
- Some chronic patients are coming back to the ED because they are not adequately being cared for in the community (e.g., long waits to see a specialist, can’t afford puffers etc.);
- Primary care physicians are sending patients to the ED for stat / urgent laboratory tests (e.g. pneumonia);
- Primary care physicians are sending patients to the ED for specialist referrals;
- Convenience of ED/UCC increases volume;
- Urgent/Emergent providers do not have a clear and consistent understanding of their role(s);
- Lack of provider knowledge of real issue driving patients’ to show up (i.e. data gap);
- Insufficient viable alternatives for patients;
- Lack of common understanding of where the accountability lies and what are objective deliverables/outcomes for the community versus urgent/emergent;
- Insufficient care for the elderly so default is ED (including lack of management of non-medical needs);
- Services are limited in small rural communities (i.e. capacity of HHR);
- Shortage of skilled support in the community;
- Only ED physicians can access hospital services that patients require – not primary care physicians.
Framework for the Working Groups

The Working Groups are an extension of SECHEF, reporting directly to the Clinical direction-setting committee, made up of clinical leaders from SEHCEF. The clinical direction setting committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with patients and ensure any redesign meets patient needs;
- Engage with colleagues from across the region, not only within the hospitals, but across partner sectors (e.g., primary care, community sector etc.);
- Consider leading practices to set the vision and characteristics of the transformation;
- Consider redesign approaches based on evidence and an analytical approach;
- Focus on transformational change rather than the operational issues that exist today.

3.0. Logistics and Process

3.1. Duration of Service

The Working Group will meet three to four times between January and April, 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or other requirements from SECHEF. In addition, the Working Group could be called upon to conduct further work or due diligence to further support the transformational changes in the next phase of work for the Health Care Tomorrow project.

3.2. Frequency of Meetings

The Working Group will meet on a once every three weeks to enable time for engagement and analysis in between each of the meetings. In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible. The meeting schedule will be decided at the outset as far as possible to allow for effective time management for all involved.

3.3. Decision-Making Process

While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow process. Decisions will be made by consensus.

3.4. Meeting Agenda Items and Materials

Agendas and meeting materials will be distributed to the Working Group 72 hours prior to scheduled meetings. The preparation and distribution of materials will be centralized through the KPMG Project Manager, and Working Group members are required to provide materials to the Project Manager no less than 4 days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.
4.0 Expectations for Working Group Members Regarding Attendance and Communication:

Working Group meeting dates have been set based on the best availability of the majority of members. For those not able to attend the scheduled dates, we are not able to reschedule dates. Delegates are not allowed.

Note-takers will be assigned to each of the Working Groups. Notes will be made available to all participants within 5 days of the session.

Participants that are not able to attend the Working Group session are expected to keep up to date with the Working Group activities and progress through communication with peers and review of the meeting notes. Any feedback that they would like considered should be communicated to the Working Group Lead(s) prior to the next session (at least 7 days to ensure it can be incorporated into materials).
1.0 Context for Health Care Tomorrow

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The SECHEF Development of a Sustainable Integrated Model of Hospital Care will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
Inclusive engagement with patients and residents to inform processes;
Inclusive engagement with Francophone and Indigenous communities to inform processes;
Engagement via an appreciative inquiry approach;
Options will be developed based on evidence and leading practice models;
Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
Realistic activities and timelines.

2.0 Scope and Role

The Elective Working Group is formed of hospital thought leaders, community partners and patients and will meets three to four times to redesign Elective care in Southeastern Ontario. As one of the Health Care Tomorrow Working Groups, the Elective Working Group will carry out various quantitative and qualitative analyses necessary to support development of a sustainable hospital system in the SE LHIN and support SECHEF in developing well informed recommendations to the respective Boards of Directors and the SE LHIN.

The Elective Working Group will focus on the redesign of Planned/Scheduled care with a particular focus on improving access, efficiency and effectiveness of elective care across the SE region, building on the work of the Clinical Service Roadmap. The Working Group will consider regional and system issues that can contribute to the sustainability of elective services in consideration of expected growth. The Working Group will consider appropriateness of diagnostics and current procedure volumes, and consider a strategic approach to roles for each provider in a functioning regional system of care. Potential areas for improvement will examine opportunities to reduce demand, shift settings of care, remove duplication, care pathway redesign and integration.

Defining Issue

Demand for elective services (planned/ scheduled) will grow significantly over the next decade. The province’s funding formula for Quality Based Procedures will also significantly change the way most elective procedures are funded, putting pressure on rates at which these procedures are funded. In addition access to quality services across the region can depend on where a resident lives.

Scope

Design a system of regional service delivery for elective services that improves the efficiency and quality of patient care and provides care in the right place at the right time. This would include:

1. Taking a regional strategic view of QBPs to determine who the cost effective providers are in the region and redistributing volumes based on cost and quality parameters;
2. Examining leading practices to incorporate leading business models (e.g. focused factories, central intake) in an examination of volumes and roles for each hospitals taking into consideration appropriateness and balancing against patient travel times;
3. Incorporate and align with the complex chronic Working Group to determine methods for managing patient with chronic disease and the role of secondary care plays in identifying high risk patients and preventing further chronic disease;
4. In the redesign of elective services across the region, examine the use of information technology and telemedicine to improve cost, quality and patient experience;

5. Ensuring the model of care incorporates leading practices that reduce the need to hospitalization (e.g., rapid access clinics, community-based clinics, and pre-surgical physiotherapy etc.).

**Early Issues identified from the visioning day and the scoping session:**

- Significant growth of surgical services in the next 10 years with little funding growth to match demand
- Changing funding models (QPBs) that will drive down funding per procedure
- Regulatory requirements that require service support for certain procedures (e.g., pathology availability for colorectal screening)
- Services that aren’t necessarily being provided in the right place at the right time (e.g., more cost-effective options are available that are not being used)
- Limited health human resources across the region that are not being used optimally to achieve wait times

**Framework for the Working Groups**

The Working Groups are an extension of SECHEF, reporting directly to the Clinical direction-setting committee, made up of clinical leaders from SEHCEF. The clinical direction setting committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with patients and ensure any redesign meets patient needs;
- Engage with colleagues from across the region, not only within the hospitals, but across partner sectors (e.g., primary care, community sector etc.);
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

**3.0 Logistics and Process**

**3.1 Duration of Service**

The Working Group will meet three to four times between January and April, 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group could be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow project.

**3.2 Frequency of Meetings**

The Working Group will meet on a once every three weeks to enable time for engagement and analysis in between each of the meetings. In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.
3.3 Decision-Making Process

While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow process. Decisions will be made by consensus.

3.4 Meeting Agenda Items and Materials

Agendas and meeting materials will be distributed to the Working Group 72 hours prior to scheduled meetings. The preparation and distribution of materials will be centralized through the KPMG Project Manager, and Working Group members are required to provide materials to the Project Manager no less than 4 days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.

4.0 Expectations for Working Group Members Regarding Attendance and Communication

Working Group meeting dates have been set based on the best availability of the majority of members. For those not able to attend the scheduled dates, we are not able to reschedule dates. Delegates are not allowed.

Note-takers will be assigned to each of the Working Groups. Notes will be made available to all participants within 5 days of the session.

Participants that are not able to attend the Working Group session are expected to keep up to date with the Working Group activities and progress through communication with peers and review of the meeting notes. Any feedback that they would like considered should be communicated to the Working Group Lead(s) prior to the next session (at least 7 days to ensure it can be incorporated into materials).
1.0 Context for Health Care Tomorrow

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The SECHEF Development of a Sustainable Integrated Model of Hospital Care will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
- Inclusive engagement with patients and residents to inform processes;
- Inclusive engagement with Francophone and Indigenous communities to inform processes;
- Engagement via an appreciative inquiry approach;
- Options will be developed based on evidence and leading practice models;
- Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
- Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
- Realistic activities and timelines.

2.0 Scope and Role

The Tertiary/Quaternary Working Group is formed of hospital thought leaders, community partners and patients and will meets three to four times to redesign Tertiary/Quaternary care in Southeastern Ontario. As one of the Health Care Tomorrow Working Groups, the Tertiary/Quaternary Working Group will carry out various quantitative and qualitative analyses necessary to support development of a sustainable hospital system in the South East LHIN and support SECHEF in developing well informed recommendations to the respective Boards of Directors and the South East LHIN.

The Tertiary/Quaternary Working Group will focus on the redesign of specialized care with a particular focus on improving the efficiency, effectiveness, accessibility of Tertiary/Quaternary care across the South East region. The Working Group will consider regional and system issues that can contribute to the sustainability of Tertiary / Quaternary services in consideration of expected growth. The Working Group will consider a regional approach to highly specialized services to improve access, patient flow and sustainability of the academic mandate. Potential areas for improvement will examine opportunities to reduce demand, shift settings of care, remove duplication, care pathway redesign and integration across the region.

Defining Issue

The South East LHIN is served by an Academic Health Science Centre with a significant role for teaching, research and tertiary/quaternary services. The flow of patients and providers across the system to access these specialized services often presents challenges. Access to specialists for primary and secondary care providers can prove difficult, contributing from a lack of integration that makes the transitions across the region difficult to navigate. In addition to this lack of clinical integration, there is also a lack of integration amongst the academic community across the region. Roles for providers in the region are not clearly defined within a system of tertiary care.

Scope

Design a model of tertiary/quaternary care for the residents of the region in partnership with Queen’s University Faculty of Health Sciences that:

1. Identifies the right business and role for each provider in the system based on the population need;
2. Improves patient flow between primary care providers, community hospitals and the tertiary centre;
3. Builds and strengthens partnerships within the region and outside the region to support a seamless system of tertiary care;
4. Take into consideration Ministry mandated volumes to ensure future sustainability of tertiary services in the region;
5. Design a model whereby innovation is continually being incorporated into the standard of care across the region, including emerging procedures and diagnostics;

6. Designs a model for the integration of the academic community across the region to support the growth of teaching and research and make the South East an academic hub.

**Early Issues identified from the visioning day and the scoping session:**

- Access to specialist services and a lack of integration amongst primary, secondary and tertiary care
- Current influx of emergent cases and ALC patients is causing bottlenecks straining the provision of elective tertiary services
- Concept of innovation to meet standard of care – how do we make it happen?
- Ministry mandated volumes for tertiary services
- Need definitions of primary, secondary, and tertiary care
- Geography of the region can present challenges

**Opportunities identified at the scoping session for context (i.e., not definitive)**

- Academic health science networks that articulate patient flow across geographically defined populations, and support for teaching and research across the network (UK model)
- Use of Telemedicine for rural populations to access specialist resources and reduce travel times, particularly for follow-up care

**Framework for the Working Groups**

The Working Groups are an extension of SECHEF, reporting directly to the Clinical direction-setting committee, made up of clinical leaders from SEHCEF. The clinical direction setting committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with patients and ensure any redesign meets patient needs;
- Engage with colleagues from across the region, not only within the hospitals, but across partner sectors (e.g., primary care, community sector etc.);
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

**3.0 Logistics and Process**

**3.1 Duration of Service**

The Working Group will meet three to four times between January and April, 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group could be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow project.
3.2 Frequency of Meetings
The Working Group will meet on a once every three weeks to enable time for engagement and analysis in between each of the meetings. In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

3.3 Decision-Making Process
While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow process. Decisions will be made by consensus.

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1.0 Context for Health Care Tomorrow

The following section provides context for the Health Care Tomorrow project as taken from the project charter as agreed by SECHEF.

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition between potential employers of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

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The SECHEF Development of a Sustainable Integrated Model of Hospital Care will be guided by the following principles:

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Inclusive engagement with patients and residents to inform processes;

Inclusive engagement with Francophone and Indigenous communities to inform processes;

Engagement via an appreciative inquiry approach;

Options will be developed based on evidence and leading practice models;

Options will need to align with provincial strategy, initiatives and hospital provincial mandates;

Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,

Realistic activities and timelines.

2.0 Scope and Role for the Complex Chronic Working Group

The Complex Chronic Working Group will focus on the patient population defined as those with Complex Chronic Conditions including the Frail Elderly at risk of and experiencing functional decline and other complex chronic conditions (e.g. Alzheimer’s, dementia) in Southeastern Ontario.

The Working Group is formed of hospital, community and patient thought leaders and will meet three to four times to redesign care for this patient population. As one of the Health Care Tomorrow Working Groups, the Complex Chronic Working Group will carry out various quantitative and qualitative analyses necessary to support development of a sustainable hospital system in the SE LHIN and support SECHEF in developing well informed recommendations to the respective Boards of Directors and the SE LHIN.

The Working Group will consider regional and system issues that contribute to the high rate of hospitalization for this patient population to consider the appropriate usage of this activity and propose strategies to redesign this patient flow where appropriate. The Working Group will take a holistic approach to redesigning the patient pathway across the patient’s lifespan, including but not limited to care in the home, primary care, emergency care, acute inpatient care, complex continuing care and rehabilitation, and integration and support in the community. Potential areas for improvement will examine models for geriatric and complex care, integration of services and roles within Health Links and other community agencies to consider care coordination and address rural populations and access to interdisciplinary care teams.

Defining Issue

While the services required for patients with complex chronic conditions cross all other Working Groups, the issues are many, and will grow significantly over the next decade such that this patient population requires special attention.

The seniors population will grow by 35% over the next decade. This will drive increased rates of chronic diseases, Alzheimer’s disease and dementia at almost the same rate. The care for these patients currently in the SE LHIN is highly institutionalized relying on the Emergency Department and Acute beds where other leading jurisdictions care for these patients in the community. These patients contribute to a high rate of ALC days and make it difficult to discharge into the community with the appropriate supports. Solutions to manage this patient population are required across the continuum of care with defining roles for hospital and community partners and identified enablers for clinical integration.
Scope

The Complex Chronic Working Group in partnership with primary care, Health Links, and community partners will design a care value chain to support patients with multiple chronic conditions, including the frail elderly at risk of and experiencing functional decline and other chronic conditions in the SE LHIN to reduce the hospitalization of patients with complex chronic conditions, focus on a dedicated approach to care once they are in hospital, and improve over quality of care in the system. The value chain should support patients throughout their life, and throughout their disease trajectory, including end of life care, with defined roles for hospitals and partners in that journey.

1. Develop patient profiles that describe the current patient characteristics and demographics;
2. Develop a vision for the support of patients with complex chronic conditions, including the frail elderly at risk of and experiencing functional decline based on leading practices that supports patients at home, at work, in the community, and during acute and post-acute episodes of care – this vision will ensure that the person remains the focus while their needs are being addressed (caring for them beyond just their immediate medical concern);
3. Identify the role of the hospital in supporting community partners to ensure resources are wrapped around the patient and that patients are able to manage their health throughout their life;
4. Identify gaps in current practice from the vision and opportunities to address those gaps;
5. Consider additional needs for high risk patients with Alzheimer’s disease and Dementia.

The Working Group will present a set of recommendations to SECHEF in the spring of 2015 that sets out ways to address the care needs of this population and proposed roles for the hospitals in the South East. Recognizing the role of primary and community care in supporting the care needs of this population, recommendations on the role of these providers will be taken forward to the South East LHIN, Health Links, and other community partners as necessary to support the ongoing development of the recommended approach.

Early Issues identified from the visioning day and the scoping session:

- Lack of integration, even within the hospital for patients managing multiple chronic conditions
- High rates of hospitalization that include high rates of emergency usage and acute inpatient stays.
- Patients with multiple complex conditions experience difficulties due to the resources or lack of resources available to them once they are hospitalized, which, in turn, contributes to the number of ALC days
- Lack of community resources to manage isolation
- Lack of access to multi-disciplinary specialists in the community
- Identified at Working Group session 1: Need to be cognizant of social determinants of health

Framework for the Working Groups

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The Working Groups are responsible to:

- Engage with patients and ensure any redesign meets patient needs;
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- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

3.0 Logistics and Process

3.1 Duration of Service

The Working Group will meet three to four times between January and April, 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group could be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow project.

3.2 Frequency of Meetings

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3.3 Decision-Making Process

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1.0 Context for Health Care Tomorrow

1.1 Drivers

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- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

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Inclusive engagement with patients and residents to inform processes;
- Inclusive engagement with Francophone and Indigenous communities to inform processes;
- Engagement via an appreciative inquiry approach;
- Options will be developed based on evidence and leading practice models;
- Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
- Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
- Realistic activities and timelines.

2.0 Scope and Role

The Diagnostic Imaging Working Group, formed of hospital thought leaders, will seek to achieve a regional system of Diagnostic Imaging services, and explore a clinical shared service model similar to the vision agreed by all hospital CEOs in the South East as described below. This role includes developing business cases to demonstrate the value of shared service opportunities across all Diagnostic Imaging functions.

The Diagnostic Imaging Working Group will be responsible for engaging colleagues from across the region to develop a model of improved service delivery and cost efficiency.

Shared Services Vision

On November 19th, 2014, the hospital CEOs in the South East LHIN approved the following vision:

*By 2020 a shared service organization will be fully implemented supporting the provision of all business functions.* There was recognition that this model could also support regional clinical shared services for Laboratory, Pharmacy and Diagnostic Imaging services.

Scope of the Diagnostic Imaging Working Group

The Diagnostic Imaging Working Group will support the transformation of Diagnostic Imaging services across the region to improve service delivery and efficiency through the following:

1. Develop a vision for Diagnostic Imaging services that serves the hospitals across the south east region;
2. Identify early opportunities that can be realized within the next fiscal year is possible;
3. Identify data requirements to develop business cases for Diagnostic Imaging service improvements and shared services across the region;
4. Identify a target operating model and key assumptions for the new regional service;
5. Develop a business case for Diagnostic Imaging shared services with the direction of the Diagnostic and Therapeutic Direction-setting Steering Committee; and,
6. Present recommendations to SECHEF on Diagnostic Imaging shared services and service improvements based on the results of the business case.

3.0 Framework for the Working Groups

The Working Groups are an extension of SECHEF, reporting directly to the Diagnostic and Therapeutic Direction-setting Steering Committee, made up of leaders from SECHEF. The Diagnostic and Therapeutic Direction-setting Steering Committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with clients and ensure any redesign meets client needs;
- Engage with colleagues from across the region;
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

Principles for the Diagnostic and Therapeutic Working Groups

The Working Group Leads and team members are expected to adhere to the principles described below for the development of Diagnostic and Therapeutic shared services:

1. Enable sustainability of patient care
2. Trust and collaboration
3. We can do it better together
4. Everyone is in (ownership)
5. Engage those affected
6. Cost effectiveness, more competitive at the end
7. Enhance quality and service
8. Improvement for all
9. Current state is not an option
10. Share cost of implementation
11. Appreciative inquiry
4.0 Logistics and Process

4.1 Duration of Service

The Working Group will meet three to four times between January and April 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group may be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow planning.

4.2 Frequency of Meetings

The Working Group will meet on a monthly basis to enable time for engagement and analysis in between each of the meetings.

In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

4.3 Decision-Making Process

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4.4 Meeting Agenda Items and Materials

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1.2 Objective of Health Care Tomorrow

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Each member of SECHF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
Realistic activities and timelines.

2.0 Scope and Role

The Laboratory Working Group, formed of hospital thought leaders, will seek to achieve a regional system of Laboratory services, and explore a clinical shared service model similar to the vision agreed by all hospital CEOs in the South East as described below. This role includes developing business cases to demonstrate the value of shared service opportunities across all Laboratory functions.

The Laboratory Working Group will be responsible for engaging colleagues from across the region to develop a model of improved service delivery and cost efficiency.

Shared Services Vision

On November 19th, 2014, the hospital CEOs in the South East LHIN approved the following vision:

**By 2020 a shared service organization will be fully implemented supporting the provision of all business functions.** There was recognition that this model could also support regional clinical shared services for Laboratory, Pharmacy and Diagnostic Imaging services.

The efficient delivery of business and clinical support areas will enable the hospitals in the SE to focus on core clinical services.
**Scope of the Laboratory Working Group**

The Laboratory Working Group will support the transformation of Laboratory services across the region to improve service delivery and efficiency through the following:

1. Develop a vision for Laboratory services that serves the hospitals across the south east region (with a focus on a long-term vision, not constrained to thinking about current systems as they are);
2. Identify early opportunities that can be realized within the next fiscal year is possible;
3. Identify data requirements to develop business cases for Laboratory service improvements and shared services across the region;
4. Identify a target operating model and key assumptions for the new regional service;
5. Develop a business case for Laboratory shared services with the direction of the Diagnostic and Therapeutic Direction-setting Steering Committee; and,
6. Present recommendations to SECHEF on Laboratory shared services and service improvements based on the results of the business case.

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South East Local Health Integration Network (LHIN)
Health Care Tomorrow
Terms of Reference
Diagnostics & Therapeutics Working Groups: Pharmacy

1.0 Context for Health Care Tomorrow

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- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The Health Care Tomorrow planning process will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
Inclusive engagement with patients and residents to inform processes;
Inclusive engagement with Francophone and Indigenous communities to inform processes;
Engagement via an appreciative inquiry approach;
Options will be developed based on evidence and leading practice models;
Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
Each member of SECHF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
Realistic activities and timelines.

2.0 Scope and Role

The Pharmacy Working Group, formed of hospital thought leaders, will seek to achieve a regional system of Pharmacy services, and explore a clinical shared service model similar to the vision agreed by all hospital CEOs in the South East as described below. This role includes developing business cases to demonstrate the value of shared service opportunities across all Pharmacy functions.

The Pharmacy Working Group will be responsible for engaging colleagues from across the region to develop a model of improved service delivery and cost efficiency.

Shared Services Vision

On November 19th, 2014, the hospital CEOs in the South East LHIN approved the following vision:

**By 2020 a shared service organization will be fully implemented supporting the provision of all business functions.** There was recognition that this model could also support regional clinical shared services for Laboratory, Pharmacy and Diagnostic Imaging services.

The efficient delivery of business and clinical support areas will enable the hospitals in the SE to focus on core clinical services.
Scope of the Pharmacy Working Group

The Pharmacy Working Group will support the transformation of Pharmacy services across the region to improve service delivery and efficiency through the following:

1. Develop a vision for Pharmacy services that serves the hospitals across the south east region;
2. Identify early opportunities that can be realized within the next fiscal year is possible;
3. Identify data requirements to develop business cases for Pharmacy service improvements and shared services across the region;
4. Identify a target operating model and key assumptions for the new regional service;
5. Develop a business case for Pharmacy shared services with the direction of the Diagnostic and Therapeutic Direction-setting Steering Committee; and,
6. Present recommendations to SECHEF on Pharmacy shared services and service improvements based on the results of the business case.

3.0 Framework for the Working Groups

The Working Groups are an extension of SECHEF, reporting directly to the Diagnostic and Therapeutic Direction-setting Steering Committee, made up of leaders from SECHEF. The Diagnostic and Therapeutic Direction-setting Steering Committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with clients and ensure any redesign meets client needs;
- Engage with colleagues from across the region;
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

Principles for the Diagnostic and Therapeutic Working Groups

The Working Group Leads and team members are expected to adhere to the principles described below for the development of Diagnostic and Therapeutic shared services:

1. Enable sustainability of patient care
2. Trust and collaboration
3. We can do it better together
4. Everyone is in (ownership)
5. Engage those affected
6. Cost effectiveness, more competitive at the end
7. Enhance quality and service
8. Improvement for all
9. Current state is not an option
10. Share cost of implementation
11. Appreciative inquiry

4.0 Logistics and Process

4.1 Duration of Service
The Working Group will meet three to four times between January and April 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group may be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow planning.

4.2 Frequency of Meetings
The Working Group will meet on a monthly basis to enable time for engagement and analysis in between each of the meetings.

In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

4.3 Decision-Making Process
While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow planning process. Decisions will be made by consensus.

4.4 Meeting Agenda Items and Materials
Agendas and meeting materials will be distributed to the Working Group members three (3) days prior to scheduled meetings. The preparation and distribution of materials will be centralized through the KPMG Project Manager, and Working Group members are required to provide materials to the Project Manager no less than four (4) days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.

5.0 Expectations for Working Group Members Regarding Attendance and Communication:
1. Working Group meeting dates have been set based on the best availability of the majority of members. For those not able to attend the scheduled dates, we are not able to reschedule dates. Delegates are not allowed.
2. Note-takers will be assigned to each of the Working Groups. Notes will be made available to all participants within 5 days of the session.
Participants that are not able to attend the Working Group session are expected to keep up to date with the Working Group activities and progress through communication with peers and review of the meeting notes. Any feedback that they would like considered should be communicated to the Working Group Lead(s) prior to the next session (at least 7 days to ensure it can be incorporated into materials).
1.0 Context for Health Care Tomorrow

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The Health Care Tomorrow planning process will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
- Inclusive engagement with patients and residents to inform processes;
- Inclusive engagement with Francophone and Indigenous communities to inform processes;
- Engagement via an appreciative inquiry approach;
- Options will be developed based on evidence and leading practice models;
- Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
- Each member of SECHF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
- Realistic activities and timelines.

2.0 Scope and Role

The Finance Working Group, formed of hospital thought leaders, will work to achieve the vision agreed by all hospital CEOs in the South East as described below. This role includes developing business cases to demonstrate the value of shared service opportunities across all Finance functions.

The Finance Working Group will be responsible for engaging colleagues from across the region to develop a model of improved service delivery and cost efficiency.

Shared Services Vision

On November 19th, 2014, the hospital CEOs in the South East LHIN approved the following vision:

*By 2020 a shared service organization will be fully implemented supporting the provision of all business functions (Human Resources, Finance, Information Systems, Facilities/Hotel Services).*

The efficient delivery of business and clinical support areas will enable the hospitals in the SE to focus on core clinical services.
Scope of the Finance Working Group

The Finance Working Group will support the transformation of Finance functions across the region to improve service delivery and efficiency through the following:

1. Confirm early opportunities identified by the Business Function Direction-setting Steering Committee as identified below;
2. Develop a plan of action to coordinate collective action amongst South east hospitals for confirmed early opportunities;
3. Identify data requirements to develop business cases for Finance shared services across all functions;
4. Develop a business case for Finance shared services with the direction of the Business Function Direction-setting Steering Committee, considering scenarios for outsourcing or shared services and making assumptions for the target operating model; and,
5. Present recommendations to SECHEF on Finance shared services based on the results of the business case.

3.0 Framework for the Working Groups

The Working Groups are an extension of SECHEF, reporting directly to the Business Function Direction-setting Steering Committee, made up of leaders from SECHEF. The Business Function Direction-setting Steering Committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with clients and ensure any redesign meets client needs;
- Engage with colleagues from across the region;
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

Principles for the Business Functions Working Groups

The Working Group Leads and team members are expected to adhere to the principles described below for the development of business function shared services:

1. Enable sustainability of patient care
2. Trust and collaboration
3. We can do it better together
4. Everyone is in (ownership)
5. Engage those affected
6. Cost effectiveness, more competitive at the end
7. Enhance quality and service
8. Improvement for all
9. Current state is not an option
10. Share cost of implementation
11. Appreciative inquiry

4.0 Logistics and Process

4.1 Duration of Service
The Working Group will meet three to four times between January and April 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group may be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow planning.

4.2 Frequency of Meetings
The Working Group will meet on a monthly basis to enable time for engagement and analysis in between each of the meetings.
In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

4.3 Decision-Making Process
While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow planning process. Decisions will be made by consensus.

4.4 Meeting Agenda Items and Materials
Agendas and meeting materials will be distributed to the Working Group members three (3) business days prior to scheduled meetings. The preparation and distribution of materials will be centralized through the KPMG Project Manager, and Working Group members are required to provide materials to the Project Manager no less than four (4) days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.
1.0 Context for Health Care Tomorrow

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The Health Care Tomorrow planning process will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
2.0 Scope and Role

The Information Systems (IS) Working Group, formed of hospital thought leaders, will work to achieve the vision agreed by all hospital CEOs in the South East as described below. This role includes developing business cases to demonstrate the value of shared service opportunities across all information technology / information services functions, including Health Records and Registration.

The IS Working Group will be responsible for engaging colleagues from across the region to develop a model of improved service delivery and cost efficiency.

Shared Services Vision

On November 19th, 2014, the hospital CEOs in the South East LHIN approved the following vision:

*By 2020 a shared service organization will be fully implemented supporting the provision of all business functions (HR, Finance, IS, Facilities/ Hotel Services).*
Scope of the IS Working Group

The IS Working Group will support the transformation of IS functions across the region to improve service delivery and efficiency through the following:

1. Confirm early opportunities identified by the Business Function Direction-setting Steering Committee as identified below;
2. Develop a plan of action to coordinate collective action amongst South East hospitals for confirmed early opportunities;
3. Identify data requirements to develop business cases for IS shared services across all functions;
4. Develop business cases for IS shared services with the direction of the Business Function direction-setting Steering Committee;
5. Present recommendations to SECHEF on IS shared services based on the results of the business case.

