

StrategiCare '08

The future of health care is in our hands

Phase 1 Final Report – September, 2008

Prepared by:



Introduction

At the request of the Erie St. Clair Local Health Integration Network (ESC LHIN), the hospitals of Windsor/ Essex (W/E), Hôtel-Dieu Grace Hospital (HDGH), Leamington District Memorial Hospital (LDMH), and Windsor Regional Hospital (WRH) – have engaged in a facilitated process to explore opportunities for achieving system improvements via increased integration of hospital services.

The “StrategiCare ’08” project, which started in January 2008, will build on a history of collaboration between the hospitals to develop a high level strategic plan that identifies joint strategies to address current environmental pressures while building a platform for future growth and success. While the hospital boards will remain independent, the hospitals will work together as a “Network” to plan and deliver care for W/E.

Ultimately the hospitals and the ESC LHIN expect to design a future model and staged implementation plan for transformation of the local W/E health care environment over the next five years in order to achieve:

- Sustainable services required by the local population;
- An integrated, coordinated approach to hospital services; and
- Employment opportunities for the region.

Introduction Cont'd

In this first phase of the project, the resulting strategic plan for integration was intended to provide:

- A foundation for change;
- Consensus among healthcare leaders on future directions; and
- An understanding of the challenges involved, and how to overcome them.

All involved recognized that such a strategic plan will need to consider many factors including change management, communication, interdependent projects, clinical priorities, collective agreements and other human resource obligations, and local economic circumstances.

This Phase 1 Report summarizes the work and outcomes to date by the leadership of the *StrategiCare '08* initiative. We would like to thank both the leadership of the hospitals and the ESC LHIN, and the staff who have participated to date. Without their energy and perseverance, *StrategiCare '08* would have stalled due to the significant individual pressures each of the hospitals faced.

This first phase of work focused on the development of high-level plans to strengthen integration across the three hospitals. This document begins with an overview of the hospitals' current challenges and state of program integration, followed by specific high level plans. Introductions to the expected work in Phases 2 and 3 of the initiative close the document. Contents include:

- Project approach: process and structure;
- Overview of the current W/E environment and extent of integration;
- Summary of relevant leading practices in other jurisdictions;
- Strategy and future directions; and
- Phase 2 project plan.

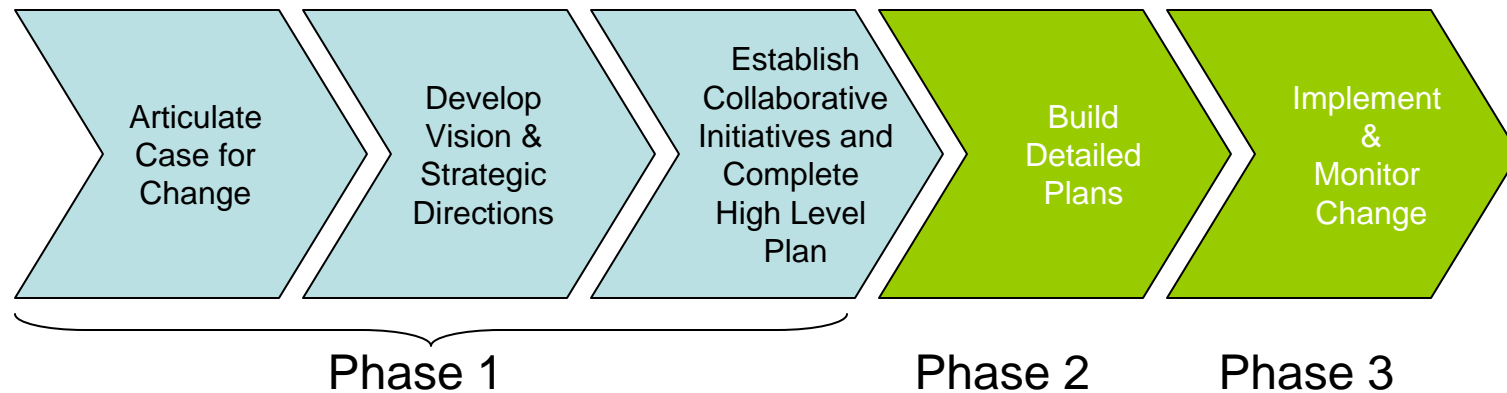
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Project Approach:
Process and Structure



Project Approach



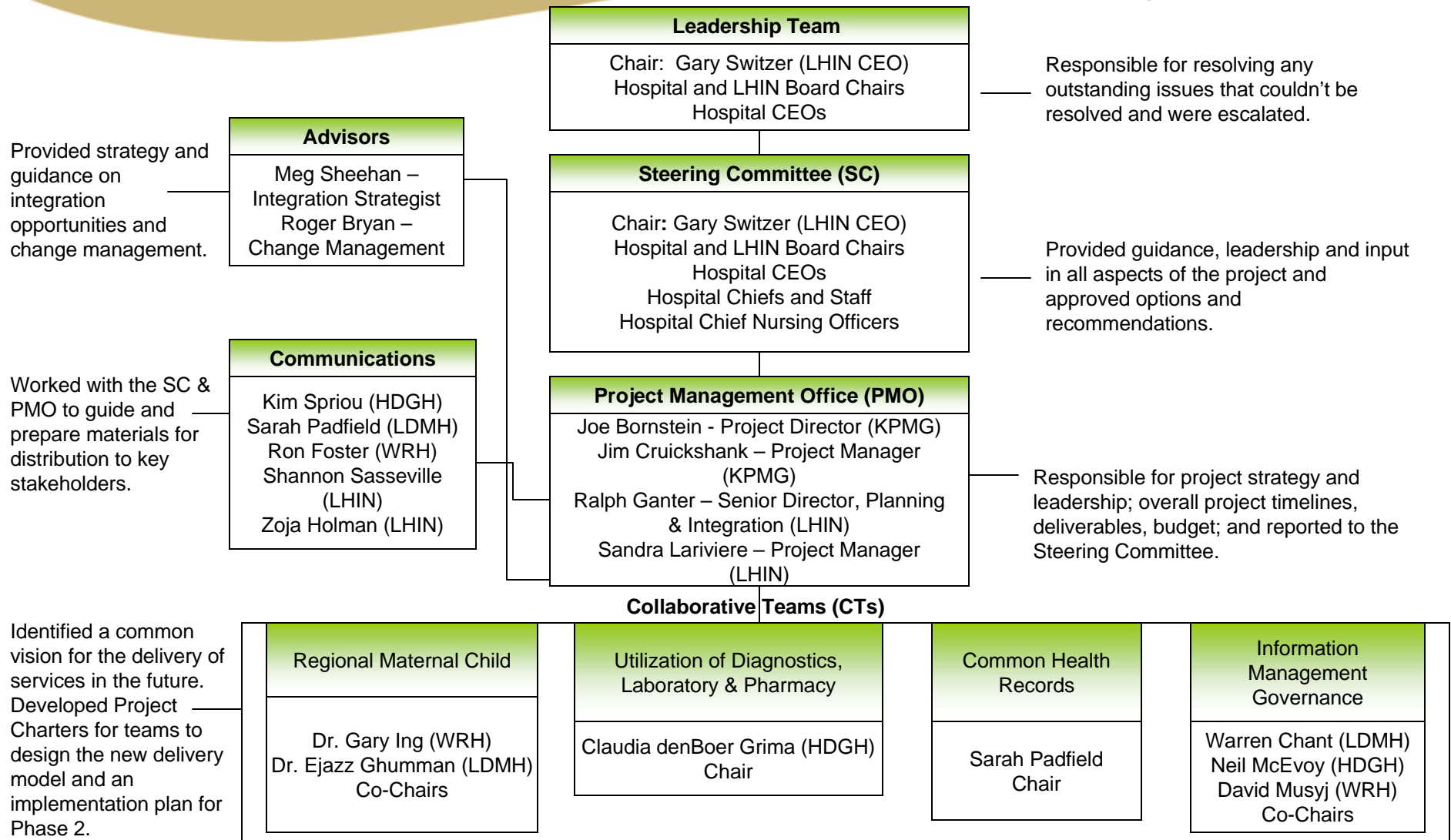
StrategiCare '08 has been planned as a three phase initiative designed to strengthen integration between the hospitals. The main phases of the project are outlined in the figure above.

Phase 1 of the project was completed on June 13, 2008. Phase 2 is estimated to be a six month project phase with a proposed start date of September 2008. Phase 3 of the project can commence as soon as Phase 2 projects are completed and next steps are approved by each hospital's Board of Directors.

Project governance consisted of a Leadership Team and a Steering Committee which met four times between January and June 2008.

Once the current state analysis and jurisdictional review was completed, several initiatives were identified for immediate exploration. The overall structure for Phase 1 is shown on the following page.

Phase 1 Project Structure



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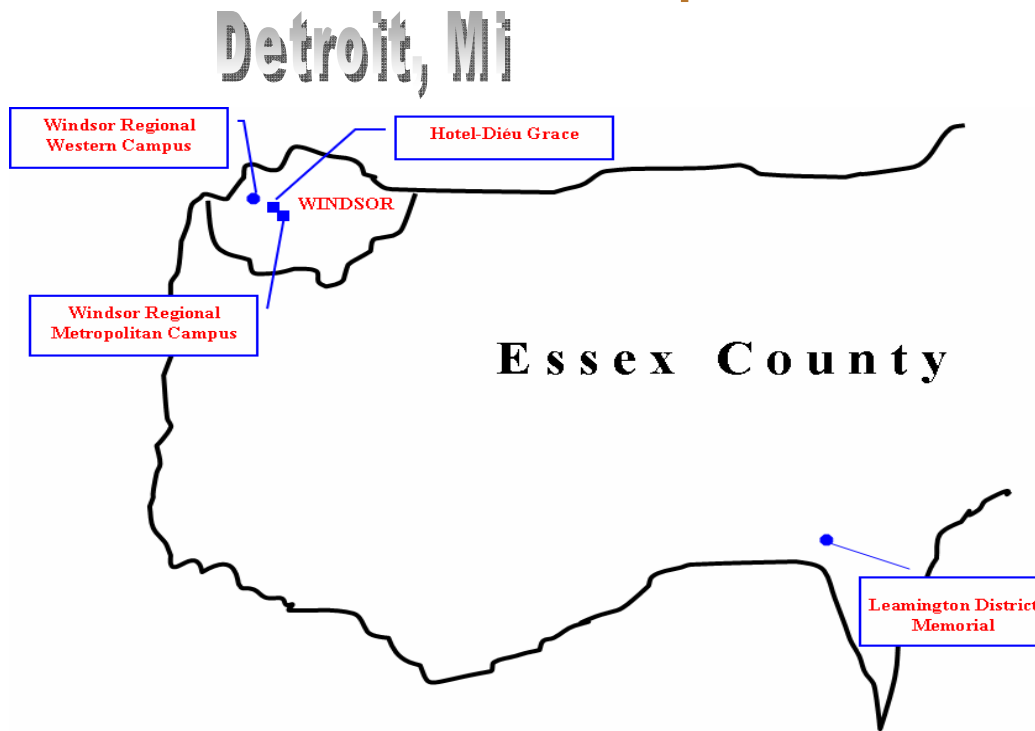
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Windsor/Essex

Current State Environment and Extent of Integration



The Hospitals of Windsor/Essex



Unlike other areas of the province, with the exception of Northern Ontario, the W/E hospitals are a significant distance from an AHSC which may lead to more complex cases being treated by the three hospitals. The region is also “under-bedded” compared to provincial averages.