3.0 Framework for the Working Groups

The Working Groups are an extension of SECHEF, reporting directly to the Business Function Direction-setting Steering Committee, made up of leaders from SECHEF. The Business Function Direction-setting Steering Committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with clients and ensure any redesign meets client needs;
- Engage with colleagues from across the region;
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

Principles for the Business Functions Working Groups

The Working Group Leads and team members are expected to adhere to the principles described below for the development of business function shared services:

1. Enable sustainability of patient care
2. Trust and collaboration
3. We can do it better together
4. Everyone is in (ownership)
5. Engage those affected
6. Cost effectiveness, more competitive at the end
7. Enhance quality and service
8. Improvement for all
9. Current state is not an option
10. Share cost of implementation
11. Appreciative inquiry

4.0 Logistics and Process

4.1 Duration of Service

The Working Group will meet three to four times between January and April 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group may be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow planning.

4.2 Frequency of Meetings

The Working Group will meet on a monthly basis to enable time for engagement and analysis in between each of the meetings.

In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

4.3 Decision-Making Process

While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow planning process. Decisions will be made by consensus.

4.4 Meeting Agenda Items and Materials

Agendas and meeting materials will be distributed to the Working Group members three (3) business days prior to scheduled meetings. The preparation and distribution of materials will be centralized through the KPMG Project Manager, and Working Group members are required to provide materials to the Project Manager no less than four (4) days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.
1.0 Context for Health Care Tomorrow

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The Health Care Tomorrow planning process will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;

Inclusive engagement with patients and residents to inform processes;

Inclusive engagement with Francophone and Indigenous communities to inform processes;

Engagement via an appreciative inquiry approach;

Options will be developed based on evidence and leading practice models;

Options will need to align with provincial strategy, initiatives and hospital provincial mandates;

Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,

Realistic activities and timelines.

2.0 Scope and Role

The Human Resources (HR) Working Group, formed of hospital thought leaders, will work to achieve the vision agreed by all hospital CEOs in the South East as described below. This role includes developing business cases to demonstrate the value of shared service opportunities across all HR functions.

The HR Working Group will be responsible for engaging colleagues from across the region to develop a model of improved service delivery and cost efficiency.

Shared Services Vision

On November 19th, 2014, the hospital CEOs in the South East LHIN approved the following vision:

By 2020 a shared service organization will be fully implemented supporting the provision of all business functions (HR, Finance, Information Systems, Facilities/Hotel Services).

The efficient delivery of business and clinical support areas will enable the hospitals in the SE to focus on core clinical services.
Scope of the Human Resource Working Group

The HR Working Group will support the transformation of HR functions across the region to improve service delivery and efficiency through the following:

1. Confirm early opportunities identified by the Business Function direction-setting group as identified below;
2. Develop a plan of action to coordinate collective action amongst South East hospitals for confirmed early opportunities;
3. Identify data requirements to develop business cases for HR shared services across all functions;
4. Develop business cases for HR shared services with the direction of the Business Function Direction-setting Steering Committee;
5. Present recommendations to SECHEF on HR shared services based on the results of the business case.

In addition to the development of a business case for shared services, the Human Resources Working Group will play a dual role to:

1. Develop a high level HR transition approach, through engagement with other working group leads
2. Support other working groups in addressing HR needs and planning as it relates to the transition of staff (e.g., labour relations strategies etc.)

3.0 Framework for the Working Groups

The Working Groups are an extension of SECHEF, reporting directly to the Business Function Direction-setting Steering Committee, made up of leaders from SECHEF. The Business Function direction-setting Steering Committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with clients and ensure any redesign meets client needs;
- Engage with colleagues from across the region;
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

Principles for the Business Functions Working Groups

The Working Group Leads and team members are expected to adhere to the principles described below for the development of business function shared services:
1. Enable sustainability of patient care
2. Trust and collaboration
3. We can do it better together
4. Everyone is in (ownership)
5. Engage those affected
6. Cost effectiveness, more competitive at the end
7. Enhance quality and service
8. Improvement for all
9. Current state is not an option
10. Share cost of implementation
11. Appreciative inquiry

4.0 Logistics and Process

4.1 Duration of Service
The Working Group will meet three to four times between January and April 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group may be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow planning.

4.2 Frequency of Meetings
The Working Group will meet on a monthly basis to enable time for engagement and analysis in between each of the meetings.

In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

4.3 Decision-Making Process
While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow planning process. Decisions will be made by consensus.

4.4 Meeting Agenda Items and Materials
Agendas and meeting materials will be distributed to the Working Group members three (3) business days prior to scheduled meetings. The preparation and distribution of materials will be centralized through the KPMG Project Manager, and Working Group members are required to provide materials to the Project Manager no less than four (4) days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.
South East Local Health Integration Network (LHIN)
Health Care Tomorrow
Terms of Reference
Business Functions Working Group: Facilities/Support Services

1.0 Context for Health Care Tomorrow

1.1 Drivers
The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow
To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision
Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles
The Health Care Tomorrow planning process will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
- Inclusive engagement with patients and residents to inform processes;
- Inclusive engagement with Francophone and Indigenous communities to inform processes;
- Engagement via an appreciative inquiry approach;
- Options will be developed based on evidence and leading practice models;
- Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
- Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
- Realistic activities and timelines.

2.0 Scope and Role

The Facilities/Support Services Working Group, formed of hospital thought leaders, will work to achieve the vision agreed by all hospital CEOs in the South East as described below. This role includes developing business cases to demonstrate the value of shared service opportunities across all Facilities/Support Services functions.

The Facilities/Support Services Working Group will be responsible for engaging colleagues from across the region to develop a model of improved service delivery and cost efficiency.

Shared Services Vision

On November 19th, 2014, the hospital CEOs in the South East LHIN approved the following vision:

*By 2020 a shared service organization will be fully implemented supporting the provision of all business functions (HR, Finance, IT, Facilities / Hotel Services).*

The efficient delivery of business and clinical support areas will enable the hospitals in the SE to focus on core clinical services.
Scope of the Facilities/Support Services Working Group

The Facilities/Support Services Working Group will support the transformation of Facilities/Support Services functions across the region to improve service delivery and efficiency through the following:

1. Confirm early opportunities identified by the Business Function Direction-setting Steering Committee as identified below;
2. Develop a plan of action to coordinate collective action amongst South East hospitals for confirmed early opportunities;
3. Identify data requirements to develop business cases for Facilities/Support Services shared services across all functions;
4. Develop business cases for Facilities/Support Services shared services with the direction of the Business Function Direction-setting Steering Committee; and,
5. Present recommendations to SECHEF on Facilities/Support Services shared services based on the results of the business case.

3.0 Framework for the Working Groups

The Working Groups are an extension of SECHEF, reporting directly to the Business Function Direction-setting Steering Committee, made up of leaders from SECHEF. The Business Function Direction-setting Steering Committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with clients and ensure any redesign meets client needs;
- Engage with colleagues from across the region;
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

Principles for the Business Functions Working Groups

The Working Group Leads and team members are expected to adhere to the principles described below for the development of business function shared services:

1. Enable sustainability of patient care
2. Trust and collaboration
3. We can do it better together
4. Everyone is in (ownership)
5. Engage those affected
6. Cost effectiveness, more competitive at the end
7. Enhance quality and service
8. Improvement for all
9. Current state is not an option
10. Share cost of implementation
11. Appreciative inquiry

4.0 Logistics and Process

4.1 Duration of Service

The Working Group will meet three to four times between January and April 2015 until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF. In addition, the Working Group may be called upon to conduct detailed design work or due diligence as the roles of each hospital are defined in the next phase of work for the Health Care Tomorrow planning.

4.2 Frequency of Meetings

The Working Group will meet on a monthly basis to enable time for engagement and analysis in between each of the meetings.

In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

4.3 Decision-Making Process

While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow planning process. Decisions will be made by consensus.

4.4 Meeting Agenda Items and Materials

Agendas and meeting materials will be distributed to the Working Group members three (3) business days prior to scheduled meetings. The preparation and distribution of materials will be centralized through the KPMG Project Manager, and Working Group members are required to provide materials to the Project Manager no less than four (4) days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.
1.0 Introduction

The hospitals in the South East Local Health Integration Network (LHIN) face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care for many services.

In recent years, there has been significant progress in important areas to improve our system for patients, including:

- Addictions and Mental Health – through the Addictions and Mental Health Redesign
- Primary Care – through the Health Links initiative
- Clinical Services Redesign – through the Clinical Services Roadmap (CSR) initiative

Hospital and system leaders within the South East Local Health Integration Network (LHIN) – represented by the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) – are currently working together to explore the future of hospital services across the South East region.

The ‘Development of a Sustainable Integrated Model of Hospital Care’ project (“the project”) will help to continue to redefine the health care system across the South East LHIN region and ensure the best care for patients, for families and now and in the future.

Vision: Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.1 Principles

The SECHEF Development of a Sustainable Integrated Model of Hospital Care will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
- Inclusive engagement with patients and residents to inform processes;
- Inclusive engagement with Francophone and Indigenous communities to inform processes;
- Engagement via an appreciative inquiry approach;
- Options will be developed based on evidence and leading practice models;
- Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
- Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
- Realistic activities and timelines.

1.2 Project Structure and Governance

1.3 Purpose of the Communications Leads Working Group
The purpose of the Communications Leads Working Group is to provide operational planning and support to the SECHEF Steering Committee related to communications and stakeholder engagement.

1.4 Scope
The scope of the Communications Leads Working Group is consistent with the scope of the SECHEF Steering Committee. Refer to Section 2.6 of the Project Charter.

2.0 Roles and Responsibilities of the Communications Leads Working Group
2.1 Role of the Communications Leads Working Group

As one of the SECHEF Steering Committee operational support resources, the role of the Communications Leads Working Group is to:

- Collaborate to develop a Shared Communication and Engagement Plan to support the project;
- Manage the ongoing refinement of the Shared Communications and Engagement Plan that will be regularly reviewed by the Project Management Office and SECHEF Steering Committee, as directed;
- Manage the execution of the Shared Communications and Engagement Plan, including the communications and engagement activities at respective organizations;
- Develop organization/community-specific communication and engagement strategies to deliver and cascade messaging and communications throughout respective organizations/communities.
- Deliver and cascade messaging and communications throughout respective organizations/communities (using approved key messages and communications materials).
- Ensure that Senior Teams at respective organizations are kept up to date on communications and engagement activities, per the Shared Communications and Engagement Plan.
- Ensure that the dissemination of the communications and messaging throughout the respective organizations are vetted through proper channels (i.e. review with CEOs, Senior Teams and HR representatives).
- Evaluate and refine the communication and engagement activities related to the project.

It is agreed that all communications and engagement activities regarding the project will be planned and executed jointly. This includes government relations activities, stakeholder outreach meetings and any other external communications. Internal communications is the responsibility of the respective hospital teams; however, there will be alignment with the agreed upon strategic direction and execution as outlined in the shared Communications and Engagement Plan.

2.2 Authority of the Working Group

The Working Group is operational in nature – with its purpose to provide operational planning and support to the SECHEF Steering Committee related to communications and stakeholder engagement.

The authority of the Working Group is delegated through the SECHEF Steering Committee and is articulated in this Terms of Reference.

The Working Group does have the authority to recommend plans and actions associated with the communication and engagement activities to the SECHEF Steering Committee. Given the importance of communications and stakeholder engagement, the SECHEF Steering Committee holds ultimate authority over this component of the project.

3.0 Membership and Individual Roles of Working Group Members

3.1 Membership

The Communications Leads Working Group will be composed of communication representatives from the seven hospitals and CCAC, as well as the South East LHIN.

The Co-Chairs of the Working Group will be representatives from two of the hospitals. The Co-Chairs will be identified through a call for interest among the seven hospital Communications Leads. The names of all individuals that express interest in the Co-Lead position will be brought forward to the SECHEF Steering Committee, where a decision will be made by the hospital CEOs based on resource availability and fairness of representation across the hospitals.
The Co-Chairs will attend the Project Management Office and SECHF Steering Committee meetings, when invited. The Co-Chairs will facilitate the Working Group and be the liaison to the other Working Groups as part of the project structure.

There will be one Lead Co-Chair who will act as the main point of contact and liaison with the SECHF CEOs and will Chair the meetings of the group.

SECHF CEO Advisors will be available to the Working Group to provide strategic input on the development and execution of the Communication and Engagement Plan, as required.

The Consultant, KPMG, will attend Working Group meetings and be a resource to the group. The resource will support the development of meeting agendas and provide verbal updates on other project components/progress that impact communications and engagement activities.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Stakeholder Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abby McIntyre</td>
<td>Brockville General Hospital</td>
</tr>
<tr>
<td>Elizabeth Bardon</td>
<td>Hotel Dieu Hospital</td>
</tr>
<tr>
<td>Theresa MacBeth</td>
<td>Kingston General Hospital (Working Group Co-Chair)</td>
</tr>
<tr>
<td>Wayne Coveyduck</td>
<td>Lennox and Addington County General Hospital</td>
</tr>
<tr>
<td>Karen Kelly</td>
<td>Perth-Smiths Falls District Hospital</td>
</tr>
<tr>
<td>Jennifer Goodwin</td>
<td>Providence Care (Working Group Co-Chair, Lead Co-Chair)</td>
</tr>
<tr>
<td>Susan Rowe</td>
<td>Quinte Health Care</td>
</tr>
<tr>
<td>Gary Buffett</td>
<td>South East CCAC</td>
</tr>
<tr>
<td>Cathy Szabo</td>
<td>Providence Care (SECHF CEO Co-Lead)</td>
</tr>
<tr>
<td>Caitlin den Boer</td>
<td>South East LHIN</td>
</tr>
<tr>
<td>Mary Clare Egberts</td>
<td>Quinte Health Care (SECHF CEO Co-Lead)</td>
</tr>
</tbody>
</table>

3.2 Sponsorship
The Communications Leads Working Group sponsor will be the Project Management Office. In this role, the Project Management Office promotes and supports the objectives of the project and defines the role of the Communications Leads Working Group through the approval of the Terms of Reference.

The Communications Leads Working Group will provide regular update reports to the Project Management Office, as well as to the SECHF Steering Committee throughout the course of the project.

3.3 Governance Liaison
It will be the responsibility of the SECHF Steering Committee (CEOs) to be the primary liaisons with their respective Boards of Directors.

3.4 Duration of Service
The Communications Leads Working Group will remain active until the completion of Phase 3 of the project.
### 3.5 Individual Roles and Accountabilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Individual(s) Responsible</th>
<th>Roles and Accountabilities</th>
</tr>
</thead>
</table>
| Communications Working Group Co-Leads | * Jennifer Goodwin, Providence Care (Lead Co-Chair)  
* Theresa MacBeth, Kingston General Hospital | * Lead and coordinate the refinement of the draft Shared Communications and Engagement Plan (draft to be developed by South East LHIN and KPMG) through collaboration with Communication Leads (via the Communications Leads Working Group) to ensure agreement on the plan.  
* Develop the final Shared Communications and Engagement Plan for the approval by the SECHEF Steering Committee and recommend amendments as required.  
* Lead and coordinate communications activities (excluding engagement activities), as per the approved Shared Communications and Engagement Plan, on behalf of the hospitals.  
* Develop communications (excluding engagement) supporting materials and tools (including key messages, presentation decks) using approved key messages.  
* Lead and coordinate the development and cascading of messaging, via liaison with Communication Leads (via the Communications Leads Working Group).  
* Attend the Project Management Office and SECHEF Steering Committee meetings on behalf of the Working Group. *only one Co-Lead required for each meeting, when required.* |
| CEO Advisors                | * Cathy Szabo, Providence Care  
* Mary Clare Egberts, Quinte Health Care | * Provide strategic input to the Working Group on the development and execution of the Communication and Engagement Plan. |
| LHIN Resource               | * Caitlin den Boer, South East LHIN | * Collaborate with the Communications Leads (via the Communications Leads Working Group) and KPMG to support the development and delivery of the Shared Communication and Engagement Plan.  
* Support the ongoing delivery of the Shared Communication and Engagement Plan.  
* Support the development and ongoing maintenance of shared communications and engagement tools (i.e. webpage, video development, etc.) |
<p>| Communication Leads         | * Abby McIntyre, Brockville General Hospital | * Represent respective organizations by providing community context and advice on communications |</p>
<table>
<thead>
<tr>
<th><strong>Health Care Tomorrow</strong></th>
</tr>
</thead>
</table>

### Phase 1 Final Report

#### Elizabeth Bardon, Hotel Dieu Hospital
- Theresa MacBeth, Kingston General Hospital
- TBD, Lennox and Addington County General Hospital
- TBD, Perth-Smiths Falls District Hospital
- Jennifer Goodwin, Providence Care
- Susan Rowe, Quinte Health Care
- Gary Buffett, South East CCAC

and engagement practices at respective organizations.

- Collaborate with the Communications Leads (via the Communications Leads Working Group) and South East LHIN Communications Lead on the development of the Shared Communication and Engagement Plan.
- Based on the agreed to Shared Communication and Engagement Plan, develop an organization/community-specific communication and engagement strategy to deliver and cascade messaging and communications throughout respective organizations/communities.
- Deliver and cascade messaging and communications throughout respective organizations/communities (using approved key messages and communications materials).
- Ensure that Senior Teams at respective organizations are kept up to date on communications and engagement activities, per the Shared Communications and Engagement Plan.
- Ensure that the dissemination of the communications and messaging throughout the respective organizations are vetted through proper channels (i.e. review with CEOs, Senior Teams and HR representatives).

#### SECHEF CEOs
- Tony Weeks, Brockville General Hospital
- Dr. David Pichora, Hotel Dieu Hospital
- Leslee Thompson, Kingston General Hospital
- Wayne Coveyduck, Lennox and Addington County General Hospital
- Bev McFarlane, Perth-Smiths Falls District Hospital
- Cathy Szabo, Providence Care
- Mary Clare Egberts, Quinte Health Care
- Jackie Redmond, South East CCAC

- Support Communication Leads in the delivery and cascading of messaging and communications throughout respective organizations; including sharing of key messages from SECHEF meetings.
- Hold overall accountability for the delivery of messaging and communications throughout respective organizations.

#### KPMG Support
- Mark Rochon, KPMG
- Drew Baillie, KPMG
- Jessica Logozzo, KPMG

- Support the development of the draft Shared Communications and Engagement Plan through leading practice research and consultation with South East LHIN representatives, Communication Leads (via the Communications Leads Working Group).
<table>
<thead>
<tr>
<th>Group), and other stakeholders (including SECHEF Steering Committee).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support, at the level of project management, the ongoing delivery of the Shared Communication and Engagement Plan (including: preparation of Communications Leads Working Group agendas, coordination of engagement activities).</td>
</tr>
<tr>
<td>Lead and coordinate stakeholder engagement activities (excluding communications activities), as per the approved Shared Communications and Engagement Plan, on behalf of the hospitals.</td>
</tr>
<tr>
<td>Develop engagement (not communications) supporting materials and tools (including invitations and presentation decks) using approved key messages.</td>
</tr>
<tr>
<td>Coordinate information sharing across project structures related to updates on communications and engagement activities, per the Shared Communications and Engagement Plan.</td>
</tr>
<tr>
<td>Provide advice and guidance on communications and engagement matters.</td>
</tr>
<tr>
<td>Provide advice and guidance on integration (risks, performance, process and operational matters, etc.)</td>
</tr>
</tbody>
</table>
4.0 Logistics and Processes

4.1 Communications Protocols
The Working Group will support the following communications protocols:

- At the end of each SECHEF Steering Committee meeting, three key messages will be approved by the SECHEF CEOs. Following the meeting a briefing note will be developed to outline the key messages – the briefing note will be distributed to SECHEF CEOs, Communications Leads and Hospital Board Chairs and Vice-Chairs (for communication with their Boards).
- Communications Leads will meet with their CEOs and/or Executive Teams following each SECHEF meeting, and as required between meetings, to ensure they are up to date and aligned on key messaging and progress – an update on these meetings will be provided to at the bi-weekly Communications Leads Working Group meeting.
- Communications Leads will agree to common messaging and consistent timing for the launch of this messaging. All organizations will launch communications and engagement activities as per the approved Shared Communications and Engagement Plan.
- Each Communications Lead is responsible to ensure that Senior Teams at respective organizations are kept up to date on communications and engagement activities, per the Shared Communications and Engagement Plan.
- Each Communications Lead is responsible to ensure that the dissemination of the communications and messaging throughout the respective organizations are vetted through proper channels (i.e. review with CEOs, Senior Teams and HR representatives).

4.2 Frequency of Meetings
The Working Group will meet weekly (each Thursday) to discuss progress updates, including progress against the development and ongoing delivery of the Shared Communications and Engagement Plan. This will also be a forum to identify any concerns and issues related to communications and engagement activities.

The Working Group will also meet regularly in person to collaborate on the development of key communications and engagement deliverables (i.e. the Shared Communications and Engagement Plan), or plan for key communications and engagement activities (i.e. education video launch). The location of the in-person meetings will alternate between the hospital sites. In-person meetings are preferred; however, under certain circumstances, teleconference may be an acceptable alternative.

4.3 Decision-Making Process
The Working Group will decide on recommendations and advice to the SECHEF Steering Committee by a process of careful deliberation respecting the wisdom and experience of all members. The Working Group will strive for consensus of opinions in its recommendations and advice to the SECHEF Steering Committee.

Consensus does not mean unanimity and the following criteria will guide achievement of consensus:

- Consensus strives to synthesize many diverse elements rather than focus on binary options
- Consensus is about process and is concerned with understanding and mitigating minority objections
- Consensus appreciates that it is in the organizations’ best interests to understand all of the options, to debate and be open to a new and better option
- The Working Group will value and respect disagreement to provide a full range of recommendations and advice to the SECHEF Steering Committee
- The Working Group members commit to supporting recommendations and advice to the SECHEF Steering Committee even if they did not support all elements of what is being provided.
Working Group key agreements will be recorded and reflected in the Working Group meeting notes.

4.4 Quorum Requirements
All Working Group members are committed to attending meetings. To constitute a formal meeting, at least four of the seven hospital Communication Leads must be present.

4.5 Proxies to Meetings
The Working Group will allow proxies for its work in special circumstances (i.e. extended vacations). Members will be responsible to get up to speed on activities following any absences.

4.6 Invited Guests
The Working Group will determine attendance by invited guests on a meeting-by-meeting basis.

4.7 Meeting Agendas, Meeting Materials and Notes
Every effort will be made to prepare and distribute meeting agendas and related materials no less than two business days in advance of the Working Group meetings.

Notes of the meetings shall be prepared, including action items, and circulated to the membership with the agenda for the following meeting.

The distribution of meeting materials will be the responsibility of KPMG for Phase 1.

4.8 Confidentiality
In order to maintain the integrity of the process, all Working Group members are asked to, unless otherwise agreed upon, keep discussions conducted at meetings and all materials prepared for use by the Working Group and stored on the project collaborative workspace as confidential.

4.9 Changes to Terms of Reference
These Terms of Reference may be amended as agreed to by Working Group members and approved by the SECHF Steering Committee.
1.0 Context for Health Care Tomorrow – Hospital Services

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow – Hospital Services

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow- Hospital Services Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The Health Care Tomorrow – Hospital Services planning process will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
• Inclusive engagement with patients and residents to inform processes;
• Inclusive engagement with Francophone and Indigenous communities to inform processes;
• Engagement via an appreciative inquiry approach;
• Options will be developed based on evidence and leading practice models;
• Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
• Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
• Realistic activities and timelines.

2.0 Scope and Role

The purpose of the Regional Change Management Leadership Group is to support the current Health Care Tomorrow – Hospital Services change management initiatives. The Group will focus on supporting the current change management requirements of the Health Care Tomorrow – Hospital Services planning, including support of the physician engagement strategy at each hospital and support of broader stakeholder groups’ change management needs.

The Group will provide a consistent approach and toolset for change management, and will partner with Communications and Human Resources Leads in each organization, as well as regionally, on the design and implementation of change initiatives. The Group is intended to support and facilitate the development and application of change management skills across the region.

The Group is comprised of a Lead individual from each of the seven hospitals, South East CCAC and South East LHIN, as well representatives from the Human Resources Working Group and the Communications Leads Working Group to ensure alignment with these critical areas. Each Lead has been identified by their respective CEO and will act as the CEO’s dedicated Lead to support the change management needs related to Health Care Tomorrow – Hospital services within the organization. The Lead will sit in on all Executive table discussions related to Health Care Tomorrow – Hospital Services planning. In terms of skill set, this individual will have strong project management skills and an understanding and experience with change management.

Scope of the Regional Change Management Leadership Group

The Regional Change Management Leadership Group is tasked to support the change management efforts of the Health Care Tomorrow – Hospital Services planning through the following:

1. Develop and coordinate the delivery of change management strategies, tools and tactics;
   The Leads are responsible for the development of a consistent approach to change management across the region related to Health Care Tomorrow – Hospital Services planning. In order to achieve this, the Leadership Group will utilize a ‘Toolkit’ (draft to be developed by KPMG) which will consist of practical tools and techniques designed to support organizational leaders (including Director and Manager levels).

2. Conduct stakeholder analysis and inform communications planning analysis for each organization, as well as at a regional level;

3. Develop and implement a detailed work plan to support change management requirements for Phase 1 and ongoing;

4. Provide change management and project management support for key stakeholder groups, as required;
5. **Coach and develop current and future leaders to build change management and project management capability;**

   In consultation with organizational leaders, including CEOs, identify leaders within the organizations to support change management initiatives within their respective areas of the organization.

   Leads will provide coaching and mentoring for identified change leaders within each organization/areas. Lead will develop training opportunities and workshops, in addition to the Toolkit, to facilitate knowledge transfer from the Change Management Leadership Group to embed within the organization/areas.

   In order to achieve sustainable change, it is the intention to create a coordinated network of change management leaders across the region to drive the change.

6. **Monitor progress and issues related to change management and change acceptance within each organization, through the completion of a monthly change management dashboard - for review by the Group on a monthly basis, and for reporting to SECHEF on a monthly basis through the SECHEF CEO Co-Leads;**

7. **Work with Communications Leads at each organization to inform the development and maintenance of a Communications Strategy to inform all stakeholders as to the progress and outcomes of the Health Care Tomorrow – Hospital Services planning; and,**

8. **Maintain strong linkage with Human Resources Leads at each organization to ensure change management efforts are aligned and consistent with Human Resources policies and procedures.**

**Role of the Regional Change Management Leadership SECHEF CEO Co-Leads**

The SECHEF CEO Co-Leads for this Leadership Group are Wayne Coveyduck and Jackie Redmond. The SECHEF CEO Co-Leads will:

1. Chair the monthly Leadership Group meetings;

2. Provide direction to the Leadership Group, acting as the liaison between the Leadership Group and SECHEF;

3. Act to resolve barriers.

**Role of the Change Management Lead**

A Regional Change Management Lead will be required to coordinate the meetings of the Leadership Group on a monthly basis. The Lead will also be responsible to coordinate the completion of the monthly change management dashboard, for review by the Group on a monthly basis, and for reporting to SECHEF on a monthly basis through the SECHEF CEO Co-Leads.

KPMG will provide support to the Regional Change Management Leadership Group in the following ways

1. Management and facilitation of Change Management Working Group within Phase 1 of planning – including provision of change management methodologies, tools and templates;

2. Management and facilitation of Change Management SECHEF CEO Leads Group;

4. Development of a Change Management toolkit – including Stakeholder analysis, communications planning tool and change management toolkit for Directors and Managers;

5. Development of a dashboard to monitor issues and track progress of the Change Management Leadership Group, including issues tracking for each organization; and,


**Reporting**

The Change Management Leadership Working Group will report, through the SECHEF CEO Co-Leads (Wayne Coveyduck and Jackie Redmond) to SECHEF on a monthly basis in Phase 1 and as required in subsequent phases. A dashboard will be developed to monitor issues and track progress of the Change Management Leadership Group, including issues tracking for each organization, which will be presented to SECHEF on a monthly basis.

A more detailed reporting framework will be developed and maintained by the Leadership Group to outline reporting relationships and timeliness.

**3.0 Logistics and Process**

**3.1 Duration of Service**

The Regional Change Management Leadership Group will form in April 2015 to support the immediate and ongoing change management needs of Phase 1 of the Health Care Tomorrow – Hospital Services planning. The Leadership Group will be required beyond Phase 1, to support the change management needs of Phase 2 activities and beyond.

**3.2 Frequency of Meetings**

The Regional Change Management Leadership Group will meet monthly, or as required.