- Total Population: 393,402
- 2 hour drive from downtown Windsor to nearest Ontario academic health sciences centre (AHSC) – London, Ontario
- Close proximity to Detroit
- Leamington is approximately 54 km from downtown Windsor
- 3 hospitals with Emergency Departments (ED)
- HDGH is the only community hospital in Ontario with a Level 1 trauma centre
- Population growth is expected
- W/E would require an additional 38 Complex Continuing Care (CCC) beds and 82 Long Term Care (LTC) beds to reach the provincial average

Data Source: OHA & Discharge Abstract Database (DAD)

Windsor/Essex Hospital Sites (2007/2008)



Leamington District Memorial Hospital (LDMH)

2007/08 Projected Gross Revenues	\$34,260,326
2007/08 MoHLTC Base Allocation	\$25,198,400
FTE	270
Acute Beds	64
Acute Mental Health Beds	N/A
Adolescent Mental Health Beds	N/A
Mental Health Beds	N/A
Rehab Beds	6
CCC Beds	19
Long Term Care Beds	N/A
Ambulatory Visits	43,200
Day Surgery Cases	1,750

A small community hospital – refers patients to and shares services with HDGH



Hotel-Dieu Grace Hospital (HDGH)

2007/08 Projected Gross Revenues	\$194,354,000
2007/08 MoHLTC Base Allocation	\$146,314,000
FTE	1,542
Acute Beds	215
Acute Mental Health Beds	68
Adolescent Mental Health Beds	N/A
Mental Health Beds	39
Rehab Beds	24
CCC Beds	N/A
Long Term Care Beds	N/A
Ambulatory Visits	184,948
Day Surgery Cases	12,700

A large community hospital with tertiary services and a trauma centre – refers certain services to WRH



Windsor Regional Hospital (WRH)

Metropolitan and Western Sites

2007/08 Projected Gross Revenues	\$249,283,000
2007/08 MoHLTC Base Allocation	\$185,938,000
FTE	2,100
Acute Beds	302
Acute Mental Health Beds	N/A
Adolescent Mental Health Beds	6
Mental Health Beds	14
Rehab Beds	50
CCC Beds	134
Long Term Care Beds	145
Ambulatory Visits	238,138
Day Surgery Cases	13,900

A large community hospital with tertiary services, regional maternal child program, and long term care and complex continuing care (CCC) services – refers certain services to HDGH

Data Source: HAPS 2007/08 Budget (November 30/2007 submissions)

2007/08 Revenue projections taken from most recent fiscal 2007/08 Q3

Financial Reports submitted on the WERS system



The Hospital “Network” of Windsor/Essex 2007/2008



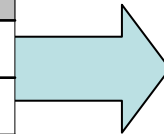
2007/08 Projected Gross Revenues	\$477,897,326
2007/08 MoHLTC Base Allocation	\$357,450,400
FTE	3,912
Acute Beds	581
Acute Mental Health Beds	68
Adolecent Mental Health Beds	6
Mental Health Beds	53
Rehab Beds	80
CCC Beds	153
Long Term Care Beds	145
Ambulatory Visits	466,286
Day Surgery Cases	28,350

Combining the hospitals’ statistics, the total W/E Hospital “Network” functions with about half a billion dollars per year, and employs almost 4000 people.

Distances to Surrounding Hospitals

W/E has a unique geography given the proximity to the hospital capacity in Detroit, Michigan, and the distance from teaching hospital facilities in Ontario. The table below illustrates the proximity of hospitals around Windsor (distances measured from HDGH).

FACILITY	DISTANCE (kms)
Windsor Essex County Hospitals:	
Windsor Regional Metropolitan Campus	4.0
Windsor Regional Western Campus	6.2
Leamington District Memorial	53.6
US Based Hospitals:	
Henry Ford Hospital	10.8
Harper University Hospital	7.0
Detroit Receiving Hospital	7.0
Children's Hospital of Michigan	6.5
Other Ontario Hospitals:	
London Health Sciences	186.6
Bluewater Health	162.8
Chatham Kent Health Alliance	82.2



Given the proximity to Detroit and the two hour drive to the nearest Ontario academic health sciences centre, it is often in the best interests of the patients to utilize the hospital services capacity in Detroit as opposed to other Ontario centres.

Windsor/Essex Systemic Challenges

Bed Supply

- Compared to provincial averages, W/E has fewer beds by category

Cost Pressures

- W/E hospitals are operating above the average Expected Cost per Equivalent Weighted Case
- Costs in operating areas such as pharmacy and lab continue to rise in excess of inflation and revenue

Aging Population

- W/E population is aging which creates increased demand for services in hospitals and in the community
- In the 45-64 age group, the 2005-2010 projected growth for Essex (16.4%), Chatham/Kent (9.9%) is above Ontario (4.0%) projections. This suggests that the majority of the future population will be comprised of seniors emphasizing the need for better health care
- The population of Leamington is already older in comparison to Windsor with the trend continuing

Human Resource Challenges

- The LHIN has fewer health professionals per 100,000 population in comparison to the rest of Ontario Nursing population – significant retirements coming without being offset by an influx of new nurses. The number of young nurses peaked in 2001 and continues to decline
- W/E also has a shortage of family physicians
- Shortage of rehab professionals creates issues of access to services across the county

2006 Bed Supply: Comparing Windsor/Essex to Ontario

The following table summarizes the bed supply in W/E compared to Ontario for most bed types (including beds in the Windsor/Essex hospitals and other facilities in the region). The assessment demonstrates that W/E is below the provincial average in most categories.

Bed Type	Beds Staffed & in Operation (S&O)		Rate/1,000**		Surplus/Shortage to meet Ontario Rate	As % of Current (S&O)
	Ontario	Windsor/Essex	Ontario	Windsor/Essex		
Med/Surgical	14,170	413	1.11	1.01	(39)	-9%
Intensive Care Unit	1,573	49	0.12	0.12	(1)	-2%
Obstetrics	1,448	43	0.11	0.11	(3)	-7%
Paediatrics	715	22	0.06	0.05	(1)	-4%
Mental Health (non-Sched 1)	97	4	0.01	0.01	1	23%
Subtotal Acute Beds	18,003	531	1.41	1.30	(43)	-8%
Psychiatric	4,516	79	0.35	0.19	(65)	-82%
CCC	5,824	148	0.45	0.36	(38)	-25%
General Rehabilitation	1,899	30	0.15	0.07	(31)	-102%
Special Rehabilitation	437	49	0.03	0.12	35	72%
Long Term Care Home (LTCH)	75,110	2,306	94.4	91.2	(82)	-4%

*Planning Decision Support Tool (PDST) November 2007 report. Varies slightly from Beds Staffed & in operation as provided in HAPS. **Using 75yr+ population for Long-Term Care Home beds (LTCH), population not age adjusted.

For acute care beds, W/E is 8% below the provincial rate. However, the largest bed shortages are in the non-acute care beds categories:

- 82% below the provincial rate for Schedule 1 Psychiatric beds
- 25% below the provincial rate for CCC beds
- 4% below the provincial rate for LTCH beds (for persons over 75 years of age)

Bed Supply Projections

The following table shows the impact of projected increases in the W/E population of 11,024 individuals from the year 2007 to year 2010 (408,147 to 419,171).

Bed Type	2007	2010	As % of current (S&O)	
			2007	2010
Med/Surgical	(39)	(51)	-9%	-12%
Intensive Care Unit	(1)	(2)	-2%	-5%
Obstetrics	(3)	(4)	-7%	-10%
Paediatrics	(1)	(1)	-4%	-6%
Mental Health (non-Sched 1)	1	1	23%	21%
Subtotal Acute Beds	(43)	(58)	-8%	-11%
Psychiatric	(65)	(69)	-82%	-87%
CCC	(38)	(43)	-25%	-29%
General Rehabilitation	(31)	(32)	-102%	-107%
Special Rehabilitation	35	35	72%	71%
Long Term Care Home (LTCH)	(82)	(167)	-4%	-7%
S&O - Beds Staffed and in Operation				

Growth in population will increase the number of bed shortages:

- Sub total acute beds from (43) to (58)
- Long-Term Care Home beds from (82) to (167)

Cost per Equivalent Weighted Case

The table below presents the actual and expected Cost per Equivalent Weighted Case for each of the hospitals in Windsor/Essex.

2006/07					
Facility	Total 2006/07 Equivalent Weighted Cases	Actual 2006/07 CPEWC	Expected 2006/07 CPEWC	Over/(Under) 2006/07 ECPEWC	Over/(Under) as % of ECPWC
HDGH	20,019	\$5,490	\$4,532	\$958	21.1
LDMH	4,262	\$4,222	\$4,363	(\$141)	(3.2)
WRH	27,662	\$4,879	\$4,411	\$469	10.6
2005/06					
HDGH	21,581	\$5,066	\$4,315	\$751	17.4
LDMH	4,077	\$4,221	\$4,202	\$19	0.5
WRH	26,350	\$4,736	\$4,251	\$485	11.4
Source of Data: Joint Policy and Planning Committee (JPPC) CPEWC – Cost per Equivalent Weighted Case ECPEWC – Expected Cost per Equivalent Weighted Case					

Overall the W/E hospital system is significantly over the ECPEWC, suggesting that there are opportunities to improve the efficiencies of operations by working together as one “network.”

Defining Integration

Integration is a term often confused with **merger** and **consolidation** when they are in fact, different as defined below:

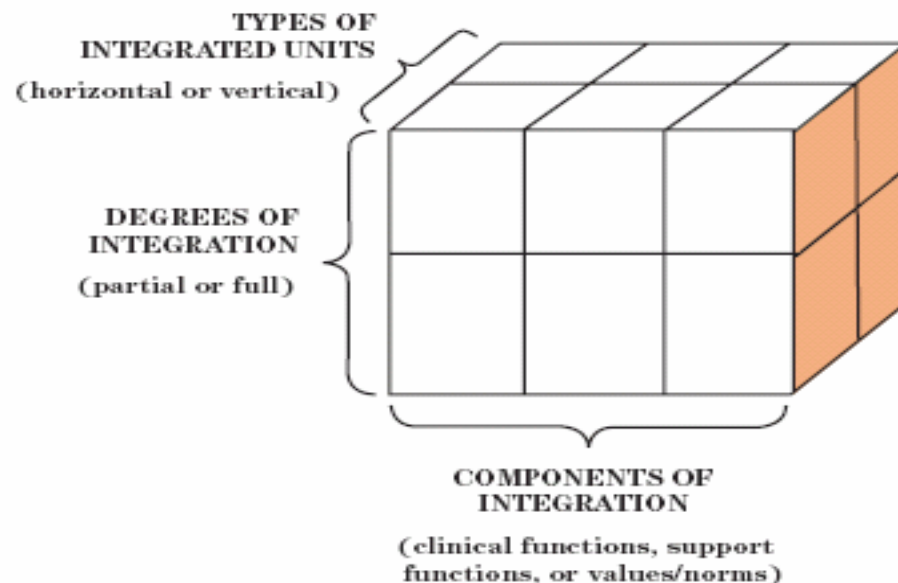
Merger: The union of two or more commercial interests or corporations; the amalgamation of similar organizations.

Integration: The process by which activities are formed, coordinated, or blended into a functioning or unified whole. There are centralized, partially centralized, and decentralized models.

Consolidation: The relocation of services from multiple sites onto one site.

Framework for Assessing the Extent of Integration

The diagram below provides a matrix developed by the Ontario Ministry of Health and Long-Term Care to categorize and define types of health care integration. These definitions speak to integration as a continuum along three dimensions – Types of Integrated Units, Degrees of Integration, and Components of Integration. The Steering Committee used this framework to evaluate the extent of integration currently in place in W/E.



A list of common programs or Program Frameworks was developed for the purpose of assessing the extent of integration of clinical programs across the W/E hospitals. It is understood that there is additional detail within each program area, however this high level summary is suitable for the current discussion.

Traditional clinical support and non-clinical hospital departments were also identified and systematically examined to determine the extent of integration in these areas.

The Clinical Program Framework list includes:

- Women and Children
- Mental Health & Addictions
- Psycho-Geriatrics
- Oncology
- Emergency
- Trauma (both adult and pediatric)
- General Internal Medicine/Family Medicine
- Cardiac Care
- Ophthalmology
- Obstetrics
- Renal/Dialysis
- Pulmonary Function
- Diabetes (both adult and pediatric)
- Surgery
- Complex Continuing Care
- Rehabilitation
- Long-Term Care
- ENT (Ear, Nose & Throat)
- Dental

Integration Matrix Applied to Windsor/Essex Hospital Programs

		<i>Horizontal Integration</i>		
Degrees of Integration (partial/full)				
		<i>Clinical Functions – Programs, Clinical Support, Corporate Support</i>		

The focus of the discussion of integration within StratiCare '08 is primarily on horizontal integration of clinical and support programs. The degree of integration was assessed against a continuum of integration that varies by **degree of integration**. This continuum is segmented into: segregated, partial and full integration as defined to the right. The hospitals were assessed as one system – results are shown on the following pages.

Degrees of Integration:

1. **Segregated integration:** Pieces of the program work independently across the hospitals.
2. **Partial integration:**
 - *Linkage focused* – a loose version of partial integration involving less formal structures and processes. It is characterized as high on communication and low on structure. Examples include guidelines and protocols.
 - *Network focused* – a tighter version of partial integration, involving more formal structures and processes. It is characterized as being high on communication and moderate-to-high in terms of structure for coordination among equals.
3. **Full integration:** Resources are pooled under one management to integrate tasks, functions, and resources in the planning and delivery of services – to limits of current collective agreements – e.g., Women and Children. Full integration does not require a program to be located at a single organization.

Summary of Current State Clinical Program Integration

Criteria	Program																	
	Women & Children	Mental Health & Addictions	Psychogeriatrics	Oncology	Emergency	Trauma (Adult & Paeds)	General Internal Medicine	Cardiac Care	Renal/Dialysis	Pulmonary Function	Diabetes (Adult & Paeds)	Surgery	CCC	Rehab	LTC	Ophthalmology	ENT	Dental
Single organizational leadership (one hospital as lead)				Full Integration					Full Integration									
Guidelines, protocols, care pathways			Linkage Focused			Full Integration												
Joint problem solving and conflict resolution		Linkage Focused	Linkage Focused	Linkage Focused		Full Integration	Linkage Focused	Linkage Focused	Linkage Focused	Linkage Focused	Linkage Focused			Linkage Focused				
Case management across the system						Full Integration												
Information sharing (enabled by technology)																		
Terms of reference for hospital roles																		
Structure for communication process				Linkage Focused											Linkage Focused			
Service agreements			Linkage Focused												Linkage Focused			
Designated coordinator			Linkage Focused															
Physician practice		Network Focused																
Stgaffing																		

Legend - Degree of Integration	
Segregated	
Linkage Focused	Linkage Focused
Network Focused	Network Focused
Full Integration	Full Integration

Observations on Clinical Programs

Trauma and Renal/Dialysis programs

- One hospital (HDGH) provides trauma and dialysis care for the W/E catchment area
- Due to this accountability and centralization at one site, these programs are by definition fully integrated, since the programs are planned, managed and evaluated by one leadership team

Oncology: Regional Cancer Program for Erie St. Clair

- Regional VP responsible to CCO for cancer programs across the region
- Integrated Cancer Program sited at Windsor Regional Hospital, the location of the Cancer Clinic
- Cancer surgery done at both WRH and HDGH, but the Oncology program is not fully integrated in its functions since different components of the “patient journey” are planned, managed, and monitored separately

Women and Children: WRH and HDGH integration

- If LDMH is not included, the Women and Children program would be considered fully integrated due to WRH’s accountability for the program within the city of Windsor
- However, since LDMH provides obstetrics services, with no formal connection to WRH, the program is shown on the chart as segregated

Psycho-geriatrics: A growing need

- This area of clinical programming was identified as a program to provide a greater profile
- As the population ages, an increasing number of elderly patients experience dementia and delusions related to either a history of mental illness, or physical illness

Observations on Clinical Programs Cont'd

Complex Continuing Care, Long-Term Care and Rehabilitation

- As with Women and Children program, WRH plays a leadership role within Windsor for these programs, while LDMH also provides these services with no formal link to WRH
- The program therefore appears segregated on the chart

Program Coordination at the LHIN Level

- Physician leads have been established to coordinate Emergency Department and Critical Care services across the LHIN
- However, the role is currently at a high level and doesn't yet have an impact on the coordination of services within Windsor/Essex

Potential for Further Integration

- Overall the summary suggests limited integration, however with minimal effort a number of programs could become more fully integrated, while maintaining services on multiple sites
- This would build on the current WRH and HDGH single accountability model for programs such as the Women and Children, Complex Continuing Care/Long-Term Care/Rehabilitation, Trauma and Renal/Dialysis by developing service agreements with LDMH

Ambulatory Clinics

- The Outpatient Services provided by each hospital are for the most part linked to the patient care programs provided on an inpatient basis
- This results in duplication and/or triplication of clinics across the sites, e.g. fracture and pre-admission clinics

Summary of Current State Clinical Support Integration

Criteria	Program																	
	Women & Children	Mental Health & Addictions	Psychogeriatrics	Oncology	Emergency	Trauma (Adult & Paeds)	General Internal Medicine	Cardiac Care	Renal/Dialysis	Pulmonary Function	Diabetes (Adult & Paeds)	Surgery	CCC	Rehab	LTC	Ophthalmology	ENT	Dental
Single organizational leadership (one hospital as lead)																		
Guidelines, protocols, care pathways																		
Joint problem solving and conflict resolution																		
Case management across the system																		
Information sharing (enabled by technology)																		
Terms of reference for hospital roles																		
Structure for communication process																		
Service agreements																		
Designated coordinator																		
Physician practice																		
Stgaffing																		

Legend - Degree of Integration	
Segregated	
Linkage Focused	
Network Focused	
Full Integration	

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Observations on Clinical and Corporate Processes



Observations on Clinical Support Processes

Integration to date focused on **Pharmacy, Diagnostic Imaging, and Laboratories**

- Integrated VP across WRH and HDGH

Pharmacy

- There is one Pharmacy Director in place for all three hospitals resulting in joint planning, development of a common strategy, policies and approaches, and organizational structures
- Full integration is limited by:
 - Different information technology and drug distribution systems in place which would require further funding to align
 - Varying labour environments
 - Three separate Pharmacy and Therapeutics committees and resulting three drug formularies
- The Pharmacy Director is also the LHIN lead for Pharmacy

Diagnostic Imaging

- Separate leadership at the department level
- Common Information Technology systems

Laboratories

- Common Director for WRH, HDGH and LDMH
- Common Information Technology infrastructure

CCAC

- Work with each hospital on an individual basis
- No common protocols

Corporate Processes

Hotel

Housekeeping

Facilities

Food Services

Sterile
Processing

Patient Transport
(internal and
external)

Materials
Management

People

Human
Resources/
Organization
Development

Occupational
Health

Education

Planning

Strategic
Planning

Operational
Planning

Capitol
Planning
(Major
Equipment)

Information

Clinical
Information/
Health Records

Decision Support

Finance

Information
Technology

Communications and Public Relations

Summary of Corporate Support Integration

Criteria	Program																
	Health Records	Decision Support	Finance	Info Technology	Planning	Human Resources	Occupational Health	Education	Housekeeping	Facilities	Materials Management	Food Services	Sterile Processing	Biomedical Engineering	Patient transport (external)	Patient Transport (internal)	Communications & Public Relations
Integrated management																	
Approaches, policies and procedures																	
Joint problem solving and conflict resolution																	
Common procurement																	
Information sharing (enabled by technology)																	
Terms of reference for hospital roles																	
Structure for communication process																	
Service agreements																	
Designated coordinator																	
Common infrastructure																	
Staffing																	

Legend - Degree of Integration	
Segregated	
Linkage Focused	
Network Focused	
Full Integration	
Significant planning underway	

Observations on Corporate Support Processes

Materials Management

- LHIN-wide integrated Supply Chain Management Business Case submitted to Ministry of Finance (OntarioBuys program) for implementation funding

Finance

- With the previously Integrated Chief Financial Officer position, there are some common policies, approaches, tools in place between WRH and HDGH

Information Technology

- HDGH provides Information Technology management for LDMH
- WRH participates in CHIS

Planning

- The joint management team meetings and W/E Hospital Coordinating Committee provide a structure for communication and joint planning

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Jurisdictional Review



Purpose of the Jurisdictional Review

KPMG conducted a Jurisdictional Review to provide context and leading practices for the StratiCare '08 project. Specific objectives included:

- Providing an **overview of trends in health care/hospital “integration”**, organizational relationships to strengthen patient care delivery, and cost-effectiveness for a specific geographical region
- Providing insight and understanding into how **hospital organizations with characteristics similar to those in W/E** have completed multi-site integrations of clinical, clinical support and corporate support programs
- Documenting how **acute care hospitals located in the same community** operate collaboratively while maintaining separate governance structures
- Learning from **successful practices** in specific “hospital systems”: what’s been done; what was accomplished; and progress and challenges
- Informing the work of the Collaborative Teams and be a catalyst for Working Team discussions on integration in health services generally

Purpose of the Jurisdictional Review Cont'd

An early step in the process of the Jurisdictional Review was to identify criteria to be used as a basis for selecting specific participating hospitals. The table below presents the selection criteria listed down the left hand side. It was important that all criteria be covered however, it was difficult to find all criteria satisfied in a single organization. The table highlights which criteria were satisfied by each hospital. In addition, cities with two acute care hospitals were also reviewed.