In-person meetings are preferred for conducting business of the Leadership Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

**3.3 Decision-Making Process**

While this is not a decision-making body, operational decisions made by the Regional Change Management Leadership Group will be guided by the Principles established at the outset of the Health Care Tomorrow planning process. Decisions will be made by consensus.

**3.4 Meeting Agenda Items and Materials**

Agendas and meeting materials will be distributed to the Leadership Group members three (3) business days prior to scheduled meetings. The preparation and distribution of materials will be centralized through the Regional Change Management Lead, and Working Group members are required to provide materials to the Change Management Lead no less than four (4) days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.
1.0 Context for Health Care Tomorrow – Hospital Services

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
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1.3 Health Care Tomorrow- Hospital Services Vision

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1.4 Planning Principles

The Health Care Tomorrow – Hospital Services planning process will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
- Inclusive engagement with patients and residents to inform processes;
- Inclusive engagement with Francophone and Indigenous communities to inform processes;
- Engagement via an appreciative inquiry approach;
- Options will be developed based on evidence and leading practice models;
- Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
- Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
- Realistic activities and timelines.

2.0 Scope and Role

Physician leadership and physician engagement are essential elements to supporting any successful change.

True physician engagement and leadership begins with understanding and addressing the underlying characteristics and values of physicians, which requires physicians to inform and lead the engagement efforts.

The purpose of the Physician Change Management Working Group is to support the current Health Care Tomorrow – Hospital Services change management initiatives, as they relate to physician change management.

The Working Group will focus on supporting the current change management requirements of physicians in the Health Care Tomorrow – Hospital Services planning, including support of the physician engagement strategy. The Working Group will inform the development of a consistent approach and toolset for physician change management and focus on the redeployment and modernization of physician practice in order to meet new and emerging needs in the South East LHIN, including equity in decision-making processes.

The Working Group is comprised of one to two representatives from each of the seven hospitals, as well representatives from Queen’s University Faculty of Health Science and the South East LHIN. In general, the Working Group is comprised of Chiefs of Staff and Presidents of the Medical Staff Association (MSA) of each hospital. Where there is not an active MSA, CEOs were asked to identify an appropriate Physician Lead.

A representative from the Regional Change Management Leadership Group will also sit on the Physician Change Management Working Group, to act as a liaison between the two Groups and provide coordination support to the group. The Regional Change Management Leadership Group representatives for each of the hospitals will also be available to support the physician change management activities at each hospital from a project management and coordination perspective.

Scope of the Physician Change Management Working Group

The Physician Change Management Working Group is tasked to support the physician change management efforts of the Health Care Tomorrow – Hospital Services planning through the following:

1. Inform and lead physician change management strategies, tools and tactics;

   The Physician Change Management Working Group members are responsible for the development of a consistent approach to physician change management across the region related to Health Care Tomorrow – Hospital Services planning. In order to
achieve this, the Physician Change Management Working Group will utilize a ‘Toolkit’ (draft to be developed by KPMG) which will consist of practical tools and techniques designed to support physician leaders through the change.

2. Conduct stakeholder analysis and inform communications planning analysis for physicians at each organization, as well as at a regional level;

3. Inform a detailed work plan to support physician change management requirements for Phase 1 and ongoing; and,

4. Monitor progress and issues related to physician change management and change acceptance within each organization, through the completion of a monthly change management dashboard - for review by the Group on a monthly basis, and for reporting to SECHEF on a monthly basis through the Working Group Co-Leads.

Role of the Physician Change Management Working Group Co-Leads

The Co-Leads for the Physician Change Management Working Group are Dr. Richard Reznick and Dr. Kim Morrison. The Co-Leads will:

1. Chair the monthly Physician Change Management Working Group meetings;

2. Provide direction to the Physician Change Management Working Group, acting as the liaison between the Physician Change Management Working Group and SECHEF;

3. Act to resolve barriers.

Role of the Regional Change Management Lead (assigned to the Physician Change Management Working Group)

A Regional Change Management Lead (from the Regional Change Management Leadership Group) will be assigned to the Physician Change Management Working Group to coordinate the meetings and activities of the Physician Change Management Working Group on a monthly basis. The Regional Change Management Lead will also be responsible to coordinate the completion of the monthly change management dashboard, for review by the Group on a monthly basis, and for reporting to SECHEF on a monthly basis through the SECHEF CEO Co-Leads.

KPMG will provide support to the Physician Change Management Working Group in the following ways

1. Development of a draft Change Management Plan, in collaboration with Change Management Working Group;

2. Development of a Physician Change Management toolkit – including stakeholder analysis, communications planning tool and change management toolkit for physician leaders;

3. Development of a dashboard to monitor issues and track progress of the Physician Change Management Working Group, including issues tracking for each organization; and,


Reporting

The Physician Change Management Working Group will report, through the Working Group Co-Leads (Dr. Richard Reznick and Dr. Kim Morrison) to SECHEF on a monthly basis in Phase 1 and as required in subsequent phases. A dashboard will be developed to
monitor issues and track progress of the Physician Change Management Working Group, including issues tracking for each organization, which will be presented to SECHEF on a monthly basis.

3.0 Logistics and Process

3.1 Duration of Service

The Working Group will form in April 2015 to support the immediate and ongoing physician change management needs of Phase 1 of the Health Care Tomorrow – Hospital Services planning. The Working Group will be required beyond Phase 1, to support the physician change management needs of Phase 2 activities and beyond.

3.2 Frequency of Meetings

The Working Group will meet monthly, or as required.

In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

3.3 Decision-Making Process

While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow planning process. Decisions will be made by consensus.

3.4 Meeting Agenda Items and Materials

Agendas and meeting materials will be distributed to the Working Group members three (3) business days prior to scheduled meetings. The preparation and distribution of materials will be centralized through the Regional Change Management Lead, and Working Group members are required to provide materials to the Regional Change Management Lead no less than four (4) days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.
South East Local Health Integration Network (LHIN)

Health Care Tomorrow

Terms of Reference

Interim Executive & Transition Working Group

1.0 Context for Health Care Tomorrow

1.1 Drivers

The hospitals in the South East LHIN face a number of factors over the next several years that will impact their ability to provide quality patient care and system sustainability:

- An aging population, with the proportion of those over age 65 will be one of the highest in the Province;
- Patients with an increasing number of chronic diseases, and increasing intensity of care for those requiring care;
- Fiscal constraints due to provincial budget pressures that limit hospital budget increases;
- An aging workforce, increasing competition of health professionals when they are needed most;
- A net negative financial impact due to health system funding reform intended to improve system quality and efficiency; and,
- Increasing evidence of the relationship between volume and quality of care

1.2 Objective of Health Care Tomorrow

To support the members of the South East Community Care Access Centre and Hospital Executive Forum (SECHEF) in determining the role each provider will adopt to improve capacity for, and access to, a high quality system of integrated care within the current and projected financial environments. To assist in refining and articulating the need for change. Specifically, to provide project management, change management and facilitation services, as well as strategic advice to support SECHEF in developing a sustainable integrated model of hospital care, while respecting its role as part of an integrated continuum of care.

1.3 Health Care Tomorrow Vision

Improve access to high quality care through the development of a ‘Sustainable System of Integrated Care’.

1.4 Planning Principles

The Health Care Tomorrow planning process will be guided by the following principles:

- A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
- Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of patient care;
- Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
Inclusive engagement with patients and residents to inform processes;
Inclusive engagement with Francophone and Indigenous communities to inform processes;
Engagement via an appreciative inquiry approach;
Options will be developed based on evidence and leading practice models;
Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
Each member of SECHEF (All hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
Realistic activities and timelines.

2.0 Scope and Role

The Transition Working Group, formed of three members from the Business Functions Direction-setting Steering Committee and two Heads from the Business Functions Working Groups, will work to achieve the vision agreed by all hospital CEOs in the South East LHIN as described below. The Transition Working Group will develop a job description, accountabilities and proposed tenure for a Transition Executive to assist with the implementation of the outcomes of the Business Functions business cases and approved plans. The governance structure and reporting relationship of the Interim Executive with the Direction-setting Steering Committee and the Board of 3SO will be also in scope.

Shared Services Vision

On November 19th, 2014, the hospital CEOs in the South East LHIN approved the following vision:

*By 2020 a shared service organization will be fully implemented supporting the provision of all business functions (Human Resources, Finance, Information Systems, and Facilities/Hotel Services).*

The efficient delivery of business and clinical support areas will enable the hospitals in the SE to focus on core clinical services.
Scope of the Transition Working Group

One critical success factor for the implementation of the 2020 Vision is the implementation of a shared service organization that can efficiently deliver the desired business and some clinical support services. In order to prepare and ready the Shared Service Organization for the expanding scope a number of key activities need to be undertaken immediately. As 3SO is currently delivering key services it is imperative that management remain focused on meeting the current service requirements. The Transition Working Group is tasked to outline the critical duties and outcomes of an Interim Executive supporting the Vision of 2020 to improve service delivery and efficiency through the following:

1. Create a job description for an Interim Executive including all duties with start and end date of the position;
2. Develop a list of critical activities and milestones;
3. Identify a reporting structure and communication protocol for the Interim Executive to the Direction setting committee;
4. Identity a reporting structure and communication protocol for the Interim Executive and 3SO Management and Board; and,
5. Set the success criteria for the Interim Executive.

3.0 Framework for the Working Groups

The Working Groups are an extension of SECHEF, reporting directly to the Business Function Direction-setting Steering Committee, made up of leaders from SECHEF. The Business Function Direction-setting Steering Committee will be responsible for providing oversight to each of the Working Groups, ensuring consistency and alignment across the Working Groups and reporting and recommendations back to SECHEF.

The Working Groups are responsible to:

- Engage with clients and ensure any redesign meets client needs;
- Engage with colleagues from across the region;
- Consider leading practices to set the vision and characteristics of the redesign;
- Consider redesign approaches based on evidence and an analytical approach; and,
- Focus on transformational change rather than the operational issues that exist today.

Principles for the Working Groups

The Working Group Leads and team members are expected to adhere to the principles described below for the development of business function shared services:

1. Enable sustainability of patient care
2. Trust and collaboration
3. We can do it better together
4. Everyone is in (ownership)
5. Engage those affected
6. Cost effectiveness, more competitive at the end
7. Enhance quality and service
8. Improvement for all
9. Current state is not an option
10. Share cost of implementation
11. Appreciative inquiry

4.0 Logistics and Process

4.1 Duration of Service
The Transition Working Group will form from April 16 to April 27 or until recommendations are made to SECHEF. Additional work may be required beyond this date to respond to questions or redesign requirements from SECHEF.

4.2 Frequency of Meetings
The Transition Working Group will meet at a minimum of one-time prior to present recommendations to SECHEF. In-person meetings are preferred for conducting business of the Working Group, however, under certain circumstances video conference and/or webinar meetings may be an acceptable alternative where possible.

4.3 Decision-Making Process
While this is not a decision-making body, operational decisions made by the Working Group will be guided by the Principles established at the outset of the Health Care Tomorrow planning process. Decisions will be made by consensus.

4.4 Meeting Agenda Items and Materials
Agendas and meeting materials will be distributed to the Working Group members three (3) business days prior to scheduled meetings. The preparation and distribution of materials will be centralized through the KPMG Project Manager, and Working Group members are required to provide materials to the Project Manager no less than four (4) days prior to the meeting date.

These Terms of Reference may be amended as agreed to by all members.
Further to the direction of SECHEF, the Transition Working Group has established the following direction for the Shared Services Project Lead:

<table>
<thead>
<tr>
<th>Role</th>
<th>Primary Interfaces</th>
<th>Principles of Success</th>
<th>Areas of Focus</th>
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</table>
| Project Lead: Shared Services Transitional Planning | Transition Working Group (oversight), 3SO Board Chair (executive and staff), business functions work group leads, hospital executives and staff (where required) | • Respect the current mandate and deliverables of the current SSO, as we plan for the future SSO  
• Organizational readiness for current SSO  
• Build confidence to move to Phase 2  
• Getting the ‘right’ board composition over the short, mid, and long-term  
• Clarity around roles of service level committees at the SSO, and at the hospital level  
• Commitment by hospital partners to a ‘common’ strategy, with flexibility to address legitimate hospital specific needs  
• Commitment by hospital partners for a period of time to allow for assessment of SSO performance and consideration of future directions  
• Clarity around gain-sharing  
• Overall, same or lower cost for all hospital partners  
• Clear understanding of the current state (baseline) against the performance of the future SSO | • Develop a work plan (first priority)  
• Interim organizational design for SSO  
• Design for service governance inclusive for all services current and future (service management processes, process deployment, committee design)  
• Recommends the roles and accountabilities for the leadership of the shared service organization  
• Establish baseline metrics for future comparison and performance reporting; cost transparency  
• Develop value proposition including criteria such as ‘to define value’, ‘not just cost’, ‘quality and service’  
• Develop branding and relationship management concepts for consideration  
• Create a transition plan (aligned to phase 1 and potentially phase 2 work group outcomes) – including recommending resource needs  
• Recommend change management and communications plan |

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<tr>
<th>Time Frame</th>
<th>Work Plan / Key Milestones (To be Built)</th>
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</table>
| Preliminary work to be carried out as part of Phase 1 planning. Work is expected to carry over into Phase 2 design. | One of the first priorities of the project lead is to create a work plan. We anticipate the work plan to lead up to June 17th, and beyond.  
Once ready, the high level ‘key milestones’ will be placed in this box. |
Health Care Tomorrow

Terms of Reference

Governance Working Group

1.0 Purpose
The purpose of the Governance Working Group is to:

Recommend to the LHIN, Hospital/CCAC Chairs and Vice Chairs Forum an approach, timing and preliminary messages for governance communication with which all South East Hospital Boards and Members, collectively and separately, will engage their communities regarding Health Care Tomorrow – Hospital Services planning.

2.0 Objectives
The Governance Working Group will recommend to the Hospital/CCAC Chairs/Vice Chairs Forum the following:

Related to communication,

1. Clarifying the purpose of Health Care Tomorrow
   - A brief communications piece regarding the Health Care Tomorrow planning that is consistent with the Communication Strategy developed by the Communications Working Group, and approved by SECHEF, which outlines its rationale, scope, inherent steps and milestone dates which, upon approval, will be circulated to the South East LHIN, Hospital and CCAC Board Members for information and will continue to serve as a reference document.

2. Communication between Hospital Leadership (Boards and CEOs) and local opinion Leaders
   - A sequenced and timed process to engage local opinion leaders, local municipal officials and MPPs, the governances of other local agencies and the public, separately and collectively, in order inform, promote understanding and gain support for the process and results of planning to best meet future healthcare needs for their communities within a regional system of care. This is intended to align with and form part of the broader project Communications Strategy.
   - Communications messages and a framework to be employed by Board Members in a continuous and phased approach to community engagement, as it pertains to Health Care Tomorrow planning, and considering other communications needs.

3. Communication between SECHEF and Boards
   - A process whereby governance members of Hospital, CCAC and LHIN Boards will be kept informed of the progress of the planning in order to come to a common understanding of the status, likely outcomes/options and risk management strategies (i.e. rationale for recommendations and associated risks). This ongoing communication ought to result in a common understanding not only of the planning and what Boards will need to consider but will also inform the development of key messages as they evolve over the course of the planning.

Related to roles and responsibilities,

4. Board roles and responsibilities
   - An understanding of Board roles and responsibilities as Board Members of hospitals in relation to the outcomes of Health Care Tomorrow as a region-wide initiative.

Related to decision-making,

5. Board decision-making
A decision-making framework that Board Members can expect as opportunities are placed before them for consideration that would outline process and timing.

3.0 Process and Supporting Materials

To support the work of the Working Group, as articulated above, the project team will develop the following documents for discussion. Once the group is satisfied with the documents they will be shared with the Hospital/CCAC Chairs/Vice Chairs Forum.

1. The first document will outline what has been developed to date by way of key messages, rationale, and communication process and timelines. It will pose questions for consideration and, where possible, options in relation to reporting, or not, the status of project considerations.

2. The second document will serve as an example of a briefing note to be shared regularly with each Board outlining project status by major Working Group areas (Business Functions, Diagnostics & Therapeutics and Clinical). The document will outline progress to date, key milestones and, where possible, options under review and likely considerations for each Board.

Having received the above materials beforehand, the Working Group will meet to:

- Discuss, amend as required and approve these for recommendation to the full Forum for discussion and general agreement; and,
- Agree on the process whereby individual Boards will agree to the deployment of this strategy and messages.

4.0 Timing

- **January 28:** Invite members to Working Group (complete)
- **February 7:** Memo to Hospital/CCAC Chairs/Vice Chairs Forum outlining Term of Reference of the Governance Working Group
- **February 9:** Creation of draft communications piece, process and messages for circulation to members of the Governance Working Group
- **February 12:** Working Group meeting #1 Working Group (teleconference)
- **Early March:** Hospital/CCAC Chairs/Vice Chairs Forum meeting (teleconference)
Listing of Participants
### SECHEF CEO Steering Committee Membership

<table>
<thead>
<tr>
<th>Organization</th>
<th>Name</th>
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<tbody>
<tr>
<td>Hotel Dieu Hospital</td>
<td>Dr. David Pichora</td>
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<tr>
<td>Brockville General Hospital</td>
<td>Tony Weeks</td>
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<tr>
<td>Kingston General Hospital</td>
<td>Leslee Thompson</td>
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<td>Lennox and Addington County General Hospital</td>
<td>Wayne Coveyduck</td>
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<td>Perth and Smiths Falls District Hospital</td>
<td>Beverley McFarlane</td>
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<td>Providence Care</td>
<td>Cathy Szabo</td>
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<td>Quinte Health Care</td>
<td>Mary Clare Egberts</td>
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<tr>
<td>Queen’s Faculty of Health Science</td>
<td>Dr. Richard Reznick</td>
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<tr>
<td>South East Community Care Access Centre</td>
<td>Jacqueline Redmond</td>
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<tr>
<td>South East LHIN</td>
<td>Paul Huras</td>
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### Visioning Day Attendance

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<td>Dr. David Pichora</td>
<td>CEO</td>
</tr>
<tr>
<td>St. Joseph's Health System</td>
<td>Dr. Kevin Smith</td>
<td>CEO</td>
</tr>
<tr>
<td>South East Local Health Integration Network</td>
<td>Paul Huras</td>
<td>CEO</td>
</tr>
<tr>
<td>Shared Support Services Southeastern Ontario (3SO)</td>
<td>Lyndon Smith</td>
<td>CEO/General Manager</td>
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<tr>
<td>Cheshire Homes (Hastings-Prince Edward) Inc.</td>
<td>Terry Richmond</td>
<td>Executive Director</td>
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<tr>
<td>Brockville General Hospital</td>
<td>Cameron McLennan</td>
<td>Vice President &amp; Chief Human Resources Officer</td>
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<td>Kingston General Hospital</td>
<td>Annette Bergeron</td>
<td>Director/Board</td>
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<tr>
<td>Lennox and Addington County General Hospital</td>
<td>Colin Catt</td>
<td>Manager, Information Services</td>
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<tr>
<td>Perth Smiths Falls Hospital</td>
<td>Nancy Shaw</td>
<td>VP, Clinical Services</td>
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<td>Quinte Health Care</td>
<td>Mark Coulter</td>
<td>Director of Diagnostic Imaging</td>
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<td>Regional Patient Advisory Council</td>
<td>D. Marie Turnbull</td>
<td>Regional Patient Advisory Council Member</td>
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<td>South East Local Health Integration Network</td>
<td>Lori Van Manen</td>
<td>Quality Improvement &amp; Implementation Facilitator</td>
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<tr>
<td>Shared Support Services Southeastern Ontario (3SO)</td>
<td>Bill Hunter</td>
<td>Manager Human Resources</td>
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<td>Community Care for Central Hastings</td>
<td>Pat Dobb</td>
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<td>Debbie Wilson</td>
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<td>Brian Allen</td>
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<td>Janet Baragar</td>
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<td>Kristen Spring Spring</td>
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<td>Vicki Huehn</td>
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<td>Hospice Prince Edward</td>
<td>Nancy Parks</td>
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<td>Matthew Armstrong</td>
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<td>Katie Clement</td>
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<td>Laurie Dube</td>
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<td>Lanark - EMS</td>
<td>Sean Teed</td>
<td>Deputy Chief</td>
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<td>Todd Schonewille</td>
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<td>Bruce Rigby</td>
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Phase 1 Final Report

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<td>Linda Price</td>
<td>Program Director of Maternal Child, Patient Flow and Interim Director of Oncology and Medical Ambulatory Clinics</td>
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<td>Upper Canada Family Health Team</td>
<td>Sherri Fournier Hudson</td>
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<td>Cynthia Martineau</td>
<td>Director, Local Health System Development</td>
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<td>Community Patient Transfer Group</td>
<td>Casey McNab</td>
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<td>Belleville Queen University Family Medicine Centre</td>
<td>Dr. Jonathan Kerr</td>
<td>Primary Care Lead</td>
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<td>Senior Consultant Health System Design &amp; Implementation Lead</td>
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Health Care Tomorrow – Hospital Services Planning
Phase 1 Final Report
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### Regional Patient Advisory Council (RPAC) Membership

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## Clinical Direction-setting Steering Committee Membership

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<td>Dr. Iain Young</td>
<td>Queen’s University</td>
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<td>Cathy Cassidy-Gifford</td>
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<tr>
<td>Theresa MacBeth</td>
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# Clinical Working Group Membership: Urgent/Emergent

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<tr>
<td>Heather Campbell</td>
<td>Quinte Health Care</td>
<td>Program Director (ED/PHC/ &amp; NHH, PECMH, TMH IP)</td>
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<tr>
<td>Carol McIntosh</td>
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<td>Program Manager</td>
</tr>
<tr>
<td>Julie Caffin</td>
<td>Kingston General Hospital</td>
<td>Program Operational Director (Cardiac, CC, ER)</td>
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<tr>
<td>Dr. Ken Edwards</td>
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<tr>
<td>Dr. Caroline Ehrat</td>
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<td>Chief, Perth Emergency Department</td>
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<tr>
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<tr>
<td>Emily Shoniker</td>
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<td>Brian McKenzie</td>
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<tr>
<td>Terry Richmond</td>
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<td>Executive Director, CSS</td>
</tr>
<tr>
<td>Lynn Linton</td>
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<td>Executive Director</td>
</tr>
<tr>
<td>Dr. Peter Cunniffe</td>
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<td>PHC, Perth Medical Centre, Physician Lead Rideau Tay, Physician</td>
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<tr>
<td>Dr. Deanna Russell</td>
<td>Kingston FHT</td>
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<td>Nousheen Kanjii</td>
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## Clinical Working Group Membership: Elective

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<td>Janet Baragar</td>
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<td>Director Surgery Program</td>
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<td>Marsha Stephen</td>
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<tr>
<td>Sabrina Martin</td>
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# Clinical Working Group Membership: Tertiary/Quaternary

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<td>Michele Bellows</td>
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<td>VP, Patient Care Services</td>
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<tr>
<td>Christine Wilkinson</td>
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<td>Director for Medicine/Critical Care, Program Director for Medicine, Critical Care, Complex Continuing Care and Rehab</td>
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<tr>
<td>Linda Price</td>
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<td>Program Director for Maternal Child and Patient Flow</td>
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<tr>
<td>Brenda Carter</td>
<td>Kingston General Hospital</td>
<td>Interim VP KGH &amp; VP SEO Cancer Care</td>
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<tr>
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<td>Director Surgical Services, DI</td>
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<tr>
<td>Leslie Wall</td>
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<tr>
<td>Dr. Stephen Archer</td>
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<td>Head of Medicine</td>
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<tr>
<td>Dr. John Rudan</td>
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<td>Chief Surgery</td>
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<td>Dr. Dan Howes</td>
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**Clinical Working Group Membership: Chronic Complex (including Frail Elderly)**

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<td>Carol Ravnaas</td>
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<td>Mike McDonald</td>
<td>Hotel Dieu Hospital</td>
<td>Chief of Patient Care &amp; CNO</td>
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<tr>
<td>Sherry Anderson</td>
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<td>Director CCC, Rehab and Palliative Care</td>
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<td>Jennifer Olajos-Clow</td>
<td>Hotel Dieu Hospital</td>
<td>Nurse Practitioner, Complex Chronic Disease</td>
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<tr>
<td>Dr. Kim Morrison</td>
<td>Lennox and Addington County General Hospital</td>
<td>COS, HL Physician Lead</td>
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<td>Caryn Langstaff</td>
<td>Providence Care</td>
<td>Program Manager Specialty Geriatrics &amp; Resorative Rehabilitation Care</td>
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<tr>
<td>Dr. Chris Frank</td>
<td>Providence Care</td>
<td>Clinical Director Geriatric Program &amp; MAC Chair</td>
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<tr>
<td>Dr Laura Marcotte</td>
<td>Kingston General Hospital</td>
<td>Director, Clinical Teaching Units, Department of Medicine, Queen’s</td>
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<tr>
<td>Dr Chris Smith</td>
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<td>Dept of Medicine</td>
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<tr>
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<td>Michael O'Keefe</td>
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<tr>
<td>Peter McKenna</td>
<td>Ridea Community Health Services</td>
<td>ED, HL Lead Rideau Tay</td>
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<tr>
<td>Mary Woodman</td>
<td>Health Links</td>
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## Diagnostics & Therapeutics Direction-Setting Steering Committee Membership

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<tr>
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<td>President &amp; CEO</td>
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<tr>
<td>Tony Weeks</td>
<td>Brockville General Hospital</td>
<td>President &amp; CEO</td>
</tr>
<tr>
<td>Dr. Stephen Archer</td>
<td>HDH, KGH, Providence Care</td>
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<tr>
<td>Dr. Annette McCallum</td>
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<tr>
<td>Dr. Robyn Houlden</td>
<td>KGH and HDH</td>
<td>Endocrinologist</td>
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<tr>
<td>Jeff Hohenkerk</td>
<td>Quinte Health Care</td>
<td>VP, Emergency and Primary Care, Human Resources, Pharmacy, DI, Lab, Infection Control, Facilities and Support Services</td>
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<tr>
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<td>Chief of Patient Care &amp; CNO</td>
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<td>EVP &amp; COO</td>
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## Diagnostics & Therapeutics Working Group Membership: Diagnostic Imaging

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<tr>
<td>Dr. Annette McCullum</td>
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<td>Working Group Co-Lead/Radiologist</td>
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<tr>
<td>Vic Sahai</td>
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# Diagnostics & Therapeutics Working Group Membership: Laboratory

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<td>Endocrinologist</td>
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<tr>
<td>Dr. Sandip Sengupta</td>
<td>KGH and PSFDH</td>
<td>Medical Director Laboratory</td>
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<td>Kim Kehoe</td>
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<td>Susan Pugh</td>
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<td>Director, Labs, Pharmacy, and Infection Control</td>
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<td>Susan Schuab</td>
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<td>Interim Lab Manager</td>
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<td>Tanya McDonald</td>
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<td>Manager, Laboratory, DI and Pharmacy</td>
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## Diagnostics & Therapeutics Working Group Membership: Pharmacy

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<tr>
<td>Mike McDonald</td>
<td>Hotel Dieu Hospital</td>
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<tr>
<td>Dr. Stephen Archer</td>
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<tr>
<td>Dr. Gerald Evans</td>
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<tr>
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<td>Karen Smith</td>
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<td>Alan Smith</td>
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<td>Veronique Briggs</td>
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<td>Jen Chiu</td>
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<tr>
<td>Rene Thibault</td>
<td>Providence Care</td>
<td>Pharmacist, Professional Practice Leader for Pharmacy</td>
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<tr>
<td>Jacqui Marino</td>
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<td>Manager of Decision Support</td>
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<tr>
<td>Gina Johar</td>
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<tr>
<td>Nousheen Kanjii</td>
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### Business Functions Direction-Setting Steering Committee Membership

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<thead>
<tr>
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<tr>
<td>Tony Weeks</td>
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<tr>
<td>Jim Flett</td>
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<td>EVP &amp; COO</td>
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<tr>
<td>Paul McAuley</td>
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<tr>
<td>Dan Coghlan</td>
<td>3SO</td>
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<tr>
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<tr>
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## Business Functions Working Group Membership: Finance