Criteria	Trillium Health Centre	Halton Healthcare Services	Fraser Health Authority	Winnipeg Regional Health Authority
Multiple Sites	✓	✓	✓	✓
Similar Characteristics				
- Budget	✓	✓	✓	
- Beds Staffed & Operating	✓	✓	✓	
- Rural/Urban Mix		✓		
Proximity to the United States			✓	✓

Forces Driving Health Services Integration Activity

Patient Coordination Needs

- Noticeable service “gaps” between providers
- Desire to optimize available resources and “system” effectiveness
- Consolidation imposed by provincial governments e.g. CCACs

Improved Technology

- Potential for more “seamless” delivery
- Potential for improved access and quality care

Cost Reductions

- Pressure to reduce overhead costs
- Reduction or elimination of costly duplication
- Reductions in provincial funding



Greater Focus on the Entire Continuum of Care

- Shift to a “wellness” model requiring better integration along the continuum
- Increased focus on prevention, not treatment
- Influence of demographics on the continuum

Improved Service Demands

- Pressure to increase ease of “navigation”
- Greater effectiveness, efficiency, care, and attention from patient perspective

Emphasis on Outcomes

- Desire for improved information for administrative and clinical decision making
- Potential for enhanced collection and analysis of outcomes data

Integration Trends in Canada

British Columbia

- Regional model (governance and service delivery)
- 5 Regional Health Authorities + 1 (specialized services)
- High degree of horizontal integration, now moving towards vertical integration
- Provincial shared services organization being established

Alberta

- Regional model (governance and service delivery)
- Advanced horizontal integration
- Beginning vertical integration

Saskatchewan

- Currently consists of 12 Regional Health Authorities
- Horizontal and vertical integration are currently government wide initiatives

NWT/Yukon:

- Regional Model (governance and service delivery)
- Regional health and social service boards consolidate planning and operations
- Some degree of both vertical and horizontal integration



Other Atlantic Provinces

- Regional models (governance and service delivery)
- PEI: Regionalized single entry and assessment system for continuing/long-term care implemented in all regions
- NFL&L: Regional integration of support structure

New Brunswick:

- Regional model (governance)
- Moving from 8 to 2 Regional Health Authorities
- Provincial Shared Services Organization in development

Ontario

- 14 LHINs, all working towards building horizontal integration
- Horizontal integration and consolidation of acute care
- Reconfiguration of hospital services with emphasis on outpatient and community service

Manitoba

- Regional Model (governance and service delivery)
- 13 Regional Health Authorities
- Primarily horizontal integration
- Recent evaluation

Quebec

- Emphasis placed on consolidating the health and social services system
- Networks of integrated services – 18 regional commissions
- Horizontal and vertical integration (with community services)

Common Themes

Non-clinical “back-office” integration is becoming more common

- Driven by transactional economies of scale
- Found within all regional authorities
- Two provinces are planning for province-wide shared services, based on analysis of costs and benefits
- Can include regional credentialing and common “medical back-office”

Programmatic framework used to achieve integration on the clinical side, in most cases

- Organized by patient need
- Focus on clinical leadership of patient programs
- Alignment with medical school department structure where it makes sense
- Facilitates joint planning with community care
- Carefully thought through program framework (e.g. Emergency Department)

Program leadership across the system does not displace local operations teams

- Program leadership focuses on program and human resource planning, performance evaluation and improvement, and standardization
- Local team focuses on day to day operations
- Program leads have one foot in the regional view, and one in the local team

Common Themes Cont'd

Smaller hospitals can be managed by a larger hospital using a contract management/service level approach

- In non-Regional Health Authority or merger environments
- Maintains the community's relationship with its Board, and the hospital's identity

Variety of senior executive structures

- Depends on history and environment
- With two CEOs, Boards have a key role in setting expectations of collaboration and avoidance of competition
- Need for common program leadership is, however, consistent

Common information technology platform

- Often the starting point for integration
- Integrated Information Technology facilitates integration of clinical and non-clinical operations across multiple sites

Success Factors for Integration

Environmental Success Factors

- History of successful integration
- A favourable political and social environment

Purpose-Related Success Factors

- A shared vision driving the integration
- Concrete, attainable goals and objectives
- Vision, goals and objectives that are uniquely tailored to the local circumstances

Participant Success Factors

- Mutual respect, understanding & trust
- An appropriate cross section of participants
- Self interest as a motivator
- Ability and willingness to compromise
- Role clarity for participants

Process & Structural Success Factors

- Multiple layers of participation
- Tailoring to fit local circumstances
- Flexible and adaptable processes and structures
- An appropriate pace of development

Communication Success Factors

- Opportunities for open and frequent communication
- Informal relationships and communication links to augment formal relationships and communication

Resource Success Factors

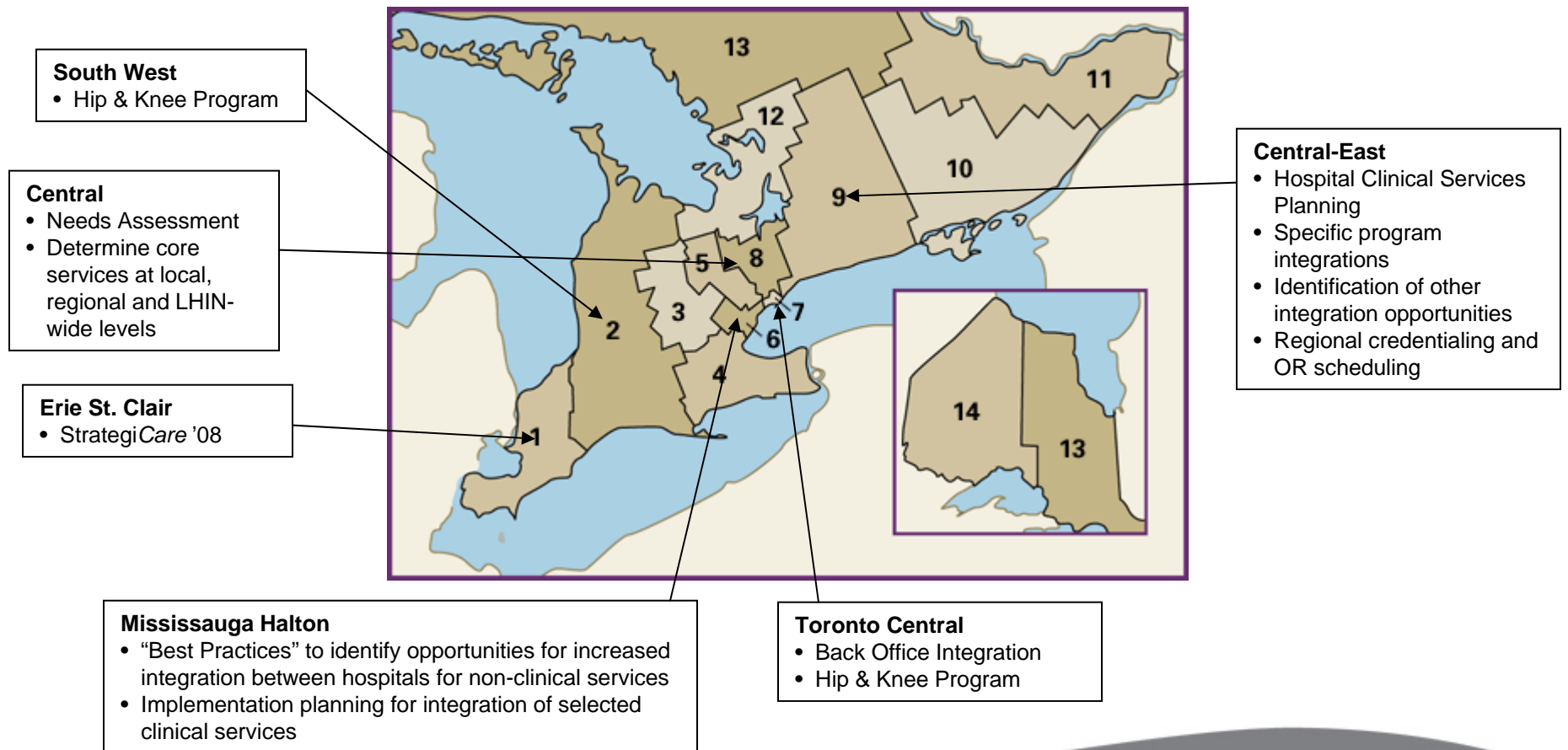
- Sufficient funds to plan, implement and operate the integration
- Sufficient human resources to plan, implement and operate the integration

Factors Contributing to Achievement of Integration Benefits

Benefits of integration of hospital programs and services are derived from one or more of the following factors:

- **Economies of scale** – Processes tend to be increasingly efficient with more volume
- **Qualities of scale** – Increased volume can provide for enhanced quality of service
- **Economies of capital/technology** – Combined efforts of organizations to reduce the cost and increase efficiency of technology acquisitions
- **Economies of labour** – Enhanced ability to recruit and share specialized expertise
- **Common clinical leadership of programs** – Increased ability to coordinate clinical processes to improve health of specific populations

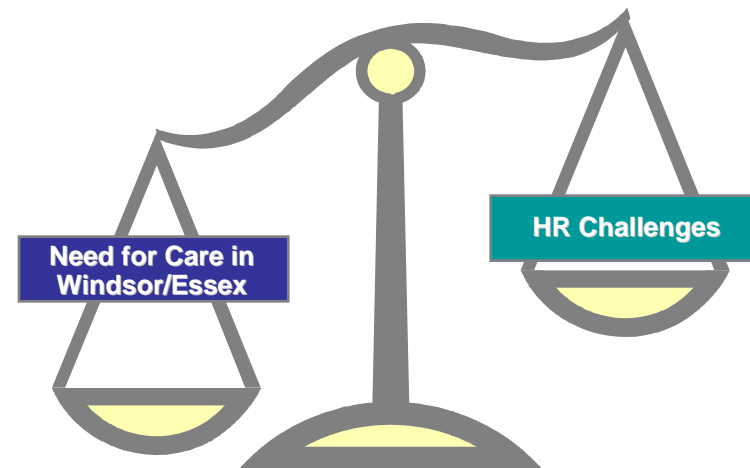
Integration Initiatives in Other LHINs (In Planning Process)



Case for Change

Although W/E hospitals are facing many challenges, the Steering Committee concluded that the main driver for further integration is the current and future shortage of health care professionals. Health care is a knowledge industry, and hospital budgets are comprised of 80% labour costs. The shortage of professionals is not only a problem for the W/E region, and will not be eliminated by local solutions alone.

Continuing to function as three separate organizations with duplications of services will only stretch limited human resources even further. Locally, one solution is to reorganize how services are provided, taking into consideration the interests of patients and their families, and leading practices in other areas which can be applied successfully here.



Balancing the W/E community requirements for hospital service with increasing shortages of healthcare professional

StrategiCare '08 is about redesigning care to make the best use of our critical resources, our people.