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<td>Brad Harrington</td>
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<td>Gert Switzer</td>
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<td>Director, Finance and Utilization Management</td>
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<tr>
<td>Steve Miller</td>
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<td>CFO &amp; COO</td>
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<tr>
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<tr>
<td>Dan Coghlan</td>
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<td>VP, Operations &amp; CFO</td>
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<tr>
<td>Brian Allen</td>
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<td>VP, Finance and Support Services</td>
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<tr>
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<tr>
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<td>VP/CIO (KGH) &amp; CIO (HDH)</td>
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<tr>
<td>Brad Harrington</td>
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<td>Steve Read</td>
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<tr>
<td>Bev McFarlane</td>
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<td>Brian Allen</td>
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<tr>
<td>Colin Catt</td>
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<tr>
<td>Stacey Roques</td>
<td>South East CCAC</td>
<td>Senior Director, Shared Services,</td>
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<tr>
<td>Dan Kazarov</td>
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<tr>
<td>Scott MacInnes</td>
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<tr>
<td>Cameron McLennan</td>
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<td>VP &amp; CHRO</td>
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<tr>
<td>Mitch Birken</td>
<td>HR, QHC</td>
<td>Director</td>
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<tr>
<td>Shari Sampson</td>
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<td>Shannon Graham</td>
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<td>VP &amp; CHRO</td>
</tr>
<tr>
<td>Sandra Carlton</td>
<td>Providence Care</td>
<td>VP, Mission, Values and People</td>
</tr>
<tr>
<td>Dave Evans</td>
<td>PSFDH</td>
<td>Manager, HR</td>
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<tr>
<td>Jennifer Goodwin</td>
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<td>Communications Representative</td>
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### Business Functions Working Group Membership: Facilities/Support Services

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<tbody>
<tr>
<td>Jeff Hohenkerk</td>
<td>QHC</td>
<td>VP, Emergency and Primary Care, Human Resources, Pharmacy, DI, Lab, Infection Control, Facilities and Support Services</td>
</tr>
<tr>
<td>Nancy Manion</td>
<td>LACGH</td>
<td>Director, Quality</td>
</tr>
<tr>
<td>Larry Erwin</td>
<td>HDH</td>
<td>Director, Facilities Management</td>
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<tr>
<td>J’Neene Coghlan</td>
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<td>VP &amp; CFO</td>
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<tr>
<td>Todd Schonewille</td>
<td>BGH</td>
<td>Director, Facilities &amp; Infrastructure</td>
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<tr>
<td>Chris MacKey</td>
<td>Providence Care</td>
<td>Director, Facility Management</td>
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<tr>
<td>Brian Allen</td>
<td>PSFDH</td>
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<td>Alexander Russell</td>
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## Communications Leads Working Group Membership

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<th>Position</th>
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<tbody>
<tr>
<td>Brockville General Hospital</td>
<td>Abby McIntyre</td>
<td>Marketing and Communications Specialist</td>
</tr>
<tr>
<td>Hotel Dieu Hospital</td>
<td>Elizabeth Bardon</td>
<td>Chief of Public Relations &amp; Community Engagement</td>
</tr>
<tr>
<td>Kingston General Hospital</td>
<td>Theresa MacBeth</td>
<td>Director, Strategy Management &amp; Communications</td>
</tr>
<tr>
<td>Lennox and Addington County General Hospital</td>
<td>Wayne Coveyduck</td>
<td>President and CEO</td>
</tr>
<tr>
<td>Perth-Smiths Falls District Hospital</td>
<td>Karen Kelly</td>
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<tr>
<td>Providence Care</td>
<td>Jennifer Goodwin</td>
<td>Director, Communications &amp; Strategy</td>
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<tr>
<td>Quinte Health Care</td>
<td>Susan Rowe</td>
<td>Director of Communications</td>
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<tr>
<td>South East CCAC</td>
<td>Gary Buffett</td>
<td>Manager, Communications</td>
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<tr>
<td>Providence Care</td>
<td>Cathy Szabo</td>
<td>President &amp; CEO</td>
</tr>
<tr>
<td>South East LHIN</td>
<td>Caitlin den Boer</td>
<td>Communications Lead</td>
</tr>
<tr>
<td>Quinte Health Care</td>
<td>Mary Clare Egberts</td>
<td>President and CEO</td>
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## Change Management Working Group Membership

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<tr>
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<tbody>
<tr>
<td>LACGH</td>
<td>Wayne Coveyduck</td>
<td>Change Management Working Group Co-Lead; CEO, LACGH</td>
</tr>
<tr>
<td>Queen’s</td>
<td>Dr. Richard Reznick</td>
<td>Change Management Working Group Co-Lead; Queen’s</td>
</tr>
<tr>
<td>CCAC</td>
<td>Jackie Redmond</td>
<td>Change Management Working Group Co-Lead; CEO, South East CCAC</td>
</tr>
<tr>
<td>HDH</td>
<td>Steve Miller</td>
<td>Chief Operating Officer and Chief Financial Officer</td>
</tr>
<tr>
<td>BGH</td>
<td>Cameron McLennan</td>
<td>Vice President &amp; Chief Human Resources Officer</td>
</tr>
<tr>
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<td>Vice President and Chief Human Resources Officer</td>
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<td>LACGH</td>
<td>Shari Sampson</td>
<td>Director, HR and Clinical Support Services</td>
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<td>PSF</td>
<td>Michele Bellows</td>
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<td>Sandra Carlton</td>
<td>VP, Mission, Values, and People</td>
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<td>QHC</td>
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<tr>
<td>Organization</td>
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<td>Kathleen Fitzpatrick</td>
<td>Director of Medical Administration</td>
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<tr>
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<td>Paul McAuley</td>
<td>Director, Strategy and Governance</td>
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<td>CCAC</td>
<td>Stacey Roques</td>
<td>Senior Director, Organizational Effectiveness</td>
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### Physician Change Management Leadership Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization/Stakeholder Group</th>
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<tbody>
<tr>
<td>Dr. Richard Reznick</td>
<td>Physician Change Management Working Group Co-Lead, Dean, Queen's Medical School</td>
</tr>
<tr>
<td>Dr. Kim Morrison</td>
<td>Physician Change Management Working Group Co-Lead, Chief of Staff, Lennox and Addington County General Hospital</td>
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<tr>
<td>Mike Fitzpatrick</td>
<td>Chief of Staff, Hotel Dieu Hospital</td>
</tr>
<tr>
<td>Dr. David Goldstein</td>
<td>Chief of Staff, Brockville General Hospital</td>
</tr>
<tr>
<td>Dr. Jamie Hynd</td>
<td>MSA President, Brockville General Hospital</td>
</tr>
<tr>
<td>Dr. David Zelt</td>
<td>Chief of Staff, Kingston General Hospital</td>
</tr>
<tr>
<td>Dr. Jay Engel</td>
<td>Oncology Surgeon, SEO Cancer Care, MSA Vice President</td>
</tr>
<tr>
<td>Dr. Mamdouh Andrawis</td>
<td>MSA President, Lennox and Addington County General Hospital</td>
</tr>
<tr>
<td>Dr. Peter Roney</td>
<td>Chief of Staff, Perth and Smiths Falls District Hospital</td>
</tr>
<tr>
<td>Dr. Kate Stolee</td>
<td>President of MSA, Perth and Smiths Falls District Hospital</td>
</tr>
<tr>
<td>Dr. Ruth Wilson</td>
<td>Vice President of Medical Affairs, Providence Care</td>
</tr>
<tr>
<td>Dr. Chris Frank</td>
<td>Clinical Director Geriatric Program &amp; MAC Chair, Providence Care</td>
</tr>
<tr>
<td>Dr. Dick Zoutman</td>
<td>Chief of Staff, Quinte Health Care</td>
</tr>
<tr>
<td>Dr. Annette Polanski</td>
<td>Chief of Radiology, Quinte Health Care</td>
</tr>
<tr>
<td>Dr. Hoshiar Abdollah</td>
<td>President, CTAQ</td>
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<td>Elizabeth Bardon</td>
<td>Regional Change Management Lead</td>
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<td>Theresa MacBeth</td>
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<td>Cynthia Martineau</td>
<td>South East LHIN Lead</td>
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<tr>
<td>Elaine Johns</td>
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</table>
1.0 Overview

This document describes a summary of the stakeholder feedback collected throughout the Health Care Tomorrow – Hospital Services planning process.

The summary of feedback contained in this report represents the following engagement activities and groups:

1. Visioning Day (October 30)
2. Online survey results
3. Francophone Visioning Day (December 4)
4. Regional Patient Advisory Committee (meetings and feedback provided outside of meetings)
5. Post-Session Survey Feedback

Document structure:

- **Section 2.0 (Overarching Themes)** – feedback is presented in Section 2.0 as overarching themes, to provide a high-level view on the nature of the feedback.
- **Section 3.0 (Stakeholder Feedback Log)** – more detailed feedback is presented in Section 3.0, as a feedback log. Within this log, the source of feedback and key themes that emerged are included.

Note: the feedback collected to date has been catalogued in its raw format and can be presented, where appropriate, if there is further information required on the themes presented in this document.

2.0 Overarching Themes

As presented in the below graphic, five overarching themes emerged from the stakeholder feedback in describing an ideal system of care in the South East region:

- **Patient Empowerment and Respect**
  - Unique needs of patients are addressed
  - Clear and appropriate two-way community (i.e. in my language)
  - Informed patients involved in care plan design

- **Access**
  - Care close to or in the home
  - Transportation
  - Reduced waiting times

- **High-Quality Care and Staff**
  - Access to specialized care (e.g. geriatrics, mental health etc.)
  - Highly-skilled and considerate staff
  - Multidisciplinary and collaborative teams

- **Providers are Connected**
  - Hospital services are seamlessly integrated with an overarching system of strong and robust community services and primary care

- **Shared Information Systems**
  - Information links between the community and hospital
  - Patient information and care plans is accessible

**Characteristics of a High-Performing Health Care System in the South East**

---

**Providers are Connected**

- Hospital services are seamlessly integrated with an overarching system of strong and robust community services and primary care

**Shared Information Systems**

- Information links between the community and hospital
- Patient information and care plans is accessible

**Patient Empowerment and Respect**

- Unique needs of patients are addressed
- Clear and appropriate two-way community (i.e. in my language)
- Informed patients involved in care plan design

**Access**

- Care close to or in the home
- Transportation
- Reduced waiting times

**High-Quality Care and Staff**

- Access to specialized care (e.g. geriatrics, mental health etc.)
- Highly-skilled and considerate staff
- Multidisciplinary and collaborative teams
### 3.0 Stakeholder Feedback Log

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Input Received From (name, title, organization)</th>
<th>Summary of Feedback Received</th>
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</thead>
</table>
| 1.  | October 30, 2014 | Visioning Day                                    | The most important **challenges** that the health system will need to address over the next ten years relate to:  
  - Demand Planning and Social Determinants of Health  
  - Changing Culture  
  - The Patient Experience and Role  
  - Access, Quality of Care, Costs & Funding  
  - Human Resources  
  - The Academic Role  
  - Community Care  

Some of **strengths** of the current system include:  
- People  
- Care delivery  
- Resources  
- Partnerships  
- Hospital approached  
- System level models of care  

Participants identified the **following new and emerging initiatives** that can address the health system challenges:  
- Overarching system redesign  
- Technology and information system  
- Leveraging the patient  
- Funding  
- New models of care  

When asked, “**What would a high-performing hospital system look like in the South East region**”, this is what we heard:  
Overarching system redesign
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</table>
| 2. | Retrieved January 26, 2015 | An ideal system of care has robust and accessible community services and primary care services; providers and patients are aware of alternative options to the ER (i.e. primary care) and destinations after discharge (e.g. CCAC) so patients move seamlessly through services.  
Examples of responses:  
- “Emergency department visits would be limited to only those cases requiring urgent and immediate care because there would be other available care options for less urgent needs and the community at large would be well educated as to those alternatives.”  
- “There would be a seamless transition for those patients transitioning between service providers with no one “falling between the cracks”.”  
- “There also should be increased CCAC support to help maintain them [patients] once discharged home which in turn could decrease returns to the ER and readmissions.”  
- “Walk in clinics so that our ER’s are open to real emergencies and not someone with a sore throat.”  
- “More urgent care and after hours clinics to relieve congestion at emergency rooms.”  
- “Educate people when to go to the emergency department.” |
|   | Webpage survey (can be accessed at [www.healthcaretomorrow.ca](http://www.healthcaretomorrow.ca)) | A good hospital system is seamlessly integrated within an overarching system that includes community services; patients flow seamlessly within.  
Examples of responses:  
- “A good hospital system would be part of a broader community of healthcare services, each with clearly defined scopes of service, working collaboratively and communicating effectively with members of the community who access those services.”  
- “I would prefer to focus my thoughts on a good health care system, rather than focusing solely on good hospital system, as there requires close collaboration between all providers in our system to ensure effective delivery of health services.” |
In an ideal system of care, we have access to specialized services and dedicated resources/units for geriatrics and mental health
Examples of responses:
- “I think a better focus on geriatric care would help our hospital and region. An ACE unit would be particularly helpful.”
- “Better resources for mental health patients who are often given little attention by doctors due to high volumes of ill patients requiring more immediate attention.”

We need more care closer to and in the home
Examples of responses:
- “I feel that the patients that can stay in their own area do better having family around to help them with their healing process that may not be able to be with them if they are in another city.”
- “Able to have surgeries close to home so that family can help care for you or assist family who wish to convalesce at home with nursing care at home.”

An ideal system of care has a centralized, accessible, and seamless system for patient information and care plans
Examples of responses:
- “My care needs and advanced directives are known and understood by all providers (ie: a shared care plan and access to this information by all providers)”
- “I would like to see continued efforts to integrate medical health records in a central location so that doctors have the latest test reports and medical history of the client without asking the client to remember their complex history”
- “Connected by electronic information sharing to each other and community providers, with integrated systems connecting to home care systems”

An ideal system of care has highly-skilled and caring staff
Examples of responses:
- “Competent, caring staff”
- “Not too busy for patients to feel like they aren’t being thoroughly looked after”
- “A good hospital would treat everyone with respect and have competent health care providers”

An ideal system of care is patient centered and considerate of unique needs
Examples of responses:
- “Align patient needs with system needs.”
- “The hospitals are not user friendly for people with disabilities - they are hard to get around in - wheel chairs are not always available and parking is difficult for the frail, sick, elderly and disabled.”

3. December 4, 2014
Francophone Visioning Day
A high-performing hospital system in the South-East would have dedicated resources for Francophone services
Examples:
- Bilingual staff available from beginning to end of the service provision process within the system.
<table>
<thead>
<tr>
<th>A high-performing hospital system in the South-East would have appropriate access and services</th>
<th>A high-performing hospital system in the South-East would have support and coordination for patients and families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
<td>Examples:</td>
</tr>
<tr>
<td>- Medical communication that is easy to understand, in French.</td>
<td>- Networking of medical information. Patient files that follow them from family practices to specialists.</td>
</tr>
<tr>
<td>- Bilingual staff at 911 and other departments, such as emergency.</td>
<td>- Informed patients who know where to go to maximize the system – avoid going to a family physician if the problem is too serious...use the right service.</td>
</tr>
<tr>
<td></td>
<td>- How is the patient and family truly involved in his or her care plan?</td>
</tr>
<tr>
<td></td>
<td>- Care should follow the patient</td>
</tr>
<tr>
<td></td>
<td>- Need to coordinate patient care and follow-up.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A high-performing hospital system in the South-East would have multidisciplinary and collaborative care</th>
<th>The main area to be changed regarding the hospital system in the South East, in order to improve care for Francophone patients:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
<td>Examples:</td>
</tr>
<tr>
<td></td>
<td>- Communication must be available at all levels, at all times. There are two barriers:</td>
</tr>
<tr>
<td></td>
<td>- Language</td>
</tr>
<tr>
<td></td>
<td>- Language level</td>
</tr>
<tr>
<td></td>
<td>- Inform progress regarding French-language service development in the system.</td>
</tr>
<tr>
<td></td>
<td>- Funding for French-language services.</td>
</tr>
<tr>
<td></td>
<td>Success for Francophone patients:</td>
</tr>
<tr>
<td></td>
<td>- Services provided in French from beginning to end, on the same level as Anglophone services</td>
</tr>
<tr>
<td></td>
<td>- Ask for patient’s preferred language upon arrival</td>
</tr>
<tr>
<td></td>
<td>- Minimum of 1 bilingual employee for each work team in order to provide access to French-language services</td>
</tr>
</tbody>
</table>
### Regional Patient Advisory Committee (sessions on October 6, January 14, February 11, and March 11, 2015 and follow-up e-mails)

The ideal patient experience is defined by both people (i.e. providers in the system and how they interact with patients) and system factors:

**People Factors**
- Strong two-way communication between providers and patients/caregivers/family
- Continuity and consistency of providers
- Confidence in staff and quality of care
- Support and advocacy (i.e. non clinical staff)
- Considerate and respectful of each patient/family’s unique needs and involves them in the design of the care plan

**System Factors**
- Seamless and timely access to care, transitions, and follow-up
- Sharing patient information via seamless IT platform
- Seamless communication between providers (i.e. hospitals, specialists, and GPs)
- Accessible care locations and/or effective use of telemedicine
- Strong community resources and primary care that are linked to hospital services

**Access**
- Being given information that allows patients the ability to choose the best care option for them (e.g. transparent wait time information, by available providers and location)
- Receiving emergency, scheduled and specialized treatment/procedures within acceptable time limits, based on leading practices
- Recognition that scheduled services can be geographically further than urgent/emergent services; as long as there is choice
- 24/7 access to care in general, especially for less acute patients (e.g. Primary Care centre with Nurse Practitioners)
- Knowing clearly what the wait times are (“not just sitting on a wait list”)
- Respect for patient time (“being cancelled is OK once, but then you are next”)
- Having support for transportation at limited/no extra cost to the patient, for those that require support
- Having support for free or subsidized parking, special needs parking, for those that require support
- Being able to easily access Primary Care (e.g. community supports, family physician)
- That medical information/records are consistently accessible to providers/patient/caregivers
- That patients can easily navigate the system and there are supports/resources dedicated to support this (e.g. social worker in ED, supports for understanding the process for admission, support for language services)
- Being able to access care outside of physical buildings (i.e. phone support, TeleMedicine)
<table>
<thead>
<tr>
<th>Buildings are physically accessible/pleasant (e.g. wheelchair access, scent-free)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective</td>
</tr>
<tr>
<td>Timely access to modern procedures in accordance with best practices</td>
</tr>
<tr>
<td>Strong communication between providers and patient/family throughout entire care journey (of medical information/records as well)</td>
</tr>
<tr>
<td>Care is respectful and tailored to the unique needs of patients</td>
</tr>
<tr>
<td>System is easily navigated and transitions are seamless</td>
</tr>
<tr>
<td>Patient Experience</td>
</tr>
<tr>
<td>Strong two-way communication between providers and patients / caregivers/ family</td>
</tr>
<tr>
<td>Continuity and consistency of providers</td>
</tr>
<tr>
<td>Considerate and respectful of each patient’s unique needs and involves them in the design of the care plan</td>
</tr>
<tr>
<td>Support and advocacy</td>
</tr>
<tr>
<td>Confidence in staff and quality of care</td>
</tr>
<tr>
<td>Seamless communication between all providers</td>
</tr>
<tr>
<td>Seamless and timely access to care, transitions, and follow-up</td>
</tr>
<tr>
<td>Seamless access to patient information between providers (e.g. IT platforms)</td>
</tr>
<tr>
<td>Accessible care locations and/or remote options (i.e. telemedicine, remote technology, etc.)</td>
</tr>
<tr>
<td>Efficient</td>
</tr>
<tr>
<td>No elimination/removal of key services</td>
</tr>
<tr>
<td>Eliminate duplication of services</td>
</tr>
<tr>
<td>Appropriate resource allocation (e.g. Personal Support Worker instead of nurse, volunteers – when possible)</td>
</tr>
<tr>
<td>Living within our means; affordable</td>
</tr>
<tr>
<td>Services available for free; limited cost for additional/extra or immediate access to services</td>
</tr>
<tr>
<td>Academics</td>
</tr>
<tr>
<td>Centres of Excellence to develop improved procedures and attract partnerships</td>
</tr>
<tr>
<td>Continuing to attract the best and brightest to the region (including community hospitals)</td>
</tr>
<tr>
<td>Teaching partnership with University of Ottawa which has a two-way benefit: offers French-language opportunities for Queen’s students (medicine, nursing and rehab) and French Language Services students at University of Ottawa can build their English-language skills (in Kingston and area)</td>
</tr>
</tbody>
</table>
Centralized Scheduling: Information Working Groups must consider

- Addresses patients’ unique needs
- Interactive
- Provides relevant and complete medical information and instructions tailored to unique needs (e.g. info in French, reminders, transportation, guidelines for those with disabilities)
- Standardized process for booking and triage
- 24/7

**Questions for Working Groups to answer:**
- How do you support access to services for those that need to travel for services (i.e. travel cost)?
- How will special needs (e.g. disability) be taken into consideration (includes travel, communication, and support while in another city, etc.)?
- How will the providers prioritize both medical and social needs?

Centres of Excellence: Information Working Groups must consider

- Accessible
- Must not diminish the quality or efficiency of care provided in the region
- Must determine which service(s) are best suited for a centre of excellence
- Strong-way communication between the centre of excellence and other providers
- French Language Services requirements

**Questions for Working Groups to consider:**
- How will the service best address patient and family needs (e.g. mobile/satellite services, travel/transportation, opening hours, after hours/weekend services, etc.)?
- Which services are most appropriate to centralize?
- What non-physician resources will be required? Do we have enough qualified resources and/or can we attract and retain them?
- How will the system interact with the centre of excellence (e.g. EMS, CCAC, private, community)
- Will the centre of excellence be located in a hospital or in the community?
- Will the funding formula need to be modified? Does the funding follow the patient?
- Will this improve access to specialized services?
- How do you best serve complex chronic patients?
- Can other Ministries collaborate to integrate other needs? (e.g. housing, social services, etc.)

Local Services: Information Working Groups must consider

- Procedure logistics and complexity/urgency
- Remote access for consultation (i.e. technology)
| 5. D&T (March 4th and April 1st) and Clinical (March 5th and April 9th) Working Group Sessions | Diagnostic & Therapeutic and Clinical Working Group Post-Session Survey Responses |

<table>
<thead>
<tr>
<th></th>
<th><strong>Questions for Working Groups to consider:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Is there an opportunity to repurpose ambulatory clinics for after-hours care and diagnostics?</td>
</tr>
<tr>
<td></td>
<td>• Will current staff be trained to meet changing needs?</td>
</tr>
<tr>
<td></td>
<td>• What are enablers to consider (e.g. technology, partnerships)?</td>
</tr>
<tr>
<td></td>
<td>• Will the provision of local services or personnel recruitment be limited/affected?</td>
</tr>
<tr>
<td></td>
<td>• Will the quality of care be improved?</td>
</tr>
<tr>
<td></td>
<td>• Could we realign our services to be more than 9-4?</td>
</tr>
<tr>
<td></td>
<td>• How will the public be educated about a new service design?</td>
</tr>
<tr>
<td></td>
<td><strong>Elective</strong></td>
</tr>
<tr>
<td></td>
<td>• The focus and direction of the work really needs to be vetted further with patients and their families (i.e., moving services to the community, central intake models, consolidation of services)</td>
</tr>
<tr>
<td></td>
<td><strong>Tertiary/Quaternary</strong></td>
</tr>
<tr>
<td></td>
<td>• Difficulty separating specialty services from tertiary/quaternary and most discussion was focused on specialty services. There was virtually no discussion about public health / prevention / etc.</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent/Emergent</strong></td>
</tr>
<tr>
<td></td>
<td>• Very little of what this working group is tasked to do is within the realm of the Emergency Department. It is all about appropriate input and output. Focus on those and not the throughput as that will be taken care of if the others are fixed. Start talking about the overall Emergency Service in the LHIN. Do we have the correct structure? Should we have all those ER’s? Should they all be open at night? How could we improve the system?</td>
</tr>
<tr>
<td></td>
<td>• A greater focus on model for improvement i.e. lean quality improvement to deploy locally and regionally. We really need greater clarity if we are going to be able to plan on new electronic medical record information system.</td>
</tr>
<tr>
<td></td>
<td><strong>Complex Chronic</strong></td>
</tr>
<tr>
<td></td>
<td>• I feel there is still difficulty in having paramedic services accepted into the circle of care.</td>
</tr>
<tr>
<td></td>
<td><strong>Laboratory</strong></td>
</tr>
</tbody>
</table>
In diagnostics, it is more than the patient, the clinician ordering the test is as important as the patient since they use the information to diagnose and treat.

- The exclusion of private labs from scope of project makes it impossible for patient-centred discussions to meaningfully occur.

**Diagnostic Imaging**

- What SECHEF is trying to “fix”, what is "broken" is not clear. Are we trying to save money? If so, be clear. If we are trying to provide care close to home--that involves primary care (predominately IHFs) and MOH IHF representative not at table. Are we providing DI service to physician practices? Then we need to know where those practices are and what the requirements are?

**Pharmacy**

- We need clear direction from CEO’s / LHIN whether there will be a Regional CEO; Regional Board or staying with current CEO / Board model.

- We need clarity with respect to the outcomes: is the goal to improve quality, reduce costs, or both? It would also be most helpful to know why acute care costs are relatively high in our LHIN and which hospital(s) are the primary contributors?
Table of Contents

1. Introduction
2. Our Engagement Approach
3. Participation in Community Engagement Events
4. Summary of Survey Results (Quantitative Response Analysis)
5. Qualitative Response Analysis
6. Open Houses
7. Final comments
1. Introduction

In the spring of 2014, the South East Local Health Integration Network (LHIN) along with its partners in the South East Community and Hospital Executive Forum (SECHEF) launched the Hospital Services Project. The purpose of the project is to develop and implement options for the sustainment of a viable hospital system. In order to refine any options under consideration, community engagement was required seeking local community input into the process and associated options. The engagement included hospital partners who were also looking for input for local community initiatives underway at some sites. All engagement was conducted collaboratively with local hospitals with a view to improving patient experience, quality, and sustainability in a regional model of health care. The importance of community services in this process was not lost as they are recognized as key contributors to the development of the local health system.

ENGAGEMENT FOR HEALTH CARE TOMORROW

Community engagement for the Hospital Services Project provided multiple opportunities for the public and other partners to get involved. Public input into decision-making is of great value and the LHIN and health service providers committed to meaningful engagement regarding system future planning and to inform the development of options for the project. The objectives of the community engagement included:

- To inform and consult with community stakeholders and the general public about their beliefs for a system of sustainable health care.
- To involve in active feedback on areas of the health care system that is important to them.
- To engage a broad and diverse range of participants from across the region in discussions to inform the future of local health care services.
This report describes the engagement activities and what the South East LHIN and its partners heard from participants. The feedback received to date will be used to guide hospital leaders in their deliberations for a sustainable health care system via the Hospital Services Project.

2. Our Engagement Approach

2.1 Intent
The development of options for the Hospital Services Project is informed by a multipronged approach. The final decisions will be guided by three key components:

1. Strategic Priorities that are informed by provincial priorities, including the Patients First: Ontario’s Action Plan for Health Care and Health System Funding Reform.

2. Environmental Scan, including:
   a. Quantitative analysis including a reflection on the implications of the funding model on regional and local services
   b. Leading practices input provided by external experts
   c. Local expert input through focus work team deliberations

3. Community Engagement that pursued a strategy that included:
   a. Outreach to provincial, municipal and county leaders to inform and increase knowledge and awareness about the project
   b. Governance to governance education sessions to increase knowledge and understanding about the ongoing conversation
   c. Staff engagement to inform and create awareness and understanding about the project activities
   d. Public web engagement with specific questions
   e. Additional dialogue opportunities through ‘open houses’

2.2 Online Engagement and Analysis
To assist the South East LHIN and SECHEF and to hear from as many local community members as possible, a decision was made to employ a web based survey. The survey instrument was developed by the South East LHIN with external input to ensure robust questionnaire design and validity of responses. The tool that was deployed through Survey Monkey was made public on April 29 and scheduled to close on May 29. As there were added requests for open houses, the survey was extended to June 5.

The distribution of the online survey was supported by media advertising and news articles across the South East LHIN, both in local newspapers and on the radio. The choice to deploy an online survey rested on the opportunity for local residents and staff to be able to choose the time of day when they were able to participate. This access opportunity provided a venue for those who may have been restricted from attending any in-person events. Understanding that the on-line access may be a barrier for some, a paper copy was also made available and distributed upon request to support those unable to complete the web based version.
The survey was also supported by a web-based portal at www.healthcaretomorrow.ca by which those seeking further information on the Hospital Project as well as other LHIN activities and a Health Care System overview could locate the required information. The portal was also the primary access point for the French-based survey as to encourage Francophone participation.

The survey design assumed a simple random sample of the South East LHIN population, as well as patients and clients who utilize health care services within the South East LHIN geography. Although this is not a very robust design, it is still capable of generating reliable estimates for South East LHIN residents and users of services. The results are however, not necessarily representative of population subgroups (i.e. regional geographies, demographic groups or individuals with certain conditions like mental health issues may not be well represented in the analysis). They can though, serve as an indicator of general feedback, a reference for corroborating findings and additional evidence in support of health service planning.