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Vision, Strategic Directions, and Principles



A New Vision for the Windsor/Essex Hospital “Network”

The hospitals of W/E have identified the following vision statements to guide the redesign of the Service Delivery Model. These include:

- ***The W/E hospitals will form an integrated network focused on improving the health of the population of W/E. The network will be further developed by strengthening our engagement with community health providers to coordinate patient and client care***
- ***Our goal is to keep residents of the community healthy and out of the hospital. Home and community services will be the first line of care, with the right hospital services as back-up, back-up we hope our residents don't need***

Strategies to Support the Vision

The three hospitals in W/E participating in StrategiCare '08 are committed to taking action to achieve this vision. Specific strategies identified by the hospitals to support achievement of the new vision. The strategies include:

Strategy 1 – A Strong Community Foundation

- Our health system focuses on delivering excellent care to the community through a vertical range of hospital programs and services
- Our residents will be able to access hospital services without leaving the county
- Our hospital system will be recognized as a leader in the delivery of care to the community we serve

Strategy 2 – Develop W/E Programs across the three hospitals that improve the health of the communities

- We will develop evidence based programs that operate across the three hospitals
- We will develop a strong performance management framework and maintain a focus on process improvement to ensure high quality of care and continuous quality improvement across the system
- We will work together as one team of service providers across programs

Strategy 3 – Consolidation of Back Office

- We will continue to develop a shared supply chain with other ESC hospitals
- We will further develop other back office services such as Human Resources, Finance, Process Improvement, Education, etc
- We will offer these back office supports to other community health organizations in W/E

Strategies to Support the Vision Cont'd

Strategy 4 - Integrated Information Technology Planning and Management

- We will work within the Consolidated Health Information Services (CHIS) collaborative to develop integrated Information Technology within W/E
- We will share information to support planning on a hospital system level
- We will develop consistent, standardized information to guide and support decision making

Strategy 5 – Health Professions Teaching Programs

- We will leverage local academic programs to attract talent to the region
- We will leverage local academic programs to become a leader as a community hospital system

Discussions around the vision led to the development of the following characteristics that would serve as criteria for the development of a renewed hospital system serving W/E:

- Collaborative programs across hospitals and agencies
- Excellent hospital care to the community
- Continuous improvement of processes
- Reduction of duplication
- Wise use of human resources
- A philosophy focused on prevention and healing

Principles for Planning and Implementation

To guide the implementation of all integration projects, the Steering Committee developed the following principles:

Design Principles

- Be patient-focused with emphasis on: access to care; care and safety; preference and utilization of services; satisfaction, and effective navigation/flow through our health care continuum
- Be respectful of our staff and the skills and experience they contribute
- Focus on creating efficiency and increasing productivity
- Demand a high standard of service delivery
- Integrate care and partnership, maximize the contribution of the entire workforce, and enable mobility of the workforce across the system
- Develop common processes/policies/practices to improve quality and safety of patient care
- Plan centrally, deliver locally, centralize where necessary
- Link to community resources to support wellness and prevention
- Strengthen accountability
- Require decisive, timely action

Principles for Planning and Implementation Cont'd

People Principles

- All three hospitals will work together in the future and plan centrally
- Involve staff from all three hospitals in planning
- Minimize adverse impact on staff
- Treat unionized and non-unionized staff equitably
- Respect the role of unions and their collective agreements in this process
- Respect and involve unions in the planning process
- Work openly and collaboratively with unions and their employee representatives
- Continue to provide open, honest communication with staff
- Develop strategies to support staff in the transition

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Project Charters



Project Charters

Results of Collaborative Team Work

The four teams were asked to deliver the following information:

- Problem statement
- Future program vision
- Key processes and stakeholders
- Expected improvements from integration
- Individuals or skill sets required to move the initiative to a next phase of detailed planning.

A brief summary of the work done by each work team is presented on the following pages. Detailed Project Charters for the first collaborative initiatives are provided in the appendices.

Project Charter Summaries

Charter 1 – Regional Maternal Child Program

Problem Statement

- Maternal Child Services are provided at LDMH and WRH with annual volumes of 317 and 4143 deliveries respectively (i.e. LDMH delivers 7% and WRH 93% of W/E deliveries - 2006/07 data-Provincial Health Planning Database)
- The major issue is the sustainability of the Obstetrics program in Leamington and its catchment area
- Related issues include enhanced choice for expectant mothers regardless of where they reside, and recruitment and training of health professionals

Vision for the Future

- In 2010, care for women and babies in the W/E community is provided by a single Regional Program, with standardized processes, carepaths, and outcomes at two sites, WRH and LDMH. The program is affiliated with the Schulich School of Medicine and St. Clair College, and functions as an academic program, providing training opportunities for medical, nursing, midwifery and other health professions students
- The Program is led by a single management team with an administrative director and Chief of Obstetrics, to ensure collaborative planning, and optimal use of resources across the region
- Nurses and other staff are oriented and trained at both sites, with the ability to rotate staff to provide broader experience and more enriching careers
- Common policies and processes are in place across the region for the role of mid-wives and home deliveries

Project Charter Summaries Cont'd

Charter 2 – Utilization of Diagnostics, Laboratory and Pharmacy

Problem Statement

- Utilization patterns with respect to diagnostics and pharmaceutical care are not widely known or documented
- Assumptions that inappropriate utilization is occurring and contributing to a higher cost per weighted case across W/E needs to be clarified and validated

Vision for the Future

- Ordering/prescribing practice will align with best practice utilization of diagnostics and pharmaceutical care to support an optimal clinical outcome

Project Charter Summaries Cont'd

Charter 3 – Common Health Information Management Service

Problem Statement

- Human resource sustainability and challenges – Health Information Management Professionals (HIMs) and Transcriptionists
- Duplication of resources and work between the 3 hospitals (i.e. reporting requirements, access to care, projects etc.)
- Increased need for standardization and data quality
- Need to ensure cost effective service in a competitive environment
- Opportunity to create more expertise across program lines

Vision for the Future

- Develop a standardized information management process between the three hospitals that reduces duplication, focuses on the optimal efficiency of resources, and ensures data quality and consistency across the region

Project Charter Summaries Cont'd

Charter 4 – Common IT Governance

Problem Statement

- We do not have a migration pathway to common/shared Information Technology services among the Windsor/Essex hospitals
- This will inevitably extend, though CHIS, to the entire LHIN

Vision for the Future

- Common/and shared Information Technology services across the three hospitals

Making it Happen!

There are several key enablers that will support the vision and strategies. These include:

Project Management Office

- A shared project management office (LHIN and hospitals) that provides project management support and leadership to cross hospital programs and initiatives
- Provides arms-length, executive insight into a series of projects that may compete for time and resources yet are all in alignment with *StrategiCare '08*

Community Partner Involvement

- A process is required for communication, invitation and involvement in the next Phase of planning

Communication and Change Management Strategies

- “Social Marketing” to demonstrate the benefits
- Strong leadership from the top to demonstrate the priorities

Lean/Six Sigma

- Continued use of process improvement techniques as needed

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Phase 2 Plans



Purpose and Work Plan for Phase 2

The purpose of Phase 2 of StrategiCare '08 is to complete a detailed design for integration that will result in:

- Detailed implementation plans for collaborative Initiatives and other projects identified and described in StrategiCare '08 Phase 1
- Consensus among hospital leadership on a hospital master plan for W/E

The Work Plan for Phase 2 is based on:

- Knowledge gained from Phase 1
- An initial vision for the W/E hospital system
- Our understanding of the deliverables and skills required to deliver Phase 2 to the expectations of the LHIN and the hospitals of W/E
- Continued momentum of the project from Phase 1 through to Phase 2
- Establishment of a PMO to oversee the Phase 2 projects
- The need to foster ownership of detailed plans in hospital stakeholder
- Recognition that the success of the StrategiCare '08 initiative and future integration projects requires focused project management with involvement of the LHIN staff
- Working closely with the staff of the LHIN to build an internal project management framework for the LHIN
- Transitioning the PMO leadership for Phase 3 of StrategiCare '08 to the W/E hospitals

StrategiCare '08

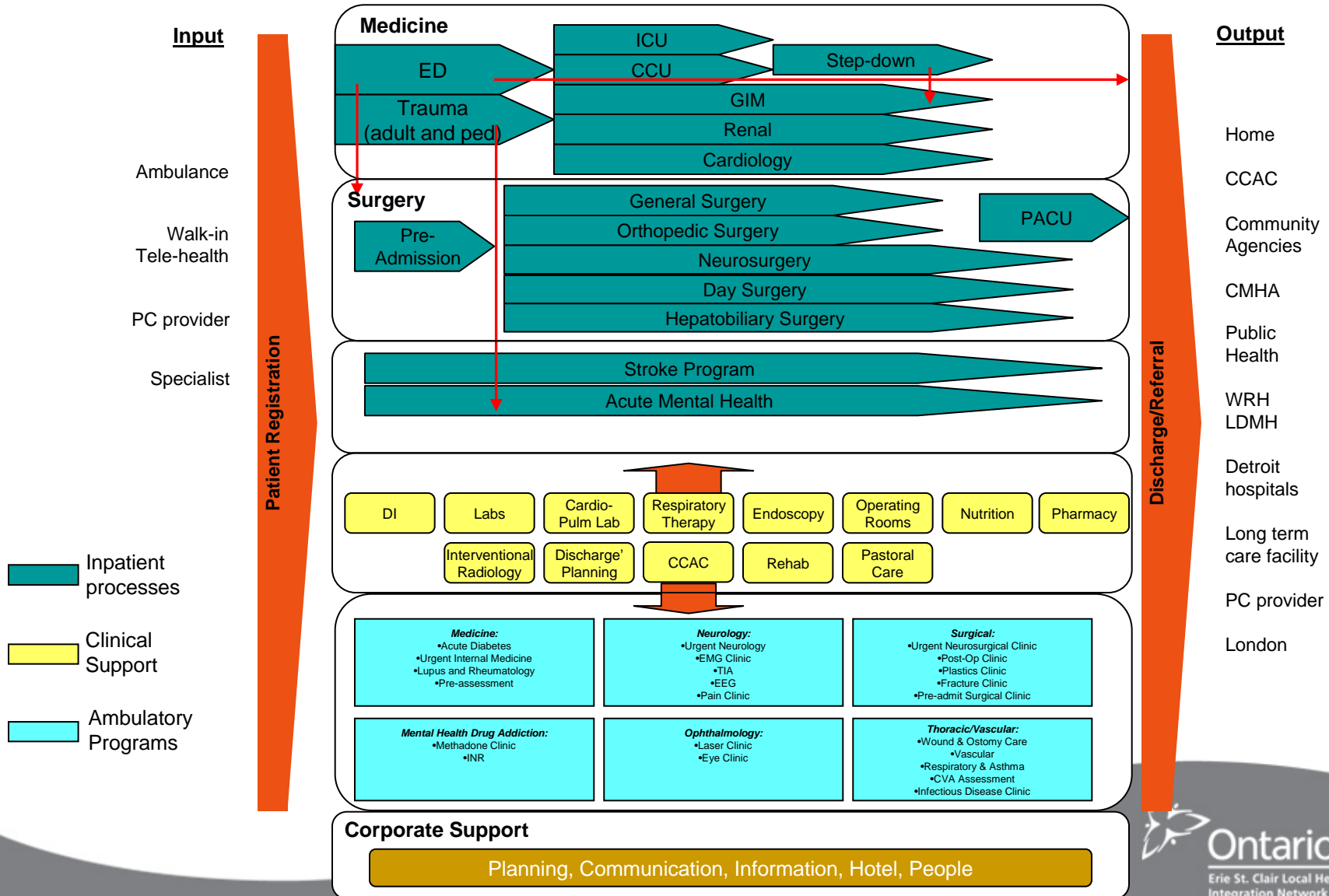
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Appendices