The analysis was based on data collected up to the survey close on June 5th. A series of quality assurance checks were employed prior to generating final estimates. This process resulted in 188 of the 1,723 responses having to be removed, mainly because of incompletions to the survey instrument. Quantitative analysis was conducted using SPSS ver 21 while qualitative analysis utilized QSR Nvivo ver 10.

2.3 Open Houses
Recognizing that some of the public may not be comfortable sharing comments online, an additional feedback mechanism was established to reach more population subgroups. Open Houses were utilized as a means to meet with members of the public and organizational staff interested in learning more about the Hospital Services Project and other health care activities. This format provided the opportunity for those in attendance to present ideas, share opinions and to discuss concerns. Items brought forward during those sessions were also collected and thematically incorporated into the overall analysis.

3. Participation in Community Engagement Activities

Overall, the reply to the public engagement was exceptional and exceeded any previous response rate. The high level of participation is likely attributable to the communications strategy that included stakeholder, employee and community outreach. Table 1 provides an overview of the level of participation for each mode of engagement.

<table>
<thead>
<tr>
<th>Engagement</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web-based Survey</td>
<td>1,535 completed responses</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Francophone</td>
<td>56 completed responses</td>
</tr>
<tr>
<td>Open House</td>
<td>351</td>
</tr>
<tr>
<td>Written submissions</td>
<td>30</td>
</tr>
</tbody>
</table>
4. Summary of Survey Results

4.1 Who we heard from

**Respondent Geography of Residence and Hospital Corporation Mostly Utilized**

Figure 1 shows the distribution of respondents from the survey by Health Link area of residence and by hospital most used for services. The Quinte Health Link, comprising Belleville, Quinte West, Prince Edward County and Brighton, was represented by the largest number of respondents (533 or 36% of completed respondents), most of whom utilized the services of Quinte Healthcare Corporation (QHC) as the primary hospital corporation. The 365 (or a quarter of overall) respondents from Kingston Health Link utilized Kingston General Hospital (KGH) as the main hospital site followed by Hotel Dieu Hospital (HDH) for ambulatory services. Brockville General Hospital (BGH) was mostly used by the residents of Thousands Islands Health Link which recorded 327 (or 22%) respondents while Rideau-Tay Health Link accounted for 120 respondents, most of whom attended the Perth and Smiths Falls District Hospital (PSFDH). Apart from the Rural Hastings Health Link with 65 respondents who mostly utilized only the QHC facility, the other rural Health Links depended on multiple sites for receiving hospital care. When compared to the actual distributions across the LHIN, the Quinte Health Link was largely over-represented and all other Health Links were the opposite. For hospitals QHC and BGH are the only facilities with an over-representation of respondents.

![Figure 1: Geographical distribution of respondents by Health Link and Hospital Most Used for Services.](image-url)
Respondent Age-Sex Distribution

Age distribution (Figure 3) of survey respondents was somewhat variable across hospital corporations, with higher percentages of seniors (>32%) but lower percentages of young adults (21% or less) in QHC and PSFDH. The opposite was just the case in BGH and KGH. For gender (Figure 4), there was a slightly higher percentage of female respondents (>80%) for the Kingston area hospitals than the other areas in the LHIN (<75%). It should be noted that Providence Care (PC), is an anomaly due to the very low volume in survey response. Results for this hospital need to be interpreted with caution.

Francophone Distribution

In the survey, Francophone respondents accounted for four percent (56 responses) which is just above the actual percentage for the LHIN as a whole (Figure 4). The majority of the francophone population mainly utilized QHC (46.4%) and HDH (30.4%) whereas the non-francophone was more distributed among the other hospital sites (Figure 5). Note that the definition of francophone is based on the recommendation from the French Language Health Services Network of Eastern Ontario.

Figure 2: Age distribution of survey respondents

Figure 3: Gender distribution of survey respondents

Figure 4: Distribution of primary language for survey responses

Figure 5: Distribution of Francophone responses by Hospital Corporation
Respondent Role in Health Care System
Respondents in the survey were asked whether their role in the health care system was from the perspective of a recent patient/other community member or a health care provider. When examined at the hospital corporation level seven out of every 10 respondents answered on behalf of the community for the BGH, QHC and PSFDH sites (Figure 6). This was less than half for the Kingston area sites. It was important to account for this factor in the responses for the remaining components of the survey, so in some cases the results may be provided separately for each of the respondent roles.

Figure 6: Distribution of survey respondents by Role in Health Care System
4.2 What we heard

Which services should be higher priority for the health care system?

Table 1 provides a summary of results for the average rank (1-5), of the top five priority areas for the local health care system. Areas of priority transition from dark green color for lower priority to bright red if the service were considered to be a top priority. Almost uniform across all hospital sites, respondents indicated that emergency/urgent care and access to family doctors or other primary care providers should be top priority services. These results were also consistent with other engagement types employed by the LHIN. Interestingly, health promotion and disease prevention rated as the third highest priority.

Some differences in priorities were however observed across urban/rural hospital corporations. Urban centres tended to place more emphasis on the need for home care services and consider transportation to health care to be less of a priority. This is in contrast to our rural organizations which accentuate the need for transportation to health care, physiotherapy or other rehabilitation services and long-term care (also called “nursing homes”) as priorities.

It is worthwhile to note that while transportation was rated as a lower priority service, there is recognition that the survey may not have reached those most affected by lack of access to transportation services. More investigation will be required to solicit feedback from this population subgroup.

Table 1: Average Rank (1-5) for top five areas of high priority for the local health care system

<table>
<thead>
<tr>
<th>Service Areas</th>
<th>BGH</th>
<th>HDH</th>
<th>KGH</th>
<th>LACGH</th>
<th>PSFDH</th>
<th>PC*</th>
<th>QHC</th>
<th>SELHIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promotion and disease prevention (e.g., smoking cessation, healthy eating)</td>
<td>2.8</td>
<td>3.0</td>
<td>2.9</td>
<td>3.2</td>
<td>2.8</td>
<td>3.3</td>
<td>3.0</td>
<td>2.91</td>
</tr>
<tr>
<td>Chronic disease management support (e.g., diabetes care, stroke prevention, etc.)</td>
<td>3.4</td>
<td>3.3</td>
<td>3.0</td>
<td>3.5</td>
<td>3.0</td>
<td>3.0</td>
<td>3.4</td>
<td>3.26</td>
</tr>
<tr>
<td>Addiction and mental health services</td>
<td>3.2</td>
<td>3.0</td>
<td>3.0</td>
<td>3.4</td>
<td>3.1</td>
<td>2.3</td>
<td>3.2</td>
<td>3.12</td>
</tr>
<tr>
<td>Palliative/end-of-life care (e.g., counselling services, residential hospice)</td>
<td>3.5</td>
<td>3.3</td>
<td>3.3</td>
<td>2.9</td>
<td>3.3</td>
<td>3.0</td>
<td>3.3</td>
<td>3.34</td>
</tr>
<tr>
<td>Access to family doctors or other primary health care providers</td>
<td>2.3</td>
<td>2.3</td>
<td>2.7</td>
<td>2.5</td>
<td>2.0</td>
<td>2.8</td>
<td>2.2</td>
<td>2.27</td>
</tr>
<tr>
<td>Access to diagnostic testing (e.g., bloodwork, x-ray, ultrasound)</td>
<td>3.1</td>
<td>3.1</td>
<td>3.2</td>
<td>3.0</td>
<td>3.1</td>
<td>4.0</td>
<td>3.2</td>
<td>3.12</td>
</tr>
<tr>
<td>Home care services for the elderly or people with serious chronic illnesses (e.g., assistance with bathing or meal preparation in their own homes)</td>
<td>3.3</td>
<td>3.0</td>
<td>2.8</td>
<td>3.4</td>
<td>3.0</td>
<td>2.0</td>
<td>3.3</td>
<td>3.09</td>
</tr>
<tr>
<td>Long-term care (also called “nursing homes”)</td>
<td>3.5</td>
<td>3.2</td>
<td>3.0</td>
<td>2.9</td>
<td>3.1</td>
<td>3.6</td>
<td>3.7</td>
<td>3.35</td>
</tr>
<tr>
<td>Physiotherapy or other rehabilitation services</td>
<td>3.8</td>
<td>4.1</td>
<td>3.7</td>
<td>3.9</td>
<td>3.9</td>
<td>3.4</td>
<td>4.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Access to specialists</td>
<td>3.1</td>
<td>2.9</td>
<td>3.1</td>
<td>3.2</td>
<td>3.6</td>
<td>3.3</td>
<td>3.2</td>
<td>3.14</td>
</tr>
<tr>
<td>Emergency/urgent care</td>
<td>2.1</td>
<td>2.4</td>
<td>2.4</td>
<td>1.8</td>
<td>2.5</td>
<td>1.0</td>
<td>2.1</td>
<td>2.16</td>
</tr>
<tr>
<td>Other hospital-based care</td>
<td>3.7</td>
<td>3.8</td>
<td>3.7</td>
<td>3.2</td>
<td>3.9</td>
<td>3.7</td>
<td>3.7</td>
<td>3.68</td>
</tr>
<tr>
<td>Transportation to health care services</td>
<td>3.9</td>
<td>4.1</td>
<td>4.4</td>
<td>4.2</td>
<td>4.2</td>
<td>4.0</td>
<td>4.0</td>
<td>4.11</td>
</tr>
</tbody>
</table>

* PC only had 14 respondents to this question; Results should be interpreted with caution
Which services are more important?

Responses to priority ranking were divided into two different charts as there was some variation by respondent role. Table 2a demonstrates patient perspectives while Table 2b illustrates priorities for providers. According to our patients/community members across all hospital corporations, primary care is a high priority along with access to a 24 hour emergency department. On the opposite end of the spectrum, palliative care services and long-term care facilities appear to be a lower concern.

Differences within service areas can be seen by comparing responses by hospital facilities. Generally primary care, minor procedures, basic and advanced tests were not viewed as high a priority for most providers. In contrast providers ranked mental health and long term care as being higher priority services and to a smaller extent more supports for patients to be managed at home. Facilities such as LACGH and QHC in particular also place a higher priority on access to long-term and palliative care services.

Table 2a: Average Rank (1-15) for Service in Order of Importance to Respondents – Community Perspective

<table>
<thead>
<tr>
<th>Service Area</th>
<th>BGH</th>
<th>HDH</th>
<th>KGH</th>
<th>LACGH</th>
<th>PSFDH</th>
<th>PC*</th>
<th>QHC</th>
<th>SELHIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care (family physician, nurse practitioner)</td>
<td>4.1</td>
<td>2.7</td>
<td>3.9</td>
<td>1.6</td>
<td>3.2</td>
<td>5.8</td>
<td>3.0</td>
<td>3.4</td>
</tr>
<tr>
<td>After hours urgent care clinic (also called a walk-in clinic)</td>
<td>6.2</td>
<td>6.4</td>
<td>6.7</td>
<td>6.7</td>
<td>7.4</td>
<td>7.8</td>
<td>7.0</td>
<td>6.7</td>
</tr>
<tr>
<td>24 hour emergency department</td>
<td>3.6</td>
<td>4.5</td>
<td>5.4</td>
<td>3.3</td>
<td>4.2</td>
<td>3.4</td>
<td>3.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Access to a hospital bed when I need it</td>
<td>5.7</td>
<td>5.9</td>
<td>5.9</td>
<td>5.5</td>
<td>5.8</td>
<td>5.2</td>
<td>5.7</td>
<td>5.7</td>
</tr>
<tr>
<td>Specialist services including surgery</td>
<td>5.7</td>
<td>5.9</td>
<td>6.0</td>
<td>6.8</td>
<td>6.6</td>
<td>5.8</td>
<td>6.4</td>
<td>6.2</td>
</tr>
<tr>
<td>Other procedures (e.g., cataracts, endoscopy, minor surgery)</td>
<td>8.7</td>
<td>8.8</td>
<td>8.9</td>
<td>7.8</td>
<td>8.2</td>
<td>10.6</td>
<td>8.4</td>
<td>8.5</td>
</tr>
<tr>
<td>Physiotherapy or other rehabilitation care</td>
<td>10.7</td>
<td>10.4</td>
<td>9.5</td>
<td>9.7</td>
<td>8.9</td>
<td>5.8</td>
<td>9.7</td>
<td>9.8</td>
</tr>
<tr>
<td>Mental health and addiction services</td>
<td>10.0</td>
<td>9.7</td>
<td>9.5</td>
<td>10.7</td>
<td>10.0</td>
<td>6.0</td>
<td>10.5</td>
<td>10.1</td>
</tr>
<tr>
<td>Cancer services</td>
<td>9.2</td>
<td>8.5</td>
<td>8.5</td>
<td>8.5</td>
<td>9.4</td>
<td>9.2</td>
<td>8.4</td>
<td>8.7</td>
</tr>
<tr>
<td>Health clinics for specific chronic diseases (e.g., diabetes education, mental health, stroke)</td>
<td>10.6</td>
<td>9.8</td>
<td>9.1</td>
<td>9.4</td>
<td>10.4</td>
<td>9.6</td>
<td>10.4</td>
<td>10.2</td>
</tr>
<tr>
<td>Palliative/end-of-life care (e.g., counselling, hospice)</td>
<td>9.9</td>
<td>10.7</td>
<td>10.2</td>
<td>11.7</td>
<td>10.1</td>
<td>10.6</td>
<td>11.0</td>
<td>10.5</td>
</tr>
<tr>
<td>Long-term care facilities (also called “nursing homes”)</td>
<td>11.1</td>
<td>10.9</td>
<td>11.2</td>
<td>12.2</td>
<td>9.7</td>
<td>9.8</td>
<td>11.3</td>
<td>11.1</td>
</tr>
<tr>
<td>More supports to live at home longer (assisted living)</td>
<td>10.5</td>
<td>9.5</td>
<td>8.7</td>
<td>10.4</td>
<td>8.4</td>
<td>12.0</td>
<td>9.9</td>
<td>9.7</td>
</tr>
<tr>
<td>Basic tests (lab, x-ray, ultrasound)</td>
<td>6.8</td>
<td>7.8</td>
<td>8.2</td>
<td>6.8</td>
<td>8.3</td>
<td>9.4</td>
<td>7.4</td>
<td>7.5</td>
</tr>
<tr>
<td>Advanced tests (e.g., MRI, CT Scan, Interventional Radiology)</td>
<td>7.2</td>
<td>8.5</td>
<td>8.4</td>
<td>9.0</td>
<td>9.5</td>
<td>9.0</td>
<td>7.8</td>
<td>8.0</td>
</tr>
</tbody>
</table>

* PC only had 14 respondents to this question; Results should be interpreted with caution
Table 2b: Average Rank (1-15) for Service in Order of Importance to Respondents – Provider Perspective

<table>
<thead>
<tr>
<th>Service Area</th>
<th>BGH</th>
<th>HDH</th>
<th>KGH</th>
<th>LACGH</th>
<th>PSFDH</th>
<th>PC*</th>
<th>QHC</th>
<th>SELHIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care (family physician, nurse practitioner)</td>
<td>4.7</td>
<td>4.2</td>
<td>4.1</td>
<td>3.4</td>
<td>3.2</td>
<td>3.0</td>
<td>3.7</td>
<td>4.0</td>
</tr>
<tr>
<td>After hours urgent care clinic (also called a walk-in clinic)</td>
<td>5.2</td>
<td>6.0</td>
<td>6.8</td>
<td>6.8</td>
<td>5.3</td>
<td>4.2</td>
<td>7.3</td>
<td>6.5</td>
</tr>
<tr>
<td>24 hour emergency department</td>
<td>3.6</td>
<td>4.9</td>
<td>4.6</td>
<td>4.3</td>
<td>5.1</td>
<td>5.9</td>
<td>3.6</td>
<td>4.2</td>
</tr>
<tr>
<td>Access to a hospital bed when I need it</td>
<td>7.1</td>
<td>6.0</td>
<td>5.3</td>
<td>6.2</td>
<td>6.3</td>
<td>6.1</td>
<td>5.7</td>
<td>5.9</td>
</tr>
<tr>
<td>Specialist services including surgery</td>
<td>7.1</td>
<td>6.5</td>
<td>6.7</td>
<td>7.3</td>
<td>7.4</td>
<td>6.6</td>
<td>7.1</td>
<td>6.9</td>
</tr>
<tr>
<td>Other procedures (e.g., cataracts, endoscopy, minor surgery)</td>
<td>9.3</td>
<td>9.4</td>
<td>10.3</td>
<td>10.1</td>
<td>10.2</td>
<td>9.1</td>
<td>10.0</td>
<td>9.9</td>
</tr>
<tr>
<td>Physiotherapy or other rehabilitation care</td>
<td>9.8</td>
<td>9.9</td>
<td>9.9</td>
<td>9.1</td>
<td>9.5</td>
<td>8.6</td>
<td>10.0</td>
<td>9.8</td>
</tr>
<tr>
<td>Mental health and addiction services</td>
<td>8.0</td>
<td>8.0</td>
<td>8.4</td>
<td>9.4</td>
<td>7.5</td>
<td>5.8</td>
<td>9.0</td>
<td>8.4</td>
</tr>
<tr>
<td>Cancer services</td>
<td>9.3</td>
<td>8.2</td>
<td>8.3</td>
<td>8.9</td>
<td>9.1</td>
<td>10.6</td>
<td>8.3</td>
<td>8.6</td>
</tr>
<tr>
<td>Health clinics for specific chronic diseases (e.g., diabetes education, mental health, stroke)</td>
<td>9.6</td>
<td>9.6</td>
<td>9.2</td>
<td>10.3</td>
<td>8.8</td>
<td>9.1</td>
<td>9.8</td>
<td>9.5</td>
</tr>
<tr>
<td>Palliative/end-of-life care (e.g., counselling, hospice)</td>
<td>10.3</td>
<td>10.5</td>
<td>10.3</td>
<td>9.0</td>
<td>10.2</td>
<td>10.4</td>
<td>9.4</td>
<td>10.0</td>
</tr>
<tr>
<td>Long-term care facilities (also called “nursing homes”)</td>
<td>10.1</td>
<td>10.4</td>
<td>9.5</td>
<td>8.5</td>
<td>9.9</td>
<td>9.6</td>
<td>10.0</td>
<td>9.9</td>
</tr>
<tr>
<td>More supports to live at home longer (assisted living)</td>
<td>9.8</td>
<td>9.1</td>
<td>7.8</td>
<td>8.8</td>
<td>8.5</td>
<td>7.4</td>
<td>9.0</td>
<td>8.7</td>
</tr>
<tr>
<td>Basic tests (lab, x-ray, ultrasound)</td>
<td>7.3</td>
<td>8.4</td>
<td>9.7</td>
<td>8.5</td>
<td>8.5</td>
<td>11.8</td>
<td>8.5</td>
<td>8.7</td>
</tr>
<tr>
<td>Advanced tests (e.g., MRI, CT Scan, Interventional Radiology)</td>
<td>8.8</td>
<td>9.0</td>
<td>9.2</td>
<td>9.5</td>
<td>10.5</td>
<td>11.9</td>
<td>8.6</td>
<td>9.1</td>
</tr>
</tbody>
</table>

* PC only had 14 respondents to this question; Results should be interpreted with caution
What concerns individuals most about the potential of a service being moved out of the community?

Responses to this question also had some variation between the community (Table 3a) and providers (Table 3b) which warranted separate reporting for each role. Losing health care providers was the predominant concern across all facilities although more so from the perspective of the community than of the provider. Along the same lines, losing other health care resources was also considered to be a major concern almost equally at the community and provider levels. To a lesser degree but still across majority of facilities, both community and providers had concerns about being able to access services when needed or if they happen to be changed.

Although neither of the remaining concerns listed in the survey did not appear to be significant concerns overall, there were interesting facility specific differences between the community and providers. The most noteworthy among these were the additional travel cost to receive health care services for providers associated with HDH and LACGH facilities. PSFDH community respondents also felt that it was a challenge to find transportation to access health services to another community, possibly even services that are available in another LHIN jurisdiction.

Table 3a: Average Rank (1-7) for Main Concern around the Potential of a Service being moved out of the Community – Community Perspective

<table>
<thead>
<tr>
<th>Concern</th>
<th>BGH</th>
<th>HDH</th>
<th>KGH</th>
<th>LACGH</th>
<th>PSFDH</th>
<th>PC*</th>
<th>QHC</th>
<th>SELHIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult to find transportation to another community</td>
<td>4.9</td>
<td>5.2</td>
<td>4.6</td>
<td>5.8</td>
<td>4.0</td>
<td>5.6</td>
<td>4.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Added cost of travelling</td>
<td>4.9</td>
<td>5.1</td>
<td>4.5</td>
<td>5.2</td>
<td>4.6</td>
<td>3.0</td>
<td>5.0</td>
<td>4.9</td>
</tr>
<tr>
<td>Economic impact to my community</td>
<td>4.6</td>
<td>5.1</td>
<td>5.3</td>
<td>4.7</td>
<td>5.1</td>
<td>5.4</td>
<td>4.9</td>
<td>4.9</td>
</tr>
<tr>
<td>Not knowing how to access what I need when I need it</td>
<td>4.3</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.4</td>
<td>3.2</td>
<td>4.3</td>
<td>4.2</td>
</tr>
<tr>
<td>Losing a community resource</td>
<td>3.7</td>
<td>3.6</td>
<td>4.1</td>
<td>2.9</td>
<td>3.9</td>
<td>3.6</td>
<td>3.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Losing health care professionals (e.g., physicians)</td>
<td>2.7</td>
<td>2.3</td>
<td>3.0</td>
<td>2.7</td>
<td>3.0</td>
<td>4.4</td>
<td>2.4</td>
<td>2.6</td>
</tr>
</tbody>
</table>

* PC only had 14 respondents to this question; Results should be interpreted with caution

Table 3b: Average Rank (1-7) for Main Concern around the Potential of a Service being moved out of the Community – Provider Perspective

<table>
<thead>
<tr>
<th>Concern</th>
<th>BGH</th>
<th>HDH</th>
<th>KGH</th>
<th>LACGH</th>
<th>PSFDH</th>
<th>PC*</th>
<th>QHC</th>
<th>SELHIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult to find transportation to another community</td>
<td>4.5</td>
<td>4.3</td>
<td>4.7</td>
<td>4.9</td>
<td>5.0</td>
<td>3.6</td>
<td>5.0</td>
<td>4.7</td>
</tr>
<tr>
<td>Added cost of travelling</td>
<td>4.5</td>
<td>4.0</td>
<td>4.8</td>
<td>4.0</td>
<td>4.5</td>
<td>4.2</td>
<td>4.8</td>
<td>4.6</td>
</tr>
<tr>
<td>Economic impact to my community</td>
<td>4.2</td>
<td>4.9</td>
<td>5.0</td>
<td>4.4</td>
<td>4.5</td>
<td>5.1</td>
<td>4.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Not knowing how to access what I need when I need it</td>
<td>4.4</td>
<td>4.1</td>
<td>3.9</td>
<td>5.0</td>
<td>4.7</td>
<td>4.3</td>
<td>4.4</td>
<td>4.3</td>
</tr>
<tr>
<td>Losing a community resource</td>
<td>3.7</td>
<td>4.0</td>
<td>3.6</td>
<td>3.3</td>
<td>3.0</td>
<td>4.3</td>
<td>3.6</td>
<td>3.6</td>
</tr>
<tr>
<td>Losing health care professionals (e.g., physicians)</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
<td>3.1</td>
<td>3.1</td>
<td>3.3</td>
<td>2.7</td>
<td>3.1</td>
</tr>
</tbody>
</table>

* PC only had 14 respondents to this question; Results should be interpreted with caution
What is the most important issue when deciding to seek treatment of more specialized care?
The most important issue in deciding to seek treatment was evidently the wait time until you can actually access the treatment (Table 4). This was followed by the reputation of the specialist providing the treatment and whether it was a Centre of Excellence for a specific treatment (i.e., Heart Institute). This result is suggestive that seeking timely treatment is important and there is also the possibility that residents are willing to travel if it means that they can access treatment more quickly. There were no notable differences between the community and provider responses for this question.

Table 4: Average Rank (1-6) for Most Important Issue when Deciding to Seek Treatment if more Specialized Care is needed

<table>
<thead>
<tr>
<th>Most Important Issue</th>
<th>BGH</th>
<th>HDH</th>
<th>KGH</th>
<th>LACG</th>
<th>PSFD</th>
<th>PC*</th>
<th>QHC</th>
<th>SELHI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wait time until you can access the treatment</td>
<td>2.3</td>
<td>2.1</td>
<td>2.1</td>
<td>2.0</td>
<td>2.1</td>
<td>1.9</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Reputation of specialist providing treatment</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.7</td>
<td>2.9</td>
<td>2.8</td>
<td>2.7</td>
<td>2.6</td>
</tr>
<tr>
<td>A Centre of Excellence that specializes in the treatment</td>
<td>2.9</td>
<td>2.9</td>
<td>2.7</td>
<td>3.4</td>
<td>3.0</td>
<td>2.9</td>
<td>2.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Access to timely information regarding treatment and follow-up</td>
<td>3.7</td>
<td>3.7</td>
<td>3.6</td>
<td>3.5</td>
<td>3.6</td>
<td>3.9</td>
<td>3.8</td>
<td>3.7</td>
</tr>
<tr>
<td>Distance to travel from home to place providing treatment</td>
<td>4.3</td>
<td>4.8</td>
<td>4.9</td>
<td>4.5</td>
<td>4.1</td>
<td>4.6</td>
<td>4.4</td>
<td>4.5</td>
</tr>
<tr>
<td>Previous experience with the provider</td>
<td>5.1</td>
<td>5.1</td>
<td>5.2</td>
<td>4.9</td>
<td>5.1</td>
<td>5.0</td>
<td>5.2</td>
<td>5.1</td>
</tr>
</tbody>
</table>

* PC only had 14 respondents to this question; Results should be interpreted with caution

more important | less important
5. Qualitative Analysis

Qualitative information (unstructured, non-numerical), was analyzed using the NVivo software package. Information was classified, sorted and arranged by question and response. To identify trends in responses, information was cross-examined by question using frequency queries. Geographic identifiers (Health Link location) were used to explore regional differences. Data was then coded by emerging patterns and examined for trends using frequency distributions.

As suggested by previous results, information was explored by comparing differences between patient/community member and provider responses. Table 5 summarizes the overall and sub-level components discovered through analysis for each of the respective groups.

Table 5: High Level Themes captures by patient response to Health Care Tomorrow.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Provider</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access i.e. wait times in ED, for diagnostics, walk-in clinics, 24-hour Non-Urgent care centre</td>
<td>Access i.e. wait times in ED, proximity, choice</td>
</tr>
<tr>
<td>2</td>
<td>Quality of care i.e. staffing challenges, better communication</td>
<td>Quality of care i.e. show compassion, respect patients, involve families</td>
</tr>
<tr>
<td>3</td>
<td>System integration i.e. better linkages with primary care, improved communication providing more timely updates on patients</td>
<td>Provision of care i.e., improved communication between providers, cleanliness of site</td>
</tr>
</tbody>
</table>

Overall what did not work?
- Waits/delays which were long, no sense of urgency
- Not understanding or not knowing what was happening due to poor communication from care providers
- Care providers lack compassion and care, have no bedside manner, are rude and unkind, unprofessional
- Services are disjointed, there is no follow-through/ follow-up after I leave the hospital, there is a lack of communication between the physician and patient
- Poor quality: food, unclean environment, condition of building

Overall what worked well?
- Caring Staff who are knowledgeable
- Proximity to Services
- Access to Specialists/Programs
- Quick wait times
5.1 Access
Access was a central theme in the qualitative analysis and was identified at both the level of the community as well as the provider (Figure 7). As in the quantitative results, reducing wait times, especially in the ER and for diagnostic tests stood out as significant concerns regardless of role. From the community perspective proximity of health services was also viewed as somewhat important particularly as a local hospital or primary health care site. Availability of options was also mentioned though to a much smaller degree. From the provider perspective respondents would like some consideration towards utilizing nurse practitioners, especially for non-urgent cases. There was also an appeal for access to a 24-hour clinic in both the Quinte and Thousand Islands Health Links.

Figure 7: Response from the community and provider perspectives - Access
5.2 Quality of Care

Quality of care from the perspective of the community can be enhanced by providing informed or compassionate care. Patients should be respected and physicians should seek to understand the concerns of their patients showing patience and accommodating family members of patients and clients. Community education and promotion of available services has also been suggested as a mechanism to improve quality of care overall.

Figure 8: Response from the community perspective – Quality of Care
5.3 Provision of Service

Provision of service was one of the central themes that resonated among community respondents (Figure 9). Overall patients indicated that some staff may be fatigued effecting the quality of care that is being received by the individual. It was also indicated that improved communication amongst various health care providers and between provider and patient, including response times would overall provide a better patient experience. Furthermore it was noted that facilities within the region need to improve their environmental cleanliness and perhaps upgrade facilities.

Figure 9: Response from the community perspective – Provision of Service
5.4 Staffing
A number of noteworthy areas evolved as the Staffing theme was examined in more detail (Figure 10). Providers indicated concerns about interprofessional relationships, more specifically the respect and communication towards one another, however, providers also regarded the Patient to Staff ratio to be unsafe and a major cause of the stress and environmental tension.

Figure 10: Response from the provider perspective – Staffing

5.5 System Integration
The final theme that was identified from a provider perspective was system integration (Figure 11). Providers indicated a desire for more system integration, including better linkages with primary care and improved communication across services. Another concern is the referral process to community supports but more importantly long-term care. Overall providers felt that improved technology could support system integration by allowing for timely updates creating a conduit for communication.

Figure 11: Response provider perspective – System Integration
6. Open Houses

Open houses are defined by the International Association of Public Participation (IAP2) as an informal setting with multiple displays where participants rotate through stations and discuss specific topics with project staff. Information is presented cafeteria-style, with participants ‘shopping’ for information of interest.

This type of community engagement sits at the ‘Inform’ level of the IAP2 spectrum.

The ‘Open Houses’ as part of the Health Care Tomorrow initiative were provided as an extension of the web-based survey, to reach out to more communities and provide an opportunity for residents to participate in the engagement process that may not have access to, or be comfortable with an online feedback mechanism. The ‘Open Houses’ also allowed participants to complete the survey on-site via iPads or through a paper-based format.

Despite extensive media coverage and outreach, attendance at most of the sessions was modest but resulted in 351 total participants at the sessions. Sites and attendances rates are provided in the chart below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bancroft</td>
<td>36</td>
</tr>
<tr>
<td>Brockville</td>
<td>40</td>
</tr>
<tr>
<td>Picton</td>
<td>63</td>
</tr>
<tr>
<td>Quinte West</td>
<td>34</td>
</tr>
<tr>
<td>Napanee</td>
<td>10</td>
</tr>
<tr>
<td>Kingston</td>
<td>29</td>
</tr>
<tr>
<td>Perth</td>
<td>12</td>
</tr>
<tr>
<td>Smiths Falls</td>
<td>11</td>
</tr>
<tr>
<td>Brighton</td>
<td>24</td>
</tr>
<tr>
<td>Belleville</td>
<td>29</td>
</tr>
<tr>
<td>Westport</td>
<td>47</td>
</tr>
<tr>
<td>Sharbot Lake</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>351</strong></td>
</tr>
</tbody>
</table>

These sessions were supported by various members of SECHEF and board members who also participated in informing and gathering feedback. This format provided the chance for the public to present ideas, to share opinions and to discuss concerns. Reflections from attendees were captured during each session by on-site recorders.

The items brought forward were collected and grouped into five main themes as follows:

- Patient care;
- Models of care/Services;
- Information sharing/communication;
- Funding; and
- Seniors care
More specifically, the main themes included the following opinions:

- Need for better access to a physician or primary care provider;
- Retain 24-hour emergency services in local communities/close to home;
- Need for in-patient beds close to home;
- There is a willingness to travel for specialized procedures;
- Community Support Services are essential in rural areas;
- Concerns over changes in community supports offered by the Community Care Access Centre; and
- In general, there appears to be a lack of understanding or clarity about the types of services available in their local communities or hospital.

The items reflected here are a compilation of those most frequently mentioned. Other areas of feedback were provided and will be included in the more comprehensive analysis for the IHSP that is still underway.
7. Final Comments

The community engagement process for Health Care Tomorrow – Hospital Services Project generated valuable input for consideration in the development of options for the project. The response rate was at the highest level ever received by the LHIN and demonstrated the interest of residents offering input into what was most important to them and feedback on ways to strengthen the health care system.

While this information has offered more detailed input and analysis than previously recognized, it must be acknowledged that some population sub-groups and geographies may be underrepresented in this analysis. As indicated previously, the information gleaned can generate reliable estimates and additional evidence in support of health service planning. Overall, the community engagement process to date has provided tremendous value to this stage of the work towards the development of the regional plan.
Health Care Tomorrow has committed to the following criteria to guide the work of the Hospital Services planning and to inform decision-makers. The criteria are intended for use in the development and evaluation of Clinical and Diagnostic & Therapeutics opportunities/options/recommendations. The criteria are based on the Health Quality Ontario (HQO) Quality Framework and are meant to:

- Provide guidance to Boards, SECHEF and working groups on important features of a future state health care system
- Ensure alignment to Ontario’s quality framework
- Inform the design of new models by stimulating consideration for improvements within and between providers
- Support evaluation of opportunities and options recognizing that the evaluation will be a combination of qualitative and quantitative assessments.
- Support transparent decision making that recognizes that in particular circumstances consideration of criteria will likely result in criteria being in conflict and requiring trade offs
- Support the assessment of the impact of opportunities, options and recommendations in the final report

How the criteria were shaped:

- KPMG developed the initial framework and definitions based on the HQO Framework;
- Patients, through the Regional Patient Advisory Council, were asked to provide feedback on the criteria by defining what each criteria means from a patient perspective (RPAC feedback is included in the fifth column of the framework below);
- Working Groups provided feedback on criteria through an exercise at their Working Group sessions on March 4 (Diagnostics & Therapeutics) and March 5 (Clinical) (Working Group feedback is included in the fourth column of the framework below); and,
- SECHEF CEOs provided feedback on the framework and its application at the SECHEF CEO meeting on March 18, as well as via email prior to the session.

How the criteria should be used:

The criteria are intended to be considered as ‘guide posts’ to assist participants in their evaluation of opportunities/options/recommendations and to publicly explain the benefits of one option over others. In addition patients were asked to describe the impact on each of these criteria have on their patient experience, and have provided descriptions related to each criteria provided below.
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition, informed by HQO definition</th>
<th>Consideration / Sample measures</th>
<th>Feedback from Working Groups (March 4 and March 5)</th>
<th>Patient values, informed by Regional Patient Advisory Council members</th>
</tr>
</thead>
</table>
| Access      | South East LHIN residents should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes, regardless of where they live. | Considerations include:  
- Wait times  
- Travel distance for care | Overall  
- Use of technology  
- Incorporating stakeholder feedback  
- Care is standardized  
- Balance the needs across the system  
- One door/entrance to system  
- Providers working to full scope of practice  
- Space in planned system for new demand | \- Being given information that allows patients the ability to choose the best care option for them (e.g. transparent wait time information, by available providers and location)  
- Receiving emergency, scheduled and specialized treatment/procedures within acceptable time limits, based on leading practices  
- Recognition that scheduled services can be geographically further than urgent/emergent services; as long as there is choice  
- 24/7 access to care in general, especially for less acute patients (e.g. Primary Care centre with Nurse Practitioners)  
- Knowing clearly what the wait times are ("not just sitting on a wait list")  
- Respect for patient time ("being cancelled is ok once, but then you are next")  
- Having support for transportation at limited/no extra cost to the patient, for those that require support  
- Having support for free or subsidized parking, special needs parking, for those that require support  
- Being able to easily access Primary Care (e.g. community supports, family physician)  
- That medical information/records are consistently accessible to providers/patient/caregivers  
- That patients can easily navigate the system and there are supports/resources dedicated to support this (e.g. social worker in ED, supports for understanding the process for admission, support for language services)  
- Being able to access care outside of physical buildings (i.e. phone support, TeleMedicine)  
- Buildings are physically accessible/pleasant (e.g. wheelchair access, scent-free) |

Urgent/Emergent  
- Utilization of specialty clinics vs. emergency  
- CTAS volumes in ER vs community  
- Increase in access of care somewhere else  
- Being able to access care at the family physician (not just being attached to the PC physician)  
- Same day access to PC – next available appointment  
- Health Link metrics around access  
- Access to specialist appointment  
- Access to primary care after hours  
- Availability of regularly scheduled specialist clinics  
- Access to interdisciplinary clinics  

Elective  
- Transparency – all options are disclosed and client-informed  
- Choice is not limited  

Tertiary/Quaternary  
- Wait times  
- Targets of capacity (ability to define maximum capacity – over/under capacity)  
- Process - central intake  
- Faster time to procedure (do the ‘fix’ early)  

Pharmacy  
- Availability to provide pharmacy service within the region (without contracting services out e.g. compounding)  
- Retention of service function  

Labs  
- Access to clinicians  
- Access to right tests (quality of utilization, evaluation of new tests)  
- Regional repatriation of testing as appropriate |
### Criteria

<table>
<thead>
<tr>
<th>Effective</th>
<th>Patient Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition, informed by HQO definition</strong></td>
<td><strong>Definition, informed by HQO definition</strong></td>
</tr>
<tr>
<td>South East LHIN residents should receive care that works and is based on the best available scientific information.</td>
<td>Healthcare providers should offer services in a way that is sensitive to an individual’s needs and preferences based on patient and family centred care philosophy, and creates a smooth transition between services.</td>
</tr>
<tr>
<td><strong>Consideration / Sample measures</strong></td>
<td><strong>Consideration / Sample measures</strong></td>
</tr>
<tr>
<td>Considerations include:</td>
<td>Considerations include:</td>
</tr>
<tr>
<td>- Outcomes</td>
<td>- The extent to which patient’s experience of care contributes to their outcome</td>
</tr>
<tr>
<td>- Readmission rates</td>
<td>- Measures of service integration</td>
</tr>
<tr>
<td>- Length of stay</td>
<td>- One point of contact</td>
</tr>
<tr>
<td></td>
<td>- ‘No’ wait times</td>
</tr>
<tr>
<td></td>
<td>- Effective communication with patient where they understood what happened to them and whether it was what they expected (e.g. ‘did this meet your expectation?’); patient is informed</td>
</tr>
<tr>
<td></td>
<td>- Flow of information; patients and providers have access to medical records</td>
</tr>
<tr>
<td></td>
<td>- Empowering patients and professionals</td>
</tr>
<tr>
<td></td>
<td>- Cultural aspect not just philosophy</td>
</tr>
<tr>
<td></td>
<td>- Diversity of culture, physical ability, and language</td>
</tr>
<tr>
<td></td>
<td>- Sustainable</td>
</tr>
<tr>
<td></td>
<td>- Respectful of patient/family work life</td>
</tr>
<tr>
<td><strong>Feedback from Working Groups (March 4 and March 5)</strong></td>
<td><strong>Feedback from Working Groups (March 4 and March 5)</strong></td>
</tr>
<tr>
<td>Overall</td>
<td>Overall</td>
</tr>
<tr>
<td>- Quality improvement</td>
<td>- Quality improvement</td>
</tr>
<tr>
<td>- Quality of life/patient goals</td>
<td>- Quality of life/patient goals</td>
</tr>
<tr>
<td>- Patient participation</td>
<td>- Patient participation</td>
</tr>
<tr>
<td>- Standardized criteria when to perform a procedure</td>
<td>- Standardized criteria when to perform a procedure</td>
</tr>
<tr>
<td>- Ethically and Clinical decision-making framework to support high-cost activities that may in turn reduce overall system cost in the long run.</td>
<td>- Ethically and Clinical decision-making framework to support high-cost activities that may in turn reduce overall system cost in the long run.</td>
</tr>
<tr>
<td>Urgent/Emergent</td>
<td>Urgent/Emergent</td>
</tr>
<tr>
<td>- Admissions</td>
<td>- Admissions</td>
</tr>
<tr>
<td>- Readmissions</td>
<td>- Readmissions</td>
</tr>
<tr>
<td>- Access to early assessment</td>
<td>- Access to early assessment</td>
</tr>
<tr>
<td>- Rates of CTAG 4/5 in ER</td>
<td>- Rates of CTAG 4/5 in ER</td>
</tr>
<tr>
<td>- Mortality rates of individuals who were served in the home/community and who actually needed to be seen in ER</td>
<td>- Mortality rates of individuals who were served in the home/community and who actually needed to be seen in ER</td>
</tr>
<tr>
<td>- Reduced repeat visits</td>
<td>- Reduced repeat visits</td>
</tr>
<tr>
<td>Elective</td>
<td>Elective</td>
</tr>
<tr>
<td>- Resource should be aligned with appropriate patient, at the point of time when the patient needs and receives the care yet the efficiencies at that care aren’t seen until later in their care journey. (amputation versus full reconstruction of the limb)</td>
<td>- Resource should be aligned with appropriate patient, at the point of time when the patient needs and receives the care yet the efficiencies at that care aren’t seen until later in their care journey. (amputation versus full reconstruction of the limb)</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>- Stability (quality of specialized) meds/products within standards</td>
<td>- Stability (quality of specialized) meds/products within standards</td>
</tr>
<tr>
<td>Labs</td>
<td>Labs</td>
</tr>
<tr>
<td>- Accuracy (specimen collection and testing)</td>
<td>- Accuracy (specimen collection and testing)</td>
</tr>
<tr>
<td>- Get right samples the first time, no lost tests</td>
<td>- Get right samples the first time, no lost tests</td>
</tr>
<tr>
<td>- 6 dimensions of quality</td>
<td>- 6 dimensions of quality</td>
</tr>
<tr>
<td><strong>Patient values, informed by Regional Patient Advisory Council members</strong></td>
<td><strong>Patient values, informed by Regional Patient Advisory Council members</strong></td>
</tr>
<tr>
<td>- Timely access to modern procedures in accordance with best practices</td>
<td>- Timely access to modern procedures in accordance with best practices</td>
</tr>
<tr>
<td>- Strong communication between providers and patient/family throughout entire care journey (of medical information/records as well)</td>
<td>- Strong communication between providers and patient/family throughout entire care journey (of medical information/records as well)</td>
</tr>
<tr>
<td>- Care is respectful and tailored to the unique needs of patients</td>
<td>- Care is respectful and tailored to the unique needs of patients</td>
</tr>
<tr>
<td>- System is easily navigated and transitions are seamless</td>
<td>- System is easily navigated and transitions are seamless</td>
</tr>
<tr>
<td>Criteria</td>
<td>Definition, informed by HQO definition</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td></td>
<td>- Publicly reported measures</td>
</tr>
<tr>
<td></td>
<td>- Elective</td>
</tr>
<tr>
<td></td>
<td>- Reasonable distance to travel</td>
</tr>
<tr>
<td></td>
<td>- Tertiary/Quaternary</td>
</tr>
<tr>
<td></td>
<td>- Time to appointment</td>
</tr>
<tr>
<td></td>
<td>- Time with provider</td>
</tr>
<tr>
<td></td>
<td>- Friendliness</td>
</tr>
<tr>
<td></td>
<td>- Complete care</td>
</tr>
<tr>
<td></td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>- Not having to provide medication history repeatedly at transition Labs</td>
</tr>
<tr>
<td></td>
<td>- Access from diagnosis to intervention (process from order, to results for clinician(s) and e-communication to patient)</td>
</tr>
<tr>
<td></td>
<td>- Improved Lab TAT</td>
</tr>
<tr>
<td></td>
<td>- Confidence (retained) and trust in service</td>
</tr>
<tr>
<td></td>
<td>- Increase in community access</td>
</tr>
<tr>
<td></td>
<td>- Seamless access to patient information between providers (e.g. IT platforms)</td>
</tr>
<tr>
<td></td>
<td>- Accessible care locations and/or remote options (i.e. telemedicine, remote technology, etc.)</td>
</tr>
<tr>
<td></td>
<td>- Living within our means; affordable</td>
</tr>
<tr>
<td></td>
<td>- Services available for free; limited cost for additional/extra or immediate access to services</td>
</tr>
<tr>
<td></td>
<td>- No elimination/removal of key services</td>
</tr>
<tr>
<td></td>
<td>- Eliminate duplication of services</td>
</tr>
<tr>
<td></td>
<td>- Appropriate resource allocation (e.g. Personal Support Worker instead of nurse, volunteers – when possible)</td>
</tr>
<tr>
<td></td>
<td>- Living within our means; affordable</td>
</tr>
<tr>
<td></td>
<td>- Services available for free; limited cost for additional/extra or immediate access to services</td>
</tr>
<tr>
<td></td>
<td>- Return on investment</td>
</tr>
<tr>
<td></td>
<td>- Triple-aim metrics</td>
</tr>
<tr>
<td></td>
<td>- Integrated health team and health system (with patient)</td>
</tr>
<tr>
<td></td>
<td>- Health care providers working to full scope of practice</td>
</tr>
<tr>
<td></td>
<td>- Long term, systemic consideration for cost utilization with guidelines and operational structure</td>
</tr>
<tr>
<td></td>
<td>- Care measured on process and outcome measures</td>
</tr>
<tr>
<td></td>
<td>- Appropriate HR/allocation of resources across all sites</td>
</tr>
<tr>
<td></td>
<td>Pharmacy</td>
</tr>
<tr>
<td></td>
<td>- Reduce waste (smaller sites)</td>
</tr>
<tr>
<td></td>
<td>- Labs</td>
</tr>
<tr>
<td></td>
<td>- Performance relative to other labs</td>
</tr>
<tr>
<td></td>
<td>- % performance comparison</td>
</tr>
</tbody>
</table>

Efficient

Healthcare providers should continually look for ways to eliminate inefficiencies, and provide care that is in the most appropriate setting, at the right place, at the right time.

Considerations include:
- ALC
- ACSC
- CPWC
- Cost per procedure
- Reduced ALC

Overall
- Return on investment
- Triple-aim metrics
- Integrated health team and health system (with patient)
- Health care providers working to full scope of practice
- Long term, systemic consideration for cost utilization with guidelines and operational structure
- Care measured on process and outcome measures
- Appropriate HR/allocation of resources across all sites

Pharmacy
- Reduce waste (smaller sites)
- Labs
- Performance relative to other labs
- % performance comparison
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition, informed by HQO definition</th>
<th>Consideration / Sample measures</th>
<th>Feedback from Working Groups (March 4 and March 5)</th>
<th>Patient values, informed by Regional Patient Advisory Council members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academics</td>
<td>The healthcare system in the South East LHIN is integral to a vibrant and thriving teaching and research community. The research community informs improvements and innovations to care across the system through supportive partnerships with the School of Medicine, as well as Nursing, and Allied Health professionals.</td>
<td>Considerations include:  - The extent to which the School of Medicine, as well as Nursing, and Professional Practice inform improvements to care</td>
<td>Overall  - Student evaluation  - Elective  - Need to protect elective care to ensure we have academic mission</td>
<td>• Centres of Excellence to develop improved procedures and attract partnerships  • Continuing to attract the best and brightest to the region (including community hospitals)  • Teaching partnership with University of Ottawa which has a two-way benefit: offers French-language opportunities for Queens’s students (medicine, nursing and rehab) and French Language Services students at University of Ottawa can build their English-language skills (in Kingston and area)</td>
</tr>
</tbody>
</table>
Appendix E: Technical Data Analysis

This Appendix presents supplemental dataset analysis of Provincial datasets in addition to what has been provided in the main body of the report. The data presented here was selected from a wider dataset that was presented at various points throughout the project to support the current state assessment, case for transformation, and opportunity identification. The information presented here is intended to help support a deeper understanding of the issues and challenges facing the South East LHIN hospitals over the next 10 years.

1. Forecast growth in demand for hospital care varies by LHIN. LHINs expected to grow significantly will receive a greater share of future healthcare funding.

   Figure 1. Forecast growth in demand for hospital care by LHIN

   ![Forecast growth in demand for hospital care by LHIN](Image)

2. Hospital expenses are expected to grow by $122 million over 10 years as a result of population growth and ageing if no changes are made to the way care is provided.

   Figure 2. Forecast increase in hospital expenses due to population growth and aging

   ![Forecast increase in hospital expenses due to population growth and aging](Image)
3. There is a high utilization of acute inpatient beds for patients who are waiting for lower levels of care (ALC) (e.g., home care, long-term care, palliative care etc.) Use of these beds for ALC patients prevents patient throughput and affects hospital funding.

**Figure 3. ALC Use of Acute Resources**

<table>
<thead>
<tr>
<th>Discharged to</th>
<th>ALC Days</th>
<th>Transfered from</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Home</td>
</tr>
<tr>
<td>Long Term Care Home</td>
<td>14,838</td>
<td>33%</td>
</tr>
<tr>
<td>Died in hospital</td>
<td>4,014</td>
<td>10%</td>
</tr>
<tr>
<td>Home care</td>
<td>2,428</td>
<td>7%</td>
</tr>
<tr>
<td>Inpatient Rehab</td>
<td>2,090</td>
<td>6%</td>
</tr>
<tr>
<td>Complex Continuing Care</td>
<td>1,802</td>
<td>4%</td>
</tr>
<tr>
<td>Transferred to Acute</td>
<td>1,772</td>
<td>3%</td>
</tr>
<tr>
<td>Home without home care</td>
<td>728</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>28,918</td>
<td>68%</td>
</tr>
</tbody>
</table>

**Alternate Level of Care:** “When a patient is occupying a hospital bed and does not require the intensity of resources provided in that setting, the patient must be designated ALC.”¹

South East LHIN hospitals had 29,000 ALC days, or roughly 90 beds for ALC care

51 percent of ALC days were for patients waiting for admission to Long Term Care
14 percent of ALC days were for patients who died in hospital

4. The supply of LTC Beds in South East LHIN is higher than expected when compared to supply in other LHINs, by 553 beds. This implies there are strategies other than building new beds to reduce the ALC use of acute resources by patients waiting for placement to Long-term care.

Figure 4. Supply of LTC Beds in the SE LHIN

<table>
<thead>
<tr>
<th>Long Term Care Home Region</th>
<th>Beds</th>
<th>Expected Beds</th>
<th>Actual minus Expected Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Hastings</td>
<td>332</td>
<td>192</td>
<td>140</td>
</tr>
<tr>
<td>Quinte</td>
<td>898</td>
<td>797</td>
<td>100</td>
</tr>
<tr>
<td>Salmon River</td>
<td>246</td>
<td>112</td>
<td>133</td>
</tr>
<tr>
<td>Rural Kingston</td>
<td>49</td>
<td>124</td>
<td>-75</td>
</tr>
<tr>
<td>Kingston</td>
<td>919</td>
<td>783</td>
<td>136</td>
</tr>
<tr>
<td>Rideau-Tay</td>
<td>408</td>
<td>285</td>
<td>123</td>
</tr>
<tr>
<td>Thousand Islands</td>
<td>447</td>
<td>452</td>
<td>-4</td>
</tr>
<tr>
<td><strong>South East LHIN</strong></td>
<td>3,298</td>
<td>2,746</td>
<td><strong>553</strong></td>
</tr>
<tr>
<td><strong>Province</strong></td>
<td><strong>57,210</strong></td>
<td><strong>57,210</strong></td>
<td><strong>-</strong></td>
</tr>
</tbody>
</table>

Data source: LTC RAI 2012, MOF Population Projections
Excludes NE and NW LHINs


Figure 5. SE LHIN Wait Times for surgical procedures

<table>
<thead>
<tr>
<th>Surgery Type</th>
<th>South East Completed Procedures</th>
<th>Provincial Average 90th Percentile Wait Days*</th>
<th>South East 90th Percentile Wait Days*</th>
<th>SE LHIN to Provincial Average Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral and Maxillofacial Surgery and Dentistry</td>
<td>634</td>
<td>156</td>
<td>93</td>
<td>0.6</td>
</tr>
<tr>
<td>Gynaecologic Surgery</td>
<td>2,419</td>
<td>133</td>
<td>113</td>
<td>0.9</td>
</tr>
<tr>
<td>Paediatric Orthopaedic Surgery</td>
<td>35</td>
<td>264</td>
<td>248</td>
<td>0.9</td>
</tr>
<tr>
<td>Oncology Procedures</td>
<td>1,704</td>
<td>50</td>
<td>48</td>
<td>1.0</td>
</tr>
<tr>
<td>General Surgery</td>
<td>4,161</td>
<td>100</td>
<td>97</td>
<td>1.0</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>5,491</td>
<td>189</td>
<td>185</td>
<td>1.0</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>65</td>
<td>95</td>
<td>94</td>
<td>1.0</td>
</tr>
<tr>
<td>Ophthalmic Surgery</td>
<td>6,829</td>
<td>154</td>
<td>154</td>
<td>1.0</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>348</td>
<td>70</td>
<td>79</td>
<td>1.1</td>
</tr>
<tr>
<td>Plastic and Reconstructive Surgery</td>
<td>463</td>
<td>140</td>
<td>188</td>
<td>1.3</td>
</tr>
<tr>
<td>Paediatric Otolaryngic Surgery</td>
<td>15</td>
<td>229</td>
<td>324</td>
<td>1.4</td>
</tr>
<tr>
<td>Otolaryngic Surgery</td>
<td>862</td>
<td>190</td>
<td>337</td>
<td>1.8</td>
</tr>
<tr>
<td>Urologic Surgery</td>
<td>2,314</td>
<td>82</td>
<td>160</td>
<td>1.9</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>327</td>
<td>117</td>
<td>227</td>
<td>1.9</td>
</tr>
</tbody>
</table>

*90th Percentile Wait Time (Days) to receive surgical procedure
Restricted to Surgery types with at least 10 annual procedures
6. Five percent of the population of the LHIN uses 81% of the hospital resources. This population is older with a high proportion aged 60 and over, and high rates of chronic disease. Health Links have been developed to help reduce unnecessary use of hospitals for this population.

**Figure 6. Distribution of hospital use by the highest users**

**Figure 7. Characteristics is the top 1%, 3% and 5% of hospital users in the SE LHIN**

<table>
<thead>
<tr>
<th>Proportion of South East LHIN Population</th>
<th>One</th>
<th>One to Three</th>
<th>Three to Five</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of South East Resource Use</td>
<td>51%</td>
<td>22%</td>
<td>8%</td>
</tr>
<tr>
<td>Number of South East Residents at South East Hospitals</td>
<td>All Ages</td>
<td>4,472</td>
<td>9,350</td>
</tr>
<tr>
<td>&lt;01</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>01-17</td>
<td>2%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>18-59</td>
<td>21%</td>
<td>25%</td>
<td>45%</td>
</tr>
<tr>
<td>60-79</td>
<td>44%</td>
<td>45%</td>
<td>29%</td>
</tr>
<tr>
<td>80+</td>
<td>31%</td>
<td>24%</td>
<td>16%</td>
</tr>
<tr>
<td>Average Number of ED Visits at South East Hospitals</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Average Number of Admissions</td>
<td>2.4</td>
<td>1.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Estimated Beds Occupied at South East LHIN</td>
<td>381</td>
<td>178</td>
<td>77</td>
</tr>
<tr>
<td>Acute ALOS</td>
<td>10</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>ALC ALOS</td>
<td>3</td>
<td>0.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Percent Died in Hospital</td>
<td>16%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Percent Receiving Palliative Care</td>
<td>3%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Number of Chronic Conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>3%</td>
<td>6%</td>
<td>27%</td>
</tr>
<tr>
<td>1</td>
<td>6%</td>
<td>18%</td>
<td>25%</td>
</tr>
<tr>
<td>2</td>
<td>9%</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>3</td>
<td>13%</td>
<td>18%</td>
<td>13%</td>
</tr>
<tr>
<td>4+</td>
<td>69%</td>
<td>39%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Source: DAD, NACRS, CCMS, OMHRS, Stats Can, MOH Pop Projections, 2012/13
Appendix F – Visioning Day Summary
South East Community Care Access Centre and Hospital Executive Forum (SECHEF)

Health Care Tomorrow – Hospital Services

Visioning Day – Summary Report

October 30, 2014
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<td>Group Discussions</td>
<td>13</td>
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<tr>
<td>Conclusion</td>
<td>26</td>
</tr>
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</table>
Overview

On October 30, 2014 over 250 patients, health service providers, and community partners of the South East Local Health Integration Network (LHIN) came together in Kingston, Ontario to participate in a Visioning Day focused on shaping the future for hospital services in the South East LHIN. Participants were provided with local and global insights on health system transformation and shared their own knowledge, experience and ideas, which will be used to guide the development of a high-performing and sustainable healthcare system in the South East LHIN.

The objectives for this session were:

1. To inform key stakeholders of the project – including key drivers, activities and timelines, as well as how stakeholders will continue to be engaged throughout the project;
2. To provide global and local examples of system transformation, from which components may be drawn upon in thinking about the future of hospital services for patients in the South East LHIN; and,
3. To begin to define, collaboratively with stakeholders, the features of a high-performing hospital system within the South East LHIN that delivers integrated and high quality care for patients and families.

Opening Remarks

Paul Huras, South East LHIN

In his opening remarks, Paul Huras explained that the purpose of this session was to come together to introduce key stakeholders to the Health Care Tomorrow – Hospital Services project, as well as to begin to work collaboratively to imagine what a high-performing hospital system could look like in the South East region.