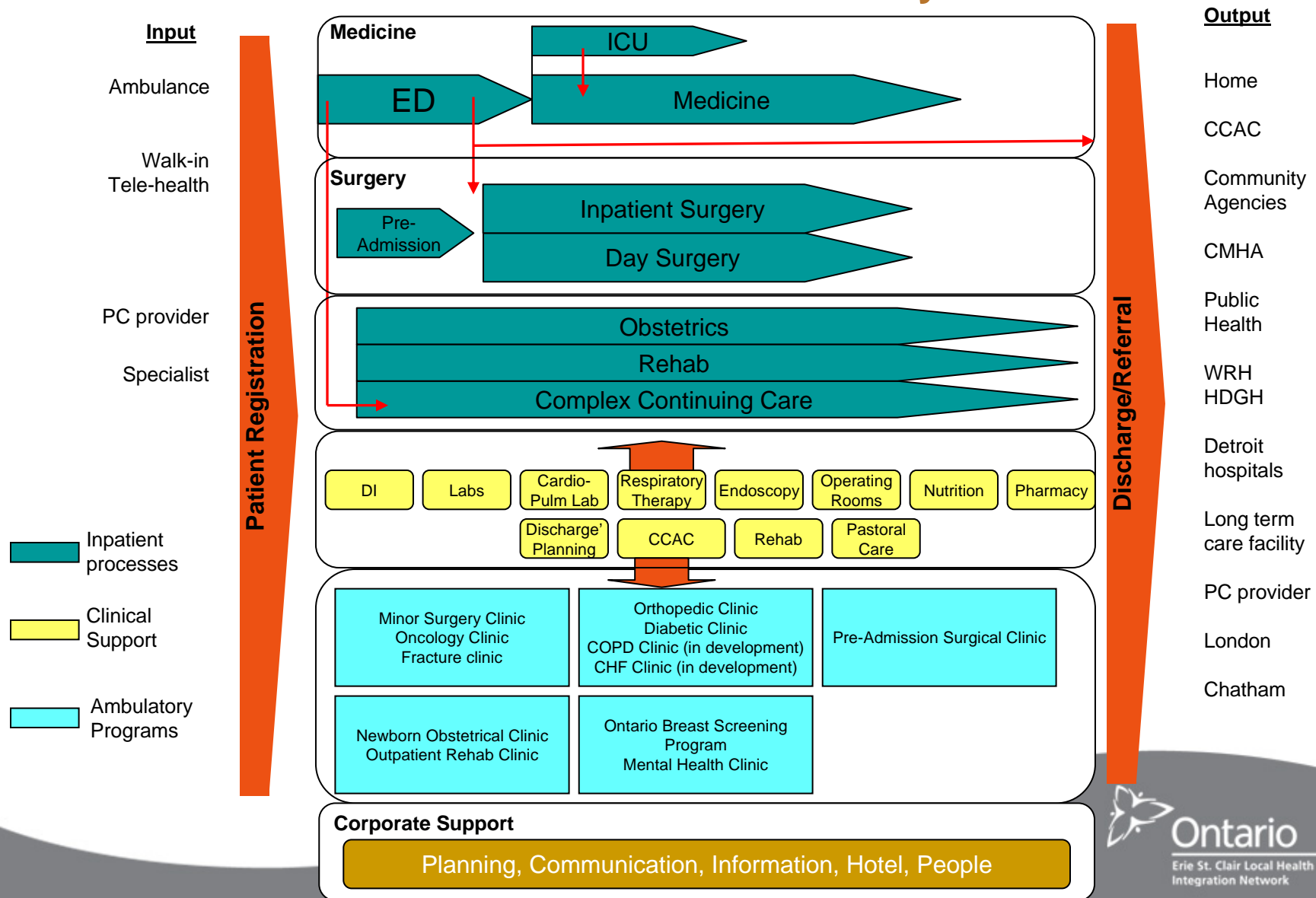
Current Service Delivery Models
Information Technology
Project Charters



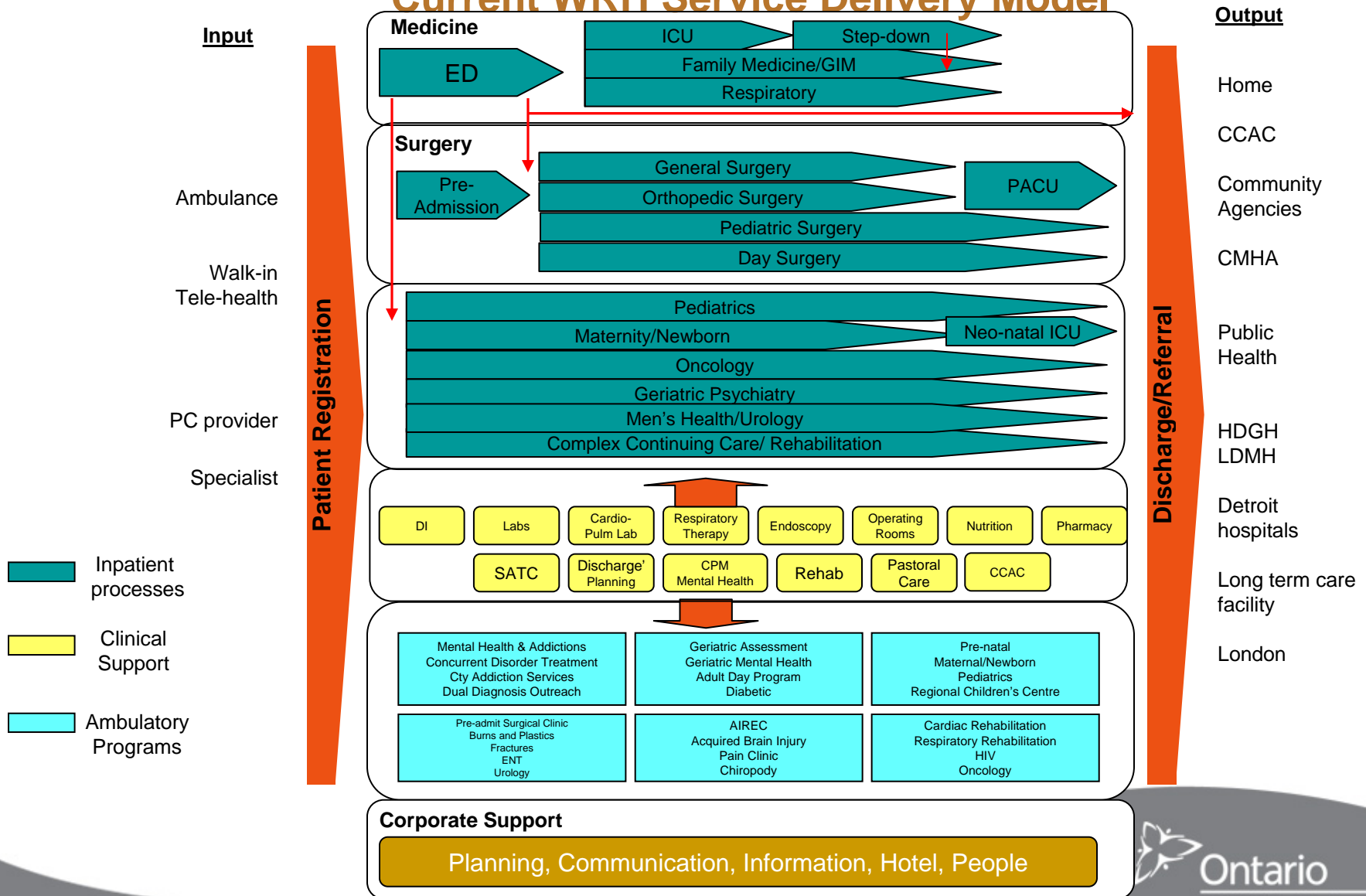
Current HDGH Service Delivery Model



Current LDMH Service Delivery Model



Current WRH Service Delivery Model



Information Technology

	HDGH	LDMH	WRH
Electronic Medical Records (EMR)	– Solcom	– Solcom	– Solcom
Pharmacy	– Mediware	– Mediware	– McKesson
Radiology	– Cerner QuadRIS	– Cerner QuadRIS	– McKesson
Admission Discharge Transfer (ADT) / A/R	– Siemens	– Siemens	– McKesson
PACS	– McKesson	– McKesson	– McKesson
Laboratory	– Triple G (GE)	– Triple G (GE)	– Triple G (GE)
Emergency Department	– iSOFT	– Combination of ADT/Reg	– McKessen
Materials Management	– ORMED	– ORMED	– AS/400 Infinium (Source Medical)
Financial – (GL)	– AS/400 Infinium	– Virtuo (medisolution)	– AS/400 Infinium



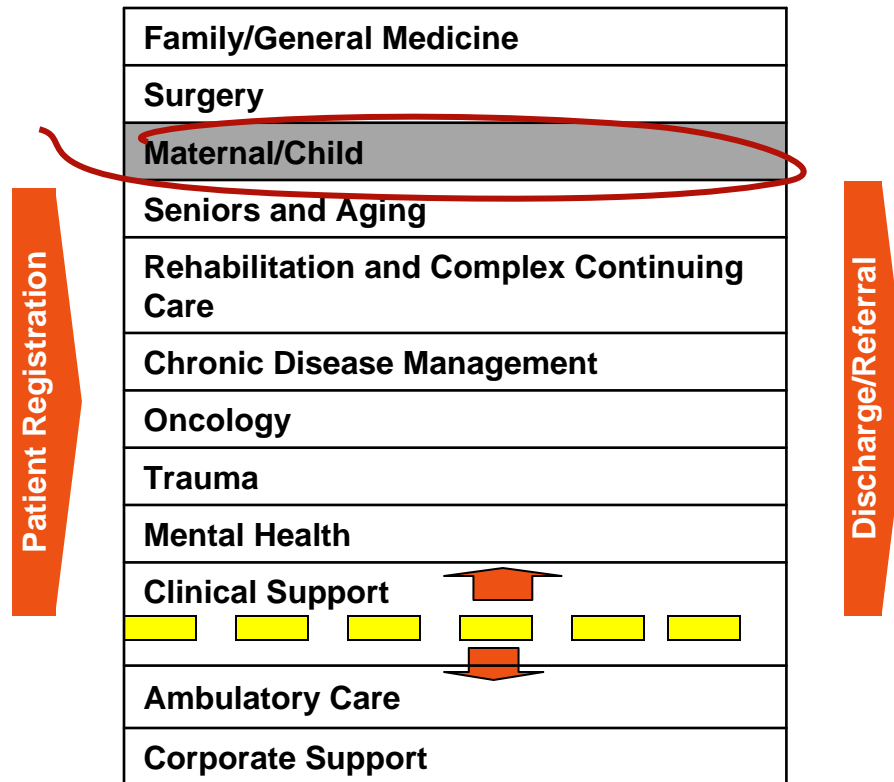
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Phase 1 Project Charters



Maternal/Child Project Charter



Program Definition:

Care of mothers and children from pregnancy through to post-natal care.

Scope – Processes:

- Registration
- Pre-natal care
- Pre-natal education
- Labour and delivery
- Post-natal care
- Home services
- Link to primary care provider and community

Maternal/Child Project Charter

Problem/Opportunity Statement

Maternal Child Services are provided at Leamington District Memorial Hospital (LDMH) and Windsor Regional Hospital (WRH) with annual volumes of 317 and 4143 deliveries respectively i.e. LDMH delivers 7% and WRH 93% of W/E deliveries (2006/07 data-Provincial Health Planning Data Base.)

The major issue is the sustainability of the Obstetrics program in Leamington and its catchment area.

Related issues include enhanced choice for expectant mothers regardless of where they reside, and recruitment and training of health professionals.

Maternal/Child Project Charter

Specific problems and opportunities include:

1. **Obstetrics Coverage**

- The one Obstetrician at LDMH is on constant call, and is supported by 2 family physicians and 3 midwives, compared to a 1 in 13 call schedule for obstetricians at WRH
- This has a significant impact on quality of work life

2. **Declining Volume**

- For a variety of reasons, including previous lack of availability of epidurals and loss of an Obstetrician, volumes at LDMH have been trending downwards over the past 5 years, making it difficult to recruit another Obstetrician
- There was a small 1% increase in volume over the past year
- However, there has been a linear steady decline in demand for Pregnancy and Childbirth services by LKE women between 2002/3 to 2006/7 (approx. 20%)

3. **Challenging Facilities**

- Space at LDMH is not optimal; the layout and location requires “over-staffing” since as volumes fluctuate, nurses can’t be used to provide other services

4. **Nursing Retention Issues**

- In this current environment, it is difficult to retain obstetrics nurses in Leamington, as their current work does not meet their career and experience expectations

5. **Strength in Collaboration**

- Considering the human resource issues and the lack of predictability of obstetrics volumes, Maternal/Child programs would be better managed if LDMH and WRH worked together to plan and deliver care for all of W/E

Maternal/Child Project Charter

Vision for a Regional Maternal Child Program

In 2010, care for women and babies in the Windsor/Essex community is provided by a single Regional Program, with standardized processes, carepaths, and outcomes at two sites, WRH and LDMH. The program is affiliated with the Schulich School of Medicine and St. Clair College, and functions as an academic program, providing training opportunities for medical, nursing, midwifery and other health professions students.

The Program is led by a single management team with an administrative director and Chief of Obstetrics, to ensure collaborative planning and optimal use of resources across the region.

Nurses and other staff are oriented and trained at both sites, with the ability to rotate staff to provide broader experience and more enriching careers. Common policies and processes are in place across the region for the role of mid-wives and home deliveries.

Performance Improvement Expected:

- Increase in volume of deliveries at LDMH
- Manageable physician coverage/on - call schedule (1/3 weekends and 1 day per week off for LDMH obstetrician)
- Increase in nursing productivity at LDMH
- Staff and patient satisfaction (improvement levels to be specified in Phase 2)

Impact of the Vision on Stakeholders

Benefits

Risks/Challenges

Mothers and Babies

- The ability to choose to deliver in their local community, or for Leamington families, to choose to deliver at LDMH or WRH
- Equitable access to care regardless of which delivery site is selected

- Public could see any change in Obstetrics at LDMH as a threat to the hospital – need to have a solid communication plan

Obstetricians

- Improved quality of life (LDMH) due to alleviation of constant on-call schedule
- Involvement in academic programs (LDMH)

- Potential resistance from WRH Obstetricians who need to cover at LDMH – need to identify the inducement required for them to support on-call and vacation coverage
- If no change, risk burn-out of the one Obstetrician at LDMH

Nursing Staff

- More fulfilling careers and rewarding professional opportunities
- Opportunity to be part of a medical training facility

- May be resistant to change and travel
- Union issues will be significant

Impact of the Vision on Stakeholders

Benefits

Risks/Challenges

***Family Physicians
and Mid-Wives***

- Back-up support from a regional program
- Could attract more GPs who deliver to Leamington

- Shrinking numbers of GPs doing deliveries is a provincial issue and will likely continue to be a challenge.

Medical Students

- A regional program provides an opportunity for family medicine students to gain experience with Obstetrics

- May be a challenge finding GP/Obstetrician preceptors particularly in Leamington

Anaesthetists

- Working with the WRH staff provides more constant exchange of learning and ideas
- Potential to expand the epidural program at LDMH

- Only a negative for anaesthetists if shift any GYN surgery volumes from WRH to LDMH

Maternal/Child Project Charter

Impact of the Vision on Stakeholders

Benefits

Risks/Challenges

Other Healthcare Professionals

- More fulfilling careers and rewarding professional opportunities
- Opportunity to be part of a medical training facility

- May be resistant to change and travel

Hospitals

- Sustainable quality of care for women and babies, through consistent standards, processes and care maps
- A robust regional program for W/E at both sites to ensure patient safety

- Managing financial implications of change
- Finding internal capacity to plan and implement change

Maternal/Child Project Charter

Draft Deliverables

- Stakeholder Engagement Plan
- Leading Practices Review
- New Coverage Schedule
- Current State Analysis (“As-Is”)
 - People (staffing models, org structure)
 - Processes (inputs, throughputs, outputs, policies, procedures)
 - Technology
 - Space
 - Issues and Opportunities
- Future State Development (“To-Be”)
 - People, Process, Technology, Space
 - Quick Wins
- Options Review
 - Status Quo; Closure of Leamington program; Regional Program
- Cost-Benefit Analysis
- Performance Management Framework
- Transition Support Plan (e.g. training, orientation, town hall meetings, workshops)
- Implementation Plan
- Business Case

Maternal/Child Project Charter

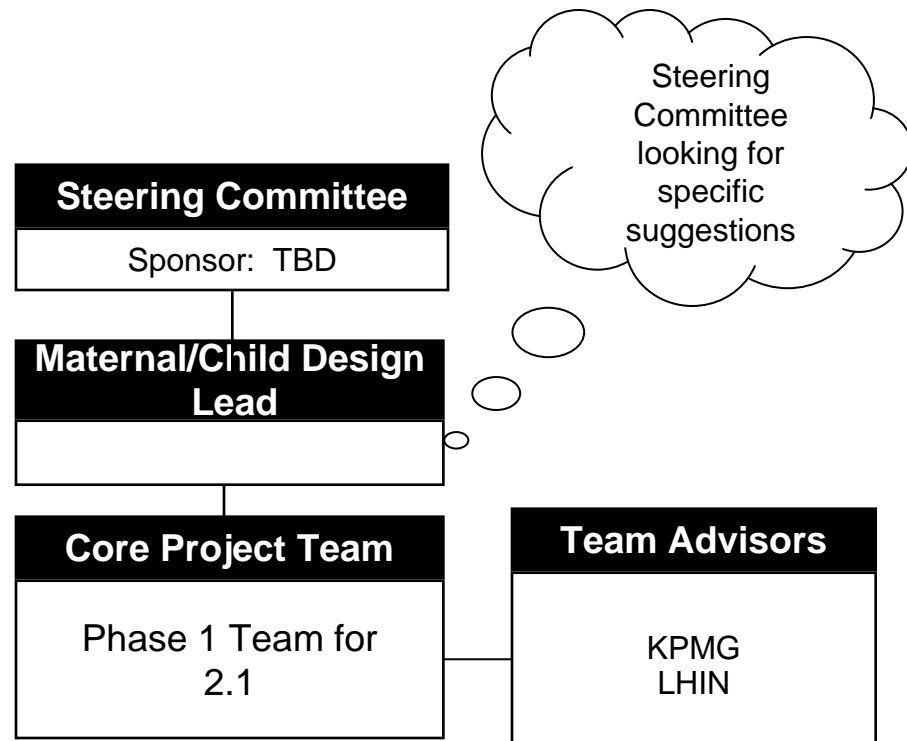
Phase 2 Strategy:

Phase 2.1

- A small and focused core team
- Initial work over the summer to initiate leading practice research, data collection, a regional coverage schedule, and other “quick wins”




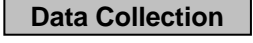



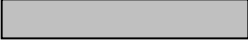


Phase 2.2

- Work on materials required for a complete Business Case will be done between mid-Sept and mid-January



Maternal/Child Project Charter

Activities and Timelines

Activities	Phase 2.1 July-August, 2008	Phase 2.2 September 2008 – Jan 15, 2009
Staff engagement plan		
New on-call schedule		Quick win implementation
Leading practice research		
Current state assessment		
Future state development		
Cost-benefit analysis		
Transition support plan		
Implementation plan		
Business case		

Utilization of Diagnostics, Laboratory and Pharmacy Project Charter

Problem Statement:

- Utilization patterns with respect to diagnostics and pharmaceutical care are not widely known or documented.
- Assumptions that inappropriate utilization is occurring and contributing to a higher cost per weighted case across W/E needs to be clarified and validated.

Improvement Target:

- Best practice guidelines/order sets are standardized across the Region.
- 100% of ordering/prescribing practice to align with best practice utilization of diagnostics and pharmaceutical care.

Key Measures:

- Variance of ordering/prescribing practice from best practice guidelines/order sets.
- Utilization and variance patterns (track and trend).

Utilization of Diagnostics, Laboratory and Pharmacy Project Charter

Ordering/prescribing practice will align with best practice utilization of diagnostics and pharmaceutical care to support an optimal clinical outcome