Paul noted that the session provided a chance to look at the possible and to establish a plan for system redesign to enable each of the health organizations in the South East LHIN to work together in the most integrated way.

Members of the Regional Patient Advisory Council (RPAC) were invited to attend the session to ensure that the voice of the patient is active in system redesign, but also to remind participants of the primary motivation behind this undertaking: our patients.

Paul noted that the South East LHIN has some of the most intelligent people in health care in Ontario and in the country – this is a time for system leaders to help drive change to transform the South East LHIN into a high-performing health system.
**Project Overview**

Dr. David Pichora, Hotel Dieu Hospital

Dr. Pichora began by describing the factors that affect the ability of hospitals to provide quality patient care and impact system sustainability, including the aging population, chronic disease and fiscal constraints. A video highlighting the state of health in the South East LHIN and its associated challenges was played to set the stage for the work to be completed in building a sustainable model of care. The video explained that healthcare needs to evolve to meet changing needs, while keeping the patient as a priority. This will involve establishing mechanisms to make the dollar go further and creating a connected system to improve movement of patients through the system. The video is available at the project webpage at: [www.healthcaretomorrow.ca](http://www.healthcaretomorrow.ca)

Dr. Pichora also emphasized the value of medical schools and colleges, and ensuring that this resource is adequately leveraged and sustained.

Dr. Pichora outlined the guiding principles for the project which lay the foundation for the South East LHIN’s approach to achieving its vision of **improving access to high quality care through the development of a ‘Sustainable System of Integrated Care’**. The principles include:

1. A clear and shared sense of purpose, particularly around the needs of the patient and quality of care;
2. Inclusive consultation with health system stakeholders, recognizing the role the hospital plays in an integrated system of care;
3. Inclusive consultation and collaboration with Hospitals, CCAC, Queen’s, and other stakeholders that work in the system to inform processes;
4. Inclusive engagement with patients and residents to inform processes;
5. Inclusive engagement with Francophone and Indigenous communities to inform processes;
6. Engagement via an appreciative inquiry approach;
7. Options will be developed based on evidence and leading practice models;
8. Options will need to align with provincial strategy, initiatives and hospital provincial mandates;
9. Each member of SECHEF (all hospitals, South East CCAC, Queen’s University and South East LHIN) have an equal opportunity to influence; and,
10. Realistic activities and timelines.
Attendees

The session had representatives from the following groups and organizations:

- Alzheimer Society of Lanark County
- Alzheimer Society of Leeds Grenville
- Belleville & Quinte West Community Health Centre
- Brockville General Hospital
- Canadian Hearing Society
- Cheshire Homes (Hastings-Prince Edward) Inc.
- Community & Primary Health Care
- Community Care for Central Hastings
- Community Patient Transfer Group
- Country Roads Community Health Centre
- County of Lennox and Addington – EMS
- French Language Health Services Network of Eastern Ontario
- Frontenac Community Mental Health & Addiction Services
- French Language Health Services Network of Eastern Ontario
- Gateway Community Health Centre
- Hospice Prince Edward
- Hotel Dieu Hospital
- Kingston Community Health Centres
- Kingston General Hospital
- Lanark - EMS
- Lanark Mental Health
- Leeds & Grenville Mental Health
- Lennox and Addington Addictions and Mental Health
- Long Term Care Organizations
- Medicine and Mental Health Programs, Kingston General Hospital
- Mental Health Support Network of South Eastern Ontario
- Perth Smiths Falls Hospital
- Prince Edward Family Health Team
- Providence Care
- Queen's University
- Quinte Health Care
- Regional Patient Advisory Council
- Rideau Community Health Services
- Rideau Tay Health Link
- Shared Support Services Southeastern Ontario (3SO)
- South East Community Care Access Centre
- South East LHIN ER Lead
- South East LHIN Physician Leads, Primary Health Care and Critical Care
- South East Local Health Integration Network
- South East Regional Cancer Program
- South Eastern Ontario Infection Control Network
- St. Joseph's Health System
- Stroke Network of Southeastern Ontario
- Tyendinaga Mohawk Territory
- Upper Canada Family Health Team
1. PROJECT OVERVIEW

Paul Huras, CEO South East LHIN and Dr. David Pichora, President & CEO Hotel Dieu Hospital

Paul provided an outline of the project work plan, including the six key deliverables:

1. Develop detailed work plan.
2. Develop the case and vision for change, including:
   - The needs of the population and the quality of services provided;
   - Confirmation of the post mitigation net hospital funding impact; and,
   - Identified gaps and opportunities based on leading practice.
4. Review of potential shared strategies for administrative efficiencies.
5. Options for support services reconfiguration (e.g., diagnostics, laboratories, etc.)
6. Options for clinical service transformation.

This will occur over the following phases:

The approach will build on existing initiatives that the South East LHIN has undertaken, including:

1. Clinical Services Roadmap
   CSR planning started two and a half years ago and identified seven clinical areas for improvement. In this process, a comprehensive assessment of each of these clinical areas was completed to establish recommendations going forward. Some of these recommendations are being implemented and others will be incorporated into the Health Care Tomorrow – Hospital Services project.

2. Addictions and Mental Health (AMH) Redesign
   This redesign began in January 2013. The South East LHIN identified a need for change due to inconsistencies with data, access to services, and care delivery, as well as a high incidence of repeat Emergency Department visits. Through research and consultation with patients the LHIN has looked into ways it can build the system to improve AMH and will bring these learnings to the table.
3. **Health Links: Local and Regional Strategy**

Health Links focuses on primary healthcare, looking at how primary care practices can better link with each other and with other community organizations (i.e. Community Care Access Centres, Addictions & Mental Health, and Community Support Services) and hospitals. This initiative identifies care for medically complex populations as the first priority, and the development of coordinated care plans. It will be important to understand the Health Links initiatives and how these align with health services in the South East LHIN.

Decisions made during the Health Care Tomorrow – Hospital Services project will likely revolve around services at the regional, sub-regional and local level, hospital positioning in regional programs, the role of the community sector, integration, system optimization, and governance. Key to this planning will be the role of the region’s academic health science centre. Health Care Tomorrow – Hospital Services will support the academic mission of fostering development of healthcare experts, bringing about evidence-based change through research, and providing excellent clinical services.

Through this planning, there is tremendous opportunity for healthcare organizations in the South East LHIN to work together to make the South East LHIN region the most attractive place in the world for new professionals to come and build their career. Each individual at the Visioning Day plays an essential role in the system, and was asked to consider what they see as the vision and how they can work together to achieve this.
2. THE CASE FOR TRANSFORMATION

Dr. Gavin Wardle, Preyra Solutions Group

Dr. Gavin Wardle, from Preyra Solutions Group, provided an overview of current state of the South East LHIN and highlighted challenges that the LHIN will face, particularly related to funding and resources. His presentation was structured around the following equation and how we should work to achieve this:

TIMELY + ACCESS + TO QUALITY + SERVICES + CLOSE TO HOME

Overall, the population of the South East LHIN is growing and aging. Meanwhile, the province is facing a deficit of $11 billion. This means that funding for health services will not keep up with the rate of population growth and aging: demand is increasing faster than funding. In order to continue to deliver quality services it will be important to redesign the system to optimize use of the resources that are in place.

- **The South East LHIN is relatively high spending**
  - The South East LHIN spent $786 million in care in 2013/14. Spend per person in this region is relatively high across all sectors, particularly hospital, long term care and home care. In community support services; however, the South East LHIN is the lowest spending. Given the increasing evidence of the community sector to support seniors in their homes, and prevent unnecessary admissions, it will be valuable to consider how these services can be better leveraged. There is great opportunity for the South East LHIN to continue to improve and make better use of the resources that are available.

- **It is important to understand the population and focus resources accordingly**
  - The South East LHIN is one of the slower growing regions in Ontario. There are variations within the LHIN with regard to population growth and aging, and strategies may be affected by these differences.

- **There is a need to examine the use of available resources to make the best use of those resources**
  - Based on projections of population growth and aging, the South East LHIN will need to spend $122 million more in the next 10 years if no changes in clinical practice were made. The government’s funding policy is to keep hospital funding below the rate of population growth. To make the best use of resources available, the LHIN must look at areas for improvement, such as: better transitions, reorganizing clinical services, reducing avoidable admissions, and servicing low acuity ED visits elsewhere.

Ultimately, it will be important to think about people, whether they receive the best care they could receive, and how this can be improved. All of this comes back to the vision: improve access to high quality care through the development of a sustainable system of integrated care.
3. KEYNOTE ADDRESS: GLOBAL INSIGHTS ON HOSPITAL SUSTAINABILITY
Mark Britnell, KPMG

Mark Britnell presented on global trends related to hospital sustainability, highlighting the value of building integrated health systems and empowering patients. These trends were established at the recent World Economic Forum that brought together 65 healthcare leaders from 30 countries. Mark began by reviewing overarching themes for a sustainable health system, which are described below:

- **Organizations and health systems are not aligned for sustainable transformation**
  - Many leaders see greater need for change in the system, rather than in their individual organizations. The challenge lies in establishing ways in which these transformative system changes can be enacted. Leaders tend to focus on transactional change, such as efficiencies and service improvements. The key to transformational improvement is to bring leaders together, as in this Visioning Day, to agree upon a common vision and drive system level change.

- **Integration is critical for improved health system sustainability**
  - People and organizations can be as perfect as they want in their own ‘fortress’, but this is not meaningful when considering the greater system that the patient experiences. For example, patients dealing with multiple chronic conditions need a system of supports that is not currently available today. The best way to achieve this is by learning from those who have already been through the process.

- **Ensure that care aligns with what patients want and empower patients to create more value**
  - Patients who actively manage their own care create better value and support the development of a more sustainable health system. This involves giving patients more power and building trust between patients and providers. In many instances there is distance between what patients want and what they get. Patients want to be seen and supported as a person, rather than a condition. They would also like to be informed and empowered partners in care. ‘Activated’ patients have shown to have better health outcomes at lower costs.

Mark then presented on broader global trends in healthcare, which are important to consider in going through the process redesign in the South East LHIN. For one, **hospitals are transforming into health systems. Innovative integration and partnership** have become a key components for development of high performance systems. There are many mergers and acquisitions occurring around the world and hospitals are looking for opportunities to integrate with primary and secondary care and with community organizations. The key is to focus services within organizations so that they all have a specialized role in
the system. No hospital needs to close, but all need to change. Looking to **high growth health systems is useful for providing new perspectives** on health reform.

**Patients themselves are becoming active partners**, and as such, providers must find ways to connect with and empower patients. Activism is also evident in funding: **payers are becoming activist**. Rather than having a passive funding system, the focus is shifting on contracting for value and outcomes.

Kaiser Permanente serves as a leading model for quality, coordinated care. Part of this success arises from the segmentation of markets: knowing who patients are and where they live. Their value proposition is to provide the right care at the right place in the right time by the right people. There is also great value in having a health system that is led by a high performing academic health science network.

In summary, the South East LHIN should be very optimistic about the opportunities for positive transformative change. The system should embed patient engagement, continuity of care, excellence, quality, safety, and rigor, while delivering the right care in the right place at the right time.
4. LOCAL INSIGHTS: IMPACT OF AN INTEGRATED HOSPITAL SYSTEM

Dr. Kevin Smith, St. Joseph’s Health System

The St. Joseph’s Health System provides a valuable example of what a high performing health system looks like in the local context. To begin, Dr. Smith presented opening thoughts on the characteristics of a high performing health system, emphasizing that such a system focuses on the journey of the patient, establishes a continuum of care from hospice to academic, and is built by working in partnership with others.

St. Joseph’s Pathway to Integration

The underlying objective for St. Joseph’s Health System integrated care was to create a health system that was faster, better and cheaper. Strategies to enable the development of such a system include:

- **Manage the micro-climate**: understand the micro-climates of Ontario and leverage micro-agencies to figure out the best model for change. Multiple micro-integrations are the practical way to drive macro-integration.

- **Build integrated patient journeys**: consider how patients want to be treated and target transition points.

- **Switch models of care**: i.e. consultations via iPad.

- **Use small empowered teams**: to encourage staff to respond to demand in innovative ways. St. Joseph’s Health System also had staff switch roles (i.e. between hospital and homecare) to foster a sense of respect and appreciation between providers.

Lessons Learned

Key lessons that St. Joseph’s learned on its transformation journey include:

- **Be willing to disrupt accepted norms**. Members of the transformation process must have a relentless attitude. Sometimes this may involve moving barriers out of the way. For example, St. Joseph’s Health System worked with the Government of Ontario to ‘change the rules’ so that funding would better benefit the patient. An essential part of continuing to improve the health system will be to transform how people are paid.

- **Data plays an important role in the process**. The data paints a stark picture of the critical areas to target and is key to guiding and monitoring the change process. Transparency is also important.

- **Patient and provider satisfaction are aligned**. Positive improvements should influence both groups.

- **The work you spend your time on every day should be reflective of your mission**.
There are many common flaws that organizations face when undertaking the transformation process. Such examples can include: using a hospital only pathway, maintaining paternalistic systems, lack of standardization, and competing models. Instead, organizations should make decisions based on patient outcomes, plan how to achieve standardization, focus on results rather than rules, and eliminate structural impediments. If evidence for a practice path is inconclusive, select a common way for the system to approach the solution and study variation to continue to improve on this practice. This is how the best performing systems operate.

**Question & Answer with Dr. Kevin Smith & Mark Britnell**

1. **How do you engage the private system into this network model?**
   
   Incorporation is less important than results. We should not be fearful that the private sector will invade the space. Instead, we should focus on better understanding why ‘the 30%’ are paying into this sector. It is important to ensure that we have balance between these systems so that the public sector does end up caring for all patients in the high need segments.

2. **How can we change the front door to the system?**
   
   Strategies for approaching this change include segmenting and stratifying the population; however, we should not just start at the doors, but must begin intervention upstream. This can be done by looking at data around what performance should look like and what interventions are needed. Japan has done a great job of using telemedicine and telecare, and has a unique model where they use nurses to run home services, which reduces demand on the ‘front door’ of hospitals.
   
   In the short term it is beneficial to consider how to get people out the back door to open up space (i.e. reduce blockage in terms of discharge).

3. **What are the approaches to break the silos?**
   
   This is a priority issue that can be addressed by bringing leaders together to establish a common vision, agree on deliverables, determine accountabilities, and continuously check back in to ensure that the plan is on track. Sweden provides a good model of a joint regional strategy, where Boards of organizations come together and develop shared objectives. Key strategies include getting people to commit in terms of words and deeds and developing at least two common objectives.
5. GLOBAL INSIGHTS: SYSTEM TRANSFORMATION

Lord Nigel Crisp, KPMG

Lord Crisp provided an overview of the elements that are critical to the transformation process, emphasizing the need to think about health in innovative ways and do things differently.

As former leader of the NHS, he shared insights on the 25 year journey of the UK health system. This journey is currently in its fourteenth year and aims to shift from a government dominated health system to one that is citizen led and oriented. The process of transformation has faced many challenges along the way, including political downturns and dealing with the challenges that arise due to the complex nature of healthcare. Despite these setbacks; however, the changes to date have led to a significant increase in public satisfaction. Lord Crisp’s talk presented key elements of this transformation, which include people as agents of change, the importance of passion, momentum and energy, as well as other good practices.

People as Agents of Change

Transformation is all about people. It is critical to build teams that work together and have a sense of shared and mutual accountability. Trust will be generated through shared experience. It is also important to fully engage citizens by ensuring that they are represented in the decision making process. The dialogue with patients needs to be changed from “what’s the matter with you” to “what matters to you”.

With regard to care providers themselves, professionals must be seen as important agents of change who need to both lead and support. The most radical change in service delivery is led by clinicians: these experts should be encouraged to constantly search for improvement and enabled to design services.

Passion, Momentum, Energy

Building passion, momentum and energy is important to do as leaders. For transformation it is critical to have momentum to move forward and build the narrative.

It is also critical to have the right experience at the table and to bring in different constituencies. The vision and planning should show people how they fit in and how they can lead, and should encourage and support them to go out of their comfort zones.

Good Practice

What are the elements of good practice required for transformational change? First, it is important to have a shared methodology for improvement. Establish key quality indicators and believe the data. Technology is an important enabler and can ensure that specialist networks to have access to the same data. In enacting change do not compromise on values and quality. Lastly, be prepared for change, but also for how to deal with problems that result. When you see variation, use this to think about how you can reduce inconsistencies and improve practice.
In Summary

Some of the biggest health system failures include overtreatment, uncoordinated care, and redundancies. Big change must focus on health and well-being, as well as on reducing morbidity by engaging the whole community. The Scotland “Early Years Collaborative” serves as a good example of how the country has unpacked drivers related to children’s health to make Scotland the best place to grow up. Engaging in such behaviours and practices will be valuable for thinking about health in innovative ways to establish new methods for improvement.

The South East LHIN has great opportunity to build. The LHIN also has a past to be proud of, which needs to be honoured in terms of what’s done in the future. Lord Crisp encourages the South East LHIN to be ambitious by aiming to be the best sustainable health system in Ontario, Canada, and the world.

Ultimately, transformation is about people doing things differently to make a difference. This involves building coalitions of leadership, showing individuals how they can fit in and contribute, redefining roles and relationships, and staying true to quality and value. You will succeed if you have passion, energy and ambition!
Group Discussions

SMALL GROUP DISCUSSION #1

In the first group discussion participants were asked to reflect on the current state of the health system in the South East LHIN and to identify opportunities for improvement. They addressed the following three questions:

1. What are the most important challenges for hospitals in the South East LHIN over the next 10 years?
2. What is working well today and should be continued or strengthened in the future to address the challenges we are facing in the South East LHIN?
3. Are there new or emerging initiatives that could address the challenges?

The ideas presented by participants are summarized below.

1. **What are the most important challenges for hospitals in the South East LHIN over the next 10 years?**

The following chart summarizes the most important challenges that the health system will need to address over the next ten years. These relate to: Demand Planning and Social Determinants of Health, Changing Culture, the Patient Experience and Role, Access, Quality of Care, Costs & Funding, Human Resources, the Academic Role, and Community Care Access Centres.

| Demand Planning & Social Determinants of Health | • Critical to plan for demand by taking into account social determinants of health, which provide a holistic understanding and appreciation of population needs |
| • Use of data to inform decisions |
| • Inform investment and facilitate proactive strategy |
| • Target key populations: frail elderly/aging population, chronic conditions, poverty/low socio-economic status and other vulnerable/high risk patients |
| • Also consider seasonality for services (higher demand in summer with many patients who do not have a general practitioner in the region) |
| Changing Culture | • The system is designed in a way that channels patients to the Emergency Department |
| • Need to focus on how to get patients who can be cared for outside of hospital to more appropriate settings of care |
| • Remove legal risk and regulation barriers |

COMMUNITY-ORIENTED
<table>
<thead>
<tr>
<th>Patient Experience &amp; Role</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The patient will always be the driver</td>
<td>• Patients are backlogged in emergency care and must remain with paramedic systems until space/resource available. Acute care is a bottleneck</td>
</tr>
<tr>
<td>• Informing patients to make their own care choices is a challenge. There is a lack of education for patients on how to best navigate the system</td>
<td>• Quick and ready access needs to be supported</td>
</tr>
<tr>
<td>• There is also a challenge of aligning patients with correct service(s) to meet their needs. Doctors and staff are not always aware of where to send patients</td>
<td>• Need to improve flow through the hospital locally and the system regionally (within hospital and between hospital and external partners)</td>
</tr>
<tr>
<td>• Patient education needs to be enriched and expanded to help our customers identify the best and most appropriate options for care</td>
<td>• Education on independent care practices is also important</td>
</tr>
</tbody>
</table>

**IMPROVED COMMUNICATION**
- There are general communication issues and a need to improve these across the system
- Look at communication between LTC and primary care, between providers, etc.
- Strengthen relationships within and across sectors to encourage collaboration
- Develop mechanisms to better share resources and information

**FOCUSED ON PREVENTION & EARLY DETECTION**
- We aren’t adequately addressing preventative care. This must be a focus in the system so we can prevent people from becoming patients in the first place

**ACCOUNTABLE**
- There are too many layers of decision making and a lack of clarity which is resulting in duplication of effort, roles, testing and hand-offs
- Ownership, accountability and responsibility is crucial and should be included in all levels of the system
CAPACITY

- Clinics do not offer enough access
- Housing options are limited to nursing and LTCH
- Issues with transition of services/care, such as availability for transitional care facilities
- Need to make better use of current services and increase capacity of the system to see more patients

LOCATION & SERVICES

- Challenge moving people back home and having the most appropriate services available in the home
- Patients have inequitable access and difficulty accessing care, especially for Specialist Consultations
- Many family doctors don’t seem willing to accommodate patients seeking urgent care. Access to quick care and diagnostics is available in EDs, but often cannot be provided by general practitioners
- There are not enough physicians to deal with concerns of rural and isolated populations
- We need to optimize access (i.e. to family doctor and specialized care). Patients are happier when services are offered locally
- Provide easier access to home support, day program services, and education on independent care practices
- Be aware of economic viability of communities - if community does not have an ER or basic services it will not be perceived as a desirable place to live. Focusing certain types of care/service at one particular hospital provides challenges for patients regarding transportation, lodgings, meals, and other associated expenses

TRANSFER & TRANSPORTATION

- Development of a system that works together to support moving patients to the right place
- Challenge with patient transfer: appropriate use of resources and addressing transfers appropriate mechanism (vehicle type)
- Transportation challenge is greater if we use right care right place right time – it means we need to shift care which increases transportation need
- Have some volunteer programs in place (i.e. for dialysis patients); however, there is a high demand and not enough capacity to meet it
<table>
<thead>
<tr>
<th>ACCESS TO INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve care coordination and to address challenges of travel and getting to clinics</td>
</tr>
<tr>
<td>It is difficult to find information, contributing to unnecessary repeat of tests</td>
</tr>
<tr>
<td>Lack of referral standards and transparency with regard to the best resources available for each patient case</td>
</tr>
<tr>
<td>Develop a central repository to have access to services and sharing of information between providers</td>
</tr>
<tr>
<td>There is a lack of understanding of bed mapping: would be good to know availability to prevent gridlock in the system</td>
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<table>
<thead>
<tr>
<th>Quality of Care</th>
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<tbody>
<tr>
<td>Tendency to over treat/over intervene</td>
</tr>
<tr>
<td>Lack of re-evaluation</td>
</tr>
<tr>
<td>Need to standardize and ensure consistency, and balance quality with flow</td>
</tr>
<tr>
<td>Improve infection control</td>
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<thead>
<tr>
<th>Costs &amp; Funding</th>
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<tbody>
<tr>
<td>FUNDING</td>
</tr>
<tr>
<td>Community funding is low</td>
</tr>
<tr>
<td>Coverage focuses on hospitals and physicians</td>
</tr>
<tr>
<td>Lack of flexibility in the redistribution of funding</td>
</tr>
<tr>
<td>COSTS</td>
</tr>
<tr>
<td>Services in hospital are extremely expensive</td>
</tr>
<tr>
<td>Increased volumes create cost pressures</td>
</tr>
<tr>
<td>Rising costs of technology, medication and retirement homes</td>
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<thead>
<tr>
<th>Human Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>RECRUITMENT &amp; RETENTION</td>
</tr>
<tr>
<td>Lack of operating room time resulting in specialists leaving the area. Also difficult keeping nurses and PSWs who can seek higher pay elsewhere</td>
</tr>
<tr>
<td>Difficulty attracting staff to small hospitals</td>
</tr>
<tr>
<td>Limited HR in primary care</td>
</tr>
<tr>
<td>Need to focus on stabilization of resources</td>
</tr>
<tr>
<td>DEMAND PLANNING</td>
</tr>
<tr>
<td>Difficultly predicting needs</td>
</tr>
<tr>
<td>Large proportion of hospital budgets are related to salaries, which has important cost implications</td>
</tr>
</tbody>
</table>
Most roles for new staff are part time, meaning that future generations are getting less experience and have less incentive to stay. Need a regional approach to succession planning.

- Challenge of aligning patient versus education centered mission
- Must meet expectations of prospective students – i.e. offer leading technologies

CCAC has been growing their hours to see more patients, but services that they send patients to are not able to keep up with this increased flow of patients. Hospitals and CCACs are not well integrated in the discharge process resulting in inefficiencies (seem to operate in parallel rather than together). The post-acute services space is challenging to navigate.

### 2. What is working well today and should be continued or strengthened in the future to address the challenges we are facing in the South East LHIN?

Despite the many challenges that the health system faces, the South East LHIN has also taken important steps to address some of these issues and work towards providing better care for patients. Some of the strengths of the current system include:

- Consultant services between providers
- Access to care teams
- Communication between hospital leads
- Positive attitude toward SECHEF and desire for system change
- Patient advisory committees who keep the focus on the end-user voice

- Smooth transitions, i.e. when moving from hospital to hospital
- Well-coordinated patient transfer service. Nurse practitioners play an important role in positive transfer outcomes
- Non-urgent transport put in place by the LHINs: continue to grow this model
- Telehealth: continue to improve on use of OTN

- Good community resources (i.e. CCAC & CSS) and sharing between services
- Technology/Information Systems: Emergency Department Information System (EDIS), HIS/SHIIP, IAR, eReferral, ED CCAC Notification System. There is opportunity to further improve use of these systems
- Use of quality improvement tools

- Satellite services help meet needs close to home: can further improve this support network
<table>
<thead>
<tr>
<th>Hospital Approaches</th>
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<tbody>
<tr>
<td>Good communication between hospital and primary care providers and pushing discharge summaries out before patient is discharged to community (CDR): still improvements needed</td>
</tr>
<tr>
<td>Progress in relationships with academic centre and outreach services in the smaller communities/hospitals</td>
</tr>
<tr>
<td>Hotel Dieu Hospital short stay program: 1.7 days for admission with community support and outpatient rehab</td>
</tr>
<tr>
<td>Lennox &amp; Addington: expanded clinics to include specialized care within its small hospital allowing patients to receive specialized care in the community i.e. one-day clinic provided by a specialist to minimize backlog at the larger hospital</td>
</tr>
<tr>
<td>Quinte Health Care: addressed geographical challenge by developing a transportation system to allow for easy access between the 4 hospital sites. Used for low function needs in place of EMS and to assist in deployment of resources</td>
</tr>
<tr>
<td>Providence Care: reduced inpatient beds through divestment and shifting care into the community</td>
</tr>
<tr>
<td>Kingston General Hospital: Peripheral hospitals and KGH are working well together to take acute patients. Clinics work in partnership with KGH to deliver services locally, such as chemotherapy and plastic surgery</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>System Level Models of Care</th>
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</thead>
<tbody>
<tr>
<td>The <strong>Stroke Program</strong> uses a systemic approach that trains people across the system and in a prevention clinic.</td>
</tr>
<tr>
<td>The <strong>Family Health Team</strong> model leverages allied health and system navigators. It works well, but needs to be expanded to meet demand.</td>
</tr>
<tr>
<td><strong>Health Links</strong> provides a good example of the value of communication and collaboration. Improved networks and communication can help patients easily access the most appropriate service and improve navigation, easing demand on the ER.</td>
</tr>
<tr>
<td><strong>Self-Managed Attendant Care</strong>: patients receive money to hire and train their own attendants, which provides consistency of care. This fiscally responsible strategy for care works well and allows patients to manage their own care and submit reports.</td>
</tr>
<tr>
<td><strong>SMILE Program</strong>: long term support program for frail and elderly seniors that helps with activities essential to daily living to allow them to remain in their homes</td>
</tr>
<tr>
<td><strong>Regional Care Coordinator Program</strong>: a pilot program where a care coordinator works with the client to “team build” and provide the community resources the client identifies and needs - coordinating the care beyond health care</td>
</tr>
<tr>
<td><strong>Assisted Living Program</strong>: 24-hours PSW staff assisted living apartments provide clients a level of security and support. This is a cost effective program, however</td>
</tr>
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</table>
the SE LHIN has not progressed much in this area. More assisted living would free up LTC beds which would alleviate pressures on acute care hospital beds.

- **Veterans Independence Program**: provides ground works, housework, etc. to veterans and their spouses to help them stay in their homes.

### 3. Are there new or emerging initiatives that could address the challenges?

New and emerging initiatives that can address the health system challenges fall into five broad categories: overarching system redesign, technology and information systems, patient role, funding, and models of care. Approaches to improve each of these areas are described in below:

| Overarching System Redesign | - Centralize leadership, system and accountability (i.e. reduce CEO’s, CIO’s, CFO’s)
| - Build relationships between all hospitals and community services
| - Eastern Ontario Lab system to facilitate purchase of specialized equipment that can be shared across the region
| - Consider potential for consolidation of wards/services and merging hospital sites |
| Technology & Information Systems | - Real time data solutions and automated options to reduce hand-offs of documents, reports, etc.
| - Common information system and standardized health records
| - Easier access to information across platforms, including ability to use mobile technology
| - Improvement and expansion of current initiatives: OTN, CDR and SHIIP (South East Health Integrated Information Portal), ED/CCAC notification system and HIS project
| - Patient friendly portal: shows position on wait list, provides map to direct patient to facilities in the region, etc. |
| Patient Role | - Communication/education to patients regarding appropriate roles and how to access services
| - Ensure patients are informed and empowered
| - Increase opportunities for self-managed care
| - Increase discussions with Patient Advocates to support continuous improvement |
| Funding | - Make sure the funding flows with the patient – post hospital to home care
| - Improve physician payment system to align incentives with optimal patient care |
| Models of Care | - Expand capability of community options, including CCAC, paramedicine, etc. |
- Leverage collaborative care plans, such as Health Links. Consider how to scale this program
- Work with primary care providers to ensure open appointments that CTAS 4/5 patients can be directed to
- Establish continuity of care with family doctors tracking patients through hospital and ensuring good communication back to primary care providers
- Use NPs and alternate providers to help address care needs currently served by physicians. Case managers can help with directing patients to the appropriate care (i.e. in many cases a nurse is sufficient)
- Expand the Family Health Team model in the LHIN to increase initiatives that look at reducing admits and easing discharge
- Seamless transitions of care: provider to provider, hospital to home, primary care to hospital
- Establish repatriation plans for patients who can’t be managed in the home. May require more convalescent beds
- Provide more hospice/respite care between the hospital and the home
- Establish Nurse Navigator positions. In Toronto, Nurse Navigators work in LTCHs supporting patients to help them stay out of the ER

In undergoing change, it will be essential to ensure that local perspective is maintained. It will also be important to have a sense of urgency in decision making. There should be a concerted effort to address needs thoughtfully and quickly to ensure that each action taken is a step in the right direction.
SMALL GROUP DISCUSSION #2
The second group discussion asked participants to consider elements of a high performing health system and what this could look like in the South East LHIN. They specifically addressed the following questions:

1. What would a high-performing hospital system look like in the South East region? What are the features of that system?

2. What is one thing we should be doing differently in the South East region, related to the hospital system that would improve care for the patient?

3. How will we know we are successful? What will be different about patient experience and access, quality of care, system costs, our ability to attract and retain health human resources, and our academic role?

1. **What would a high-performing hospital system look like in the South East region? What are the features of that system?**

   Participants noted that a high performing system would be seamlessly integrated, with the flexibility to adapt to changing needs across the system and over time. It would also have a common infrastructure that incorporates accountability, quality and transparent information sharing. This system would contribute to outcomes such as elimination of ALC within acute care, removal of social barriers for caregivers, and ability to meet the needs of priority populations. It will be important to eliminate rules and restrictions that are barriers to improved care, and to disseminate best practice by publishing new and better models of care.

The following chart highlights the key components of a high-performing health system, as identified by participants:

| Accessible | • Offer 7 day per week service, including increased access to urgent care centres and general practitioners  
|            | • 24/7 regional referral system  
|            | • Provide CCAC services within the hospital |
| Shared Systems | INFORMATION SYSTEMS  
|             | • Centralized database  
|             | • One electronic platform for the region/single system integrator  
|             | • IT across all providers |
| Patients and providers have access to data (data travels with patient)  
| Data driven feedback to drive change  
| Better use of OTN, iPad for consultations, eFollow up visits |

**Purchasing**
- Pooled resources to increase purchasing power. Develop an inventory of medications, equipment, beds, staff, etc.

**Integrated and Accountable Governance**
- Governance integrated across the LHIN (consider possibility for one hospital board)
- Ensure that information is shared between boards
- System oriented approach at executive and senior leadership level

**Innovative Models of Care**
- Timely, coordinated, right care right place right time
- Defined and standardized care plan from registration to clinical pathways
- Safe and seamless transition points that ensure coordinated care, eliminate duplication and facilitate ease of movement between organizations
- Improved navigation: make it clear to patients where/what to go to and when. Include navigators or patient coordinators to guide patients
- Integrated transportation system that enables teams to follow patients: remove barriers so that staff work where they are needed
- Keep outpatient services as close to the patient as possible
- Take a preventative approach: community centres/preventative care access centres
- Improved use of hospital resources (staff, beds, clinics)
- Establish centres/nodes of excellence
- Partner with academic centres and offer applied projects

**Clear Provider Roles**
- Role Clarity
- Redefine roles: i.e. greater scope of practice for EMS, nurses, etc.
- Enable front-line staff by encouraging process improvement at all levels

**Patient Empowerment**
- Educate patients to ensure they are informed in their care
- Flexibility to allow the patient to make their own experience: standardization vs. personalization

**Alignment with Community Services**
- Leverage community services
- Make decisions in consultation with community partners
- Use CCACs to improve coordination between hospital and community staff
2. What is one thing we should be doing differently in the South East region, related to the hospital system that would improve care for the patient?

Participants identified a variety of approaches that should be done differently in the South East LHIN, as captured in the diagram below. This proposed network is functionally and administratively integrated to facilitate better communication and quicker access to care across the LHIN. Other features include: streamlined services, combined organizational programs, access to data that informs decision making, and centres for specialized care.
3. **How will we know we are successful? What will be different about patient experience and access, quality of care, system costs, our ability to attract and retain health human resources, and our academic role?**

Lastly, participants were asked to consider how system changes will impact patient experience and access, quality of care, system costs, ability to attract and retain health human resources, and the academic role in the South East LHIN. Anticipated features and impacts are outlined below:

| Patient Experience and Access         | • Increased satisfaction and engagement  
|                                      | • Clear transitions and continuity of care  
|                                      | • Referrals that are always appropriate  
|                                      | • Facilitate better understanding of care and how to navigate the system  
|                                      | • Change expectations to shift toward a community based care approach  
|                                      | • Increased self-management of care  |
| Quality of Care                      | • Reduce ALC, adverse risks and readmission  
|                                      | • Narrow variation of quality  
|                                      | • Less transfer of patients between institutions  
|                                      | • Specifically defined metrics and targets that are measured along the continuum  
|                                      | • Increase patient perception of health system as being safe and secure  |
| System Costs                         | • Reduce cost per patient journey to achieve costs in line with Ontario average  
|                                      | • Bend the cost curve  
|                                      | • Use intelligence based data to inform spending  |
| Ability to Attract and Retain Human Resources | • Regional approach to HR recruiting, staffing and succession planning  
|                                      | • Ensure that expertise is shared across the region (i.e. not centralized to one organization or city)  
|                                      | • Become an employer of choice  
|                                      | • Better engage the front-line and develop incentives for these staff to stay in the system  
|                                      | • Foster a collaborative and trusting environment  
|                                      | • Create more full time positions (rather than 0.5 FTE)  
|                                      | • Achieve outcomes such as: noted reduction in staff turnover, overtime and sick time; staff that show up motivated and willing to work  |
| Academic Affiliation                 | • Regional model, not just offered in Kingston  
|                                      | • The academic health sciences network feeds the needs of the system  |
- Optimize the balance between education needs vs. client care (address concern that the academic process is taking resources away from patient care)
- Curriculum shift aligns with shift in care
- Better health education within the schools, including development of skills to interpret data
- Access to greater amounts of data that facilitate improved research opportunities

In summarizing this discussion Mark Rochon explained that transformation is about healthcare, not just hospitals. High performing health systems incorporate integration, accessibility, and communication. There should be accountability processes in place to ensure strong governance, a common information platform shared with patients and providers, clarity around roles, and improved navigation and transportation. It will be important to measure and report on a regular basis, and to look at data and utilization of the healthcare system to focus on continuous improvement of both patient and employee satisfaction.
Conclusion

In his closing remarks, Paul Huras expressed that this session was an extremely important first step in the journey of transformational change. He noted that it was encouraging to have so many participants at the session who demonstrated an active interest in sharing ideas that will help inform this change.

Through continued engagement with health leaders, clinicians, and the public, the South East LHIN will continue to develop and build a high-performing health system that improves access to high quality and sustainable care.
Development of a Sustainable Integrated Model of Hospital Care

Change through Collaboration (CtC)

February 9, 2015
Introduction

Purpose

This approach has been developed to foster collaboration among the seven hospitals in the South East LHIN and their partner organizations (e.g. SE CCAC, Queen’s University etc.) to aid in the development, implementation and continuous improvement towards a sustainable hospital system in the South East LHIN.

Background

This approach has its foundations in rigorous change management methodologies. It is based on the evidence-based NHS Change Model that has been used to create ongoing change to improve performance and create an environment of innovation in the United Kingdom. This approach also incorporates elements from the “science of collaboration”, an examination of the components that make collaboration work based on the work of Papadaki and Hirsch (2013).

NHS Change Model

The NHS Change Model is based around the premise of a shared purpose. Each of the components strives to achieve this shared purpose. The Change Model was developed to support the significant improvements that would be required throughout the NHS to achieve the “Nicholson Challenge” to find £20 billion in efficiency savings. Website: http://www.changemodel.nhs.uk/pg/dashboard

“Science of Collaboration”

The Science of Collaboration is based on an analysis of the evidence of the criteria for success for large scale collaboration. It is based on large scale biomedical research (e.g. HIV/AIDS discoveries). The criteria include the following:

• Distributed innovation
• Distributed leadership
• Complex adaptive systems
• Adaptive network-centric communications

It is based on a system that is continually learning and adapting based on the flow of information across that network.
Why Change through Collaboration?

The hospitals in the South East LHIN face a confluence of factors that will impact their ability to continue to provide excellent patient care. These factors include the following:

- Increasing demand due to population growth and aging;
- High and increasing incidence of chronic diseases that increase the intensity of care provided;
- A net negative impact on hospital budgets due to health system funding reform;
- An aging workforce that will increase competition of health human resources; and
- Increasing evidence on quality of care that will drive system redesign and integration.

All of these issues will converge to place significant strain on a system already at capacity. The solutions will require a transformational approach to how services are currently provided in the LHIN. To move the system along this path from the way services are currently provided to one of transformational change requires a broad, bold engagement strategy that supports each and every person within that system.

This strategy will address critical partnerships with patients and the role they play in their health, support for leadership and the role they play to enable change, and everyone in between as partners for collaboration who are responsible for making change happen and lasting.
CtC: Change through Collaboration

Our Shared Purpose

- Rigorous Delivery
- Leadership for Collaboration
- Improvement Methodology
- Engagement to Mobilize
- Transparent Measurement
- Spread of innovation
- System Drivers

Change through Collaboration
CtC oversight will be provided through a regional coordinating body, or Project Management Council (PMC). The CtC PMC will have representatives from each of the partner hospitals in the LHIN, the SE LHIN, Queen’s University, and the SE CCAC as shown in the graphic. The CtC PMC will be chaired by a hospital CEO as sponsor or co-CEO as co-sponsors. The hospitals will have a range of functional and clinical leaders to provide the appropriate content expertise.

The CtC PMC will be responsible for overseeing the direction, development and ongoing operations of the CtC. Each site will have a representative that will be a voting member of the PMC. The PMC will establish project management standards for all projects that are managed through the PMC. Project managers responsible for implementing projects related to the hospital sustainability project will present for approval at each phase of the project.

Project management standards will be based on the Project Management Institute (PMI) Project Management Body of Knowledge (PMBOK), a recognized global standard. A set of standard tools and templates will be developed for use by all Hospital Sustainability project managers.

The council will also be responsible for facilitating and coordinating the spread of innovation. The section on ‘Spread of Innovation’ describes this role further.
To keep it simple, the hospitals in the South East LHIN cannot provide the level of excellence today into the future without changing the way they provide services. To get this right for patients across the region, this must be achieved through collaboration.

In every jurisdiction where large scale transformation has been successful, there has been a commitment to a shared purpose.

That purpose is often supported in the ideology of “one system”. That by focusing on how to create a highly functioning system, the roles for the providers in that system are clearly defined.

*The shared purpose was further defined in the Visioning Day held on October 30, 2014 which brought stakeholders and patients together to define what a high performing health system in the South East look like. See Appendix A, Summary of the Visioning Day for those outputs.*
The role of leaders is vital to the change process. People often require visible role models, demonstrating desired behaviors and offering encouragement and support in order to support their own development and behavioral change. Leaders need to understand their strengths and how they can leverage these to support the change being implemented in the organization.

Through a targeted program to support leaders, to provide them with the skills and tools to lead change, one of the key enablers to successful change will have been established. This program includes the following:

1. Identification of both formal and informal leaders
2. Behavioural diagnostic of leadership skills
3. Alignment of leadership through targeted events
4. Leadership coaching
5. Skills development through collaboration through Leading Change workshops and training
6. Leadership Action Plans

Targeted strategies are required across all these domains to address the needs of physicians and physician leadership, Executives, Directors, and Front-line Managers.

Each domain is described further below:

1. Leadership identification
   A formal process through skills and capability matching to identify champions that will become formal change leaders to provide support and guidance to others in the organization throughout the change.

2. Leadership behavioural diagnostic
   Change Leadership Behaviors Diagnostics (CLBD) is a way to help leaders understand and reflect on their own behaviors, and what they are able to offer to support the change and what they may need to change.

   The 360-degree Leadership Diagnostic tool provides leaders with feedback on their behaviors that contribute to the success of change. These behaviors are:
   - Sets direction
   - Mobilizes action
   - Builds capability
   - Acts with courage.

   The process can be used for all leaders required to support collaboration and change.
Building leadership capacity and commitment will help to:

- Demonstrate management visibility, ownership, and accountability in the change process
- Create shared ownership to deliver results
- Help enable individuals at all levels to assume needed responsibility to facilitate change
- Create and foster confidence in management’s ability to achieve the vision/goals
- Improve management decision making and issue resolution processes.

3. Leadership alignment events

Achieving alignment within the leadership team is fundamental to a successful change program. However, this does not necessarily happen without structured engagement.

‘Generating Leadership Alignment’ events describe a range of activities, which will take leaders through a process by which they identify key issues, develop common objectives and agree the approaches to address the challenges.

These events can be utilized to achieve anything from developing a vision or a strategy, rapidly translating strategy into action, accelerating the design of new organizations or processes to designing a new product or improving the effectiveness of operations.

These collaborative events help organizations achieve their goals and resolve complex challenges quickly. They help accelerate the change process, reduce change timescales and support early realization of benefits.

4. Leadership Coaching

Coaching can be an incredibly powerful tool for focused skill development. Coaching in this instance refers to the identification of a coach, setting goals and objectives with the coachee, and establishing focused coaching sessions to coach and discuss progress towards the change process.

5. Leadership Skills development

Ongoing targeted training and skills development to support leadership throughout the change process will be critical to maintaining momentum. Leading Change workshops and training will provide leaders with a toolset that includes the following:

- Systems thinking, and how the role their organization plays in that system
- How to enable systems thinking in others, particularly skills that enable collaboration, and building from a partnership model
- The common attributes of fear and resistance around change and how to address and support staff that are anxious about the changes taking place throughout the South East LHIN.
6. Leadership Action Plans
Leadership action plans are developed during the Leading Change workshop. They are an output of the session that leaders take away with them to have a set of very direct actions they will take to lead and support change and collaboration.
A consistent improvement methodology across each of the hospitals in the LHIN provides added simplicity if each organization is speaking the same language. One approach would be to use the quality improvement methodology IDEAS (Improving and driving excellence across sectors) that has been launched by the Ministry of Health and Long-term Care to support the transformation towards a more patient-centered, value-driven healthcare system.

Designed and delivered in Ontario for Ontario, IDEAS builds on the internationally respected Advanced Training Program developed by Intermountain Healthcare in the US. IDEAS is delivered through a collaborative partnership among seven Ontario universities, including Queens, Health Quality Ontario (HQO), the Institute for Clinical Evaluative Sciences (ICES), and the Institute of Health Policy, Management and Evaluation (IHPME) at the University of Toronto.
Engagement encompasses strategies to engage with patients, staff, physicians and community partners. The underlying premise in all engagement will be to empower individuals to support and make change happen, and to rally around the shared purpose.

Components of the engagement strategy include the following:

- **Visioning for the Future**
- **Assessing change risk and the impact of cultural differences**
- **Stakeholder analysis to identify opportunities and issues**
- **Workshops and training for staff to engage on a personal level about collaboration through change**
- **Implementation project teams that will support individual change projects**
- **Engaging with Patients through Patient Experience-based Design**
- **Communication throughout the change**

Each of these components is described below.

**Visioning for the future**

A stakeholder forum that includes all hospitals, their partner organizations and patients will be held on October 30th. This forum will help to establish a shared purpose and be the staging ground for the launch of the project with the wider community.

Participants will be presented with the case for change and will be asked to validate those findings with their lived experience. A key outcome of the session will be visioning what a high performing health system will look like in the South East LHIN, with a focus on the role of hospitals in that system.

**Change Risk Assessment**

This diagnostic will shed light on organizational capacity for change. It will allow change leadership to develop the right solutions while also creating a roadmap to move the hospitals and impacted organizations through the Change to drive sustainability.

A Change Risk Assessment:

- Articulates the specific recommended actions required to proactively manage the change effort
- Provides the basis for a more accurate estimate of the impact of the planned changes on the organizations
Engagement to mobilize (2)

• Allows for the proper degree of attention and focus by the project on the impacted organizational groups
• Provides key input to downstream change management deliverables by identifying the situational enablers and barriers
• Provides insight into organization risk to drive change strategy
• Proactive means to engage stakeholder groups
• Means to drive two-way communication around resistance areas
• Is a critical framework to support future state solution based on organizational capacity for change.

Stakeholder Analysis

Stakeholders can be defined as any person / group of individuals, internal or external to the organization who will be impacted by the changes, or who could have an impact on the success of the project. A Stakeholder Analysis identifies who the stakeholders are and evaluates their current commitment and what level of commitment is required from them in order for the project to succeed.

The results of the analysis provide information to support development and/or implementation of:
• Stakeholder Management Plan
• Communication Plan
• Change Leadership Behaviors Diagnostic
• Leadership Action Plan Framework
• Risks and Issues Log.

Each of these in turn detail the actions required to strengthen stakeholder support and/or to overcome resistance.
Staff training and workshops

Transformation on the scale being proposed cannot be achieved without each individual recognizing their role to make it happen. Part of this can be achieved through communications, however facilitated sessions where individuals can ask questions and reflect on how they are being asked to do things differently helps people realize that things will be different from that point forward.

Training sessions will be provided to all Executive team members, Physicians Leaders, Directors, and Managers. These sessions will reflect on their specific role as leaders of the change. More importantly it will train these leaders to facilitate training and discussion amongst their staff. To support them in the change and provide an avenue for them to be involved, engaged and a route for bi-level communication. Additional sessions will also be provided for Union leaders, front-line staff and Academic Leaders.

Implementation project teams

Project teams will be leading each of the projects for the implementation of the hospital sustainability project. These teams will likely have representation across multiple hospital sites. Project leaders will be required to conduct training workshops with their project teams on the collaboration through change process to help them understand cultural differences and how to deal with resistance to change.

Patient experience based design

Experience based design is a method by which patients are engaged in the care redesign process. Their experiences are used as a marker to influence how care pathways are designed.

In the redesign of care pathways patient experience based design methods will be incorporated in the design phase.

Guidance on these methods can be found at the Candian Foundation for Healthcare Improvement: [http://www.cfhi-fcass.ca/WhatWeDo/PatientEngagement/PatientEngagementResourceHub.aspx](http://www.cfhi-fcass.ca/WhatWeDo/PatientEngagement/PatientEngagementResourceHub.aspx) or the Institute for Innovation and Improvement in the UK: [http://www.institute.nhs.uk/quality_and_value/experienced_based_design/the_ebd_approach_(experience_based_design).html](http://www.institute.nhs.uk/quality_and_value/experienced_based_design/the_ebd_approach_(experience_based_design).html)
Communication

Consistent and frequent communications will be required across the network of hospitals and partner organizations in the LHIN. To facilitate this the South East Hospitals communications committee established for the Hospital Sustainability project will be the ongoing body to lead and design the communications strategy. This committee will have a rotating chair on an annual basis, and include a hospital CEO as an advisor.

The key themes for the communications campaign will be one of working together across the system to build a sustainable system.

See Appendix B, the communications strategy for Health Care Tomorrow, Phase 1.
Across the hospitals in the South East there are pockets of innovation. These will continue to flourish once the Hospital Sustainability project is implemented. To encourage the spread of innovation across the network of hospitals in the LHIN, the following methods will be used:

- Accountability for facilitating and coordinating the spread of innovation is part of the role of the regional CtC Project Management Council
- A regional innovation portal will be developed to capture and share experiences on individual and hospital and shared innovations. To be effective, the management of these innovative projects requires a consistent and standardized approach to project management and outcome measurement. The portal will provide a quick capture of the specific initiative, the results, how they were achieved, and who was involved and how to contact them.
- A regional virtual huddle board will be created to facilitate cross regional initiatives and ongoing performance improvement from a regional perspective as a tool for the CtC PMC.
- As part of the regional virtual huddle board, a regional hospital sustainability scoreboard will be developed to track the performance of all projects, and their impact at attaining sustainability.
- An “innovation day” will be planned to help launch Health Care Tomorrow amongst front-line staff and Managers. These sessions help provide context to the “ask” of front-line staff and those initiatives that have worked well across other hospitals in the region.

An innovative approach to ongoing regional solution development will be the development of a virtual ‘Jidoka’. In Lean terms, it means to stop-the-line of production. In this instance, the CtC can call together providers from across the region to discuss and resolve an immediate issue (e.g. gridlock).
It is often said that what gets measured, gets done. Each project under the hospital sustainability banner will have a set of target outcome measures across multiple dimensions, for example, quality improvements, financial efficiency targets, patient experience. These measures will be agreed with the CtC PMC at the onset of the project and reported at the end of each project. These will also be reported on the dashboard that will be part of the Improvement Portal.

Measures can also be tracked throughout the project to monitor the impact across the dimensions as the project is being implemented.
The ongoing sustainability of the hospital system in the South East LHIN will depend on the ability to maintain any improvements that are achieved.

To enable this an exercise will be undertaken to assess the key measures and indicators in place as part of the contracting between hospitals, between hospitals and partner organizations, and between the SE LHIN and the hospitals. These indicators help to drive behaviours and may need to be revised to support ongoing sustainability of the system.

A move to more value-based contracting where possible will be incorporated into any revised performance requirements.
CtC Timelines

Phase 1: Current State and Opportunity Development

- Establish vision, goals and desired outcomes, assess organizational risk and cultural readiness to change, lay the foundation to support the change process

Phase 2

- Develop change interactions to address key target groups affected by the change

Phase 3

- Support transition to the new environment

Rigorous Delivery

Leadership for Collaboration

Engagement to Mobilize

Spread of Innovation

System Drivers

Communication

Elements

- Project phase
- Objective
- Establish Project Management Council
- Establish Project Standards, Policies and Process
- Leadership Identification and Diagnostic
- Leadership toolkit development
- Leadership alignment events and action plans
- Leadership coaching and leading change workshops
- Visioning Day
- Stakeholder engagement: visioning
- Stakeholder engagement: future state development (Working Groups)
- Change risk assessment
- Change strategy
- Stakeholder engagement: Understanding the change
- Develop regional innovation portal
- Develop regional virtual huddle board & scoreboard
- Innovation Day Launch
- Review system drivers and incentives
Appendix H – Decision-making and Dispute Resolution Process
This document serves to clarify the decision-making process for the Health Care Tomorrow – Hospital Services planning. As part of the decision-making process, a dispute resolution process has been proposed for discussion at the March 18 SECHF CEO meeting, and is now being presented for recommendation to the Chairs and Vice-Chairs of each hospital Board. This process will then be presented to the Boards of the hospitals, CCAC and LHIN.

In October 2014, all Boards passed a resolution that committed each organization to communicate their perspectives with regard to options and proposed directions established by SECHF. In keeping with the resolution and in the spirit of wishing to promote the collective aspirations of all participants to achieve a sustainable, high quality health care system, this dispute resolution process has been established.

The outcome of Phase 1 of the Health Care Tomorrow – Hospital Services planning will be a set of opportunities, options and recommendations for system transformation that will contribute to the sustainability of the hospital system in South East LHIN. The opportunities and recommendations will be developed and guided by the principles, as established by SECHF in the Project Charter.

SECHF will strive for consensus of opinions in its recommendations and advice to the hospital Boards and the South East LHIN.

Consensus does not mean unanimity, and the following criteria will guide achievement of consensus:

- Consensus strives to arrive at a point where all members can support (or at least live with) the recommendations;
- Consensus strives to synthesize many diverse elements and consider all options;
- Consensus involves a process that seeks to achieve an understanding of all views and resolve (where possible) minority objections; and,
- SECHF will value and respect disagreement to provide a full range of recommendations and advice to the hospital Boards and South East LHIN.
The following are principles for decision-making, informed by the Accountability for Reasonableness (A4R) framework, Daniels (2006):

- **Fiduciary Responsibility**\(^1\): All views by Boards will be in consideration of a fiduciary responsibility to the broader health system and patient care, as well as to their own organization.
- **Open and honest communication**: All views will be brought forward in a way that respects open and honest communication with its partners, including transparency on rationale for such views.
- **Relevance**: Decisions should be based on reasons (i.e. evidence, criteria, principles and values) that fair-minded people can agree are relevant under the circumstances.
- **Publicity**: Decisions and their rationales should be publicly accessible.
- **Revision**: There should be opportunities to revisit and revise decisions and a mechanism to resolve disputes. A sufficient and appropriate amount of time will be provided for stakeholders to conduct their own due diligence and identify any alternative views prior to a decision being required to be made by participating organizations.
- **Empowerment**: Effort should be made to minimize power differences and to ensure effective stakeholder participation.
- **Enforcement**: There should be voluntary or public regulation to ensure the other four conditions are met.

**Process for developing recommendations:**
1. A set of system directions and priorities will be established by SECHEF based on a review of the evidence and an established vision by thought leaders in the South East;
2. Recommendations on system redesign will be made through consensus with adequate time for discussion and debate after each member’s concerns have been raised and addressed;
3. Each SECHEF member will present the results of the consensus recommendations to their Board of Governors for consideration for approval;
4. Recommendations as agreed to by participating hospitals and, where appropriate, the South East CCAC will be presented to the South East LHIN on the need for system transformation in alignment with the objectives set out in the project charter;

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\(^1\) The fiduciary duties of Board members require that decisions be made in the best interest of the corporation. Corbett (2014) describes “best interests” with regard to the mission, vision, values and accountabilities of the organization. Accountabilities include patients / clients, regulators, funders, donors, taxpayers, academic partners, the community served etc. Consideration must also be given to the statutory mandate that applies to health service providers that are subject to the Local Health System Integration Act (LHSIA). Accordingly, boards or providers subject to LHSIA must also have a “health system” perspective, looking at the organization through a system lens.
Participating organizations have entered into this project with the expectation that change is necessary to support a sustainable system of integrated care. While it is hoped that there will be consensus amongst the parties to implement sustainable change, participating organizations ought to also understand that there will be an opportunity to be heard in circumstances where consensus has yet to be reached. In the case of a divergent view or views from one of more hospital Boards within the South East LHIN, the following process will be followed to resolve the dispute:

1. A committee of hospital representatives will be formed to hear dissenting views comprised of the Board Chair or Vice Chair of the participating organizations and neutral party representatives (approximately three).
2. Hospital Boards who believe that there is an alternative approach to a particular recommendation will be provided with the opportunity to document their views and alternative(s) for consideration.
3. The Chairs/Vice Chairs committee established for the purpose of hearing dissenting views will meet with the organization that has submitted an alternative option to hear and attempt to resolve the circumstance. The Chairs/Vice Chairs committee may do one of the following:
   3.1 If no change to the recommendation originally proposed by SECHEF is recommended by the Chairs/Vice Chairs committee, then the committee will provide advice to the South East LHIN about a course of action.
   3.2 If the Chairs/Vice Chairs committee wishes alternatives to the recommendation originally proposed by SECHEF to be considered, then the committee will refer the matter back to SECHEF for consideration.
4. Where 3.2 takes place, one of the following will occur:
   4.1 If no changes to the consensus recommendations are made by SECHEF, the South East LHIN Board will receive the following to inform its decision-making:
      - The presentation outlined in step 2;
      - The opinion of the Chairs/Vice Chairs committee; and,
      - The considerations of SECHEF.
   4.2 If the recommendation is adjusted by SECHEF, the revised recommendation will then be presented to the participating Boards for consideration.
5. Should the matter continue to be in dispute following a revision as contemplated in 4.2, the organization(s) will make their views known to the other participating hospitals and to the South East LHIN and the LHIN will then make the final decision.