Utilization of Diagnostics, Laboratory and Pharmacy Project Charter

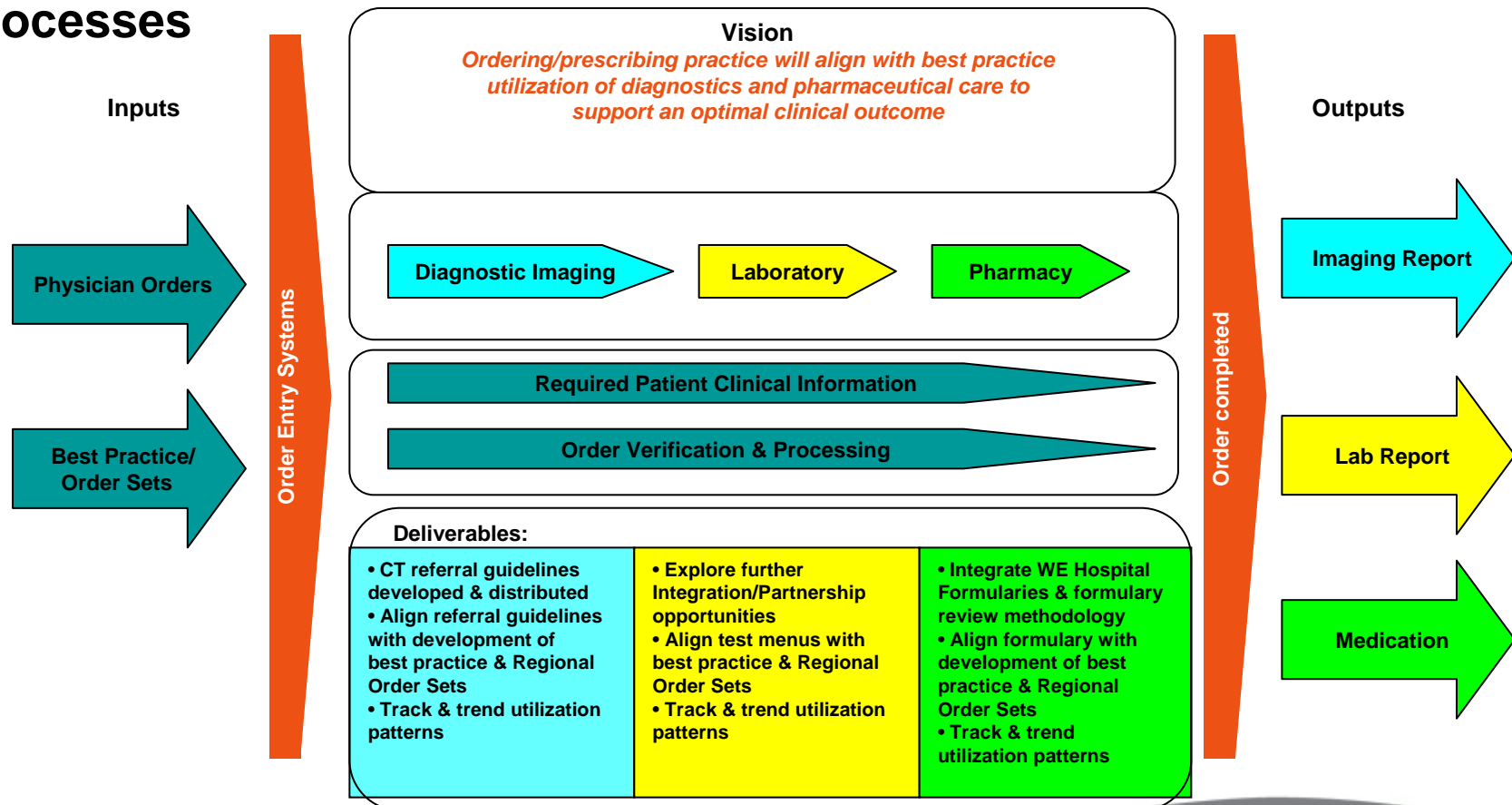
How will the services work in the future and benefits be achieved?

- Baseline best practice documented by subject matter experts
- Translation of best practice into standardized Regional best practice guidelines/order sets through a coordinated local and Regional Committee structure
- Communication of Regional best practice guidelines/order sets to ordering/prescribing individuals or groups across the Region
- Track and trend utilization and variance patterns
- Provide data to ordering/prescribing individuals or groups for review
- Practice variances identified and realigned with best practice

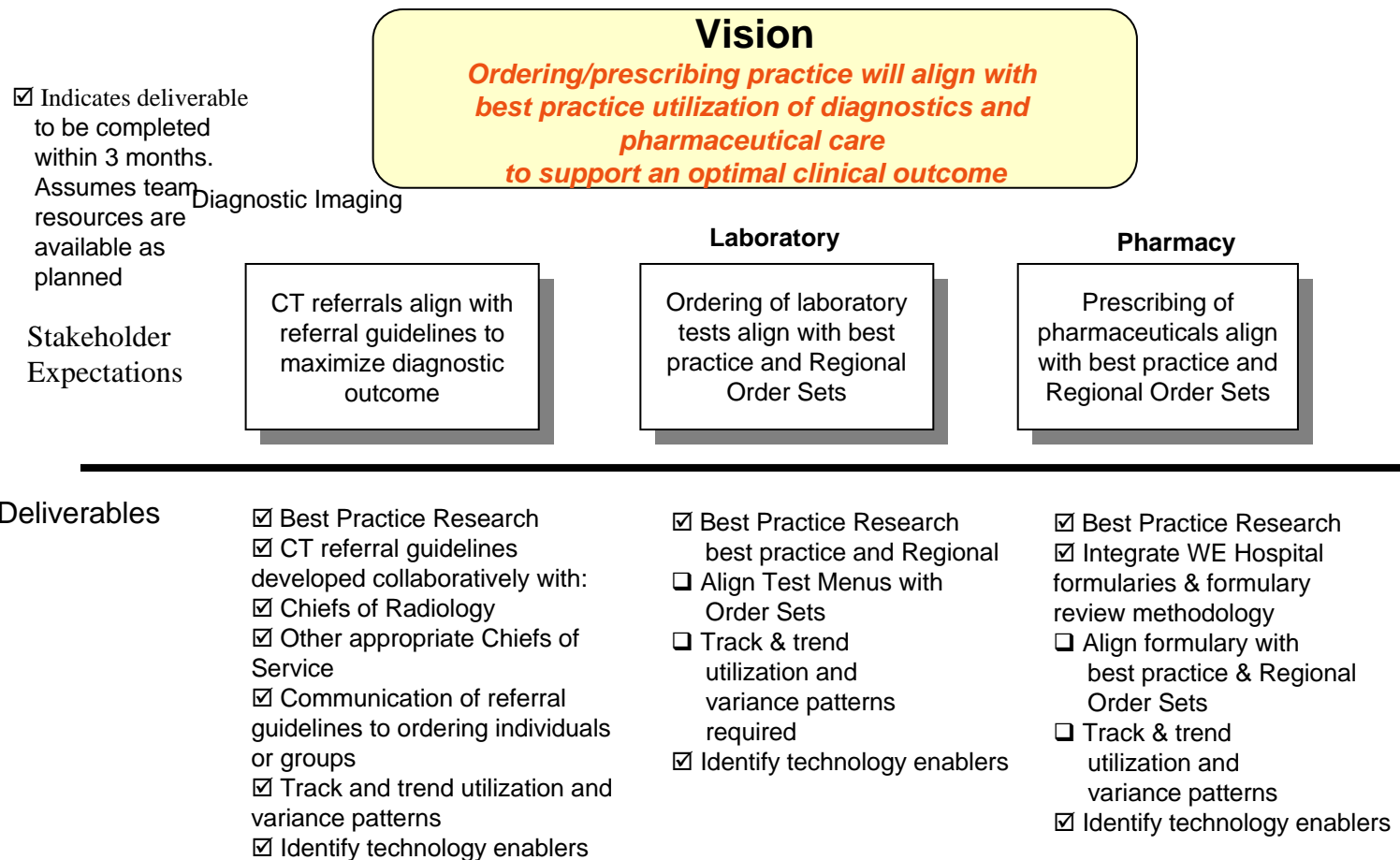
Utilization of Diagnostics, Laboratory and Pharmacy Project Charter

Service Delivery Model Framework

Processes



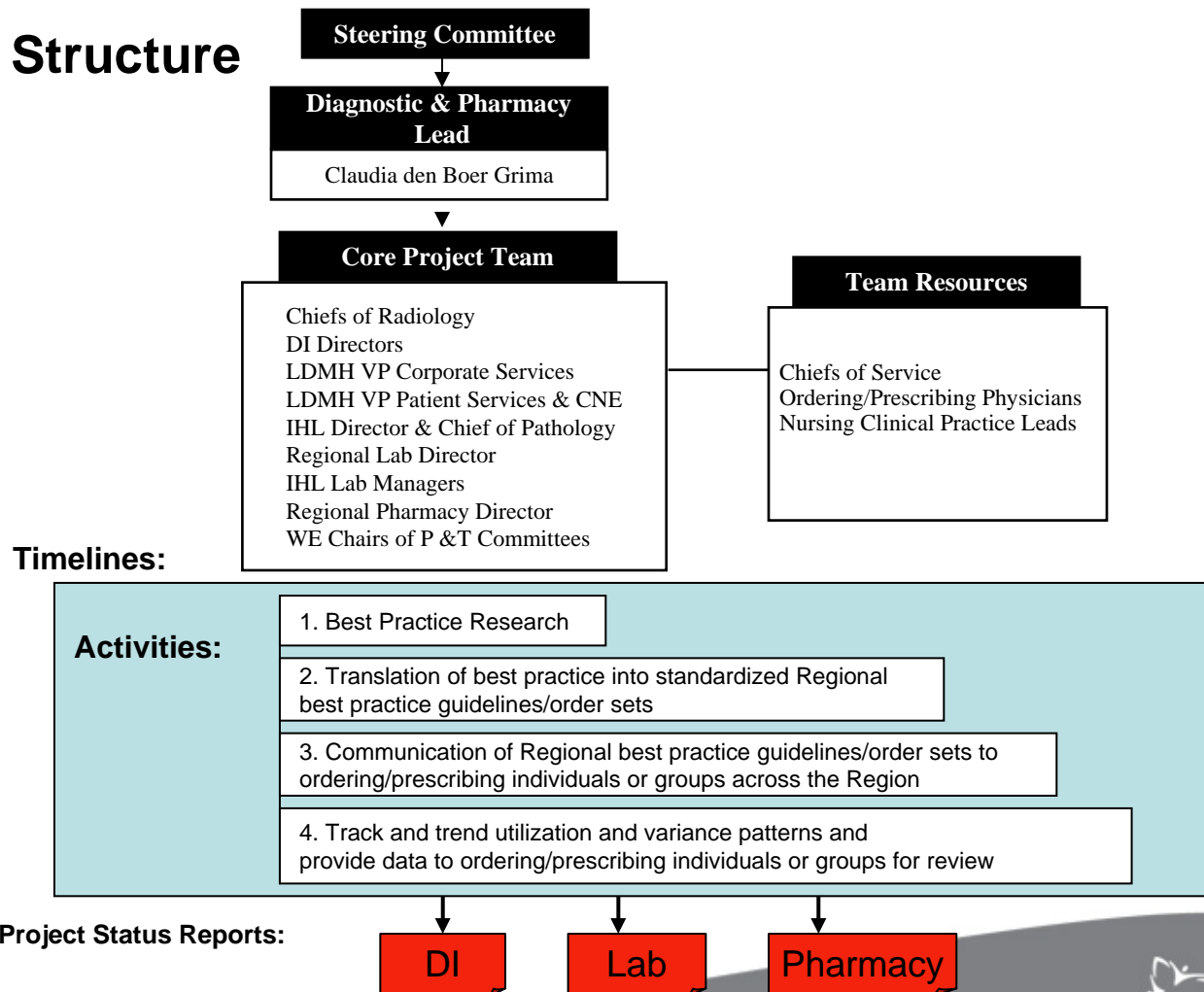
Utilization of Diagnostics, Laboratory and Pharmacy Project Charter



Vision
Ordering/prescribing practice will align with best practice utilization of diagnostics and pharmaceutical care to support an optimal clinical outcome

Utilization of Diagnostics, Laboratory and Pharmacy Project Charter

Proposed Structure



Common Health Records Charter

Problem Statement:

- Human Resource Sustainability and Challenges (Health Information Management Professionals (HIMs) and Transcriptionists)
- Duplication of Resources and Work between the 3 hospitals (e.g. reporting requirements, access to care, projects, etc.)
- Increased need for standardization and data quality
- Need to ensure cost effective service in a competitive environment
- Opportunity to create more expertise across program lines

Common Health Records Charter

Scope

	In Scope	Out of Scope
Functional Areas (i.e. Departments)	<ul style="list-style-type: none"> ▪ Coding (HIMs) ▪ Transcription ▪ Clerical (Document Management) ▪ Decision Support 	<ul style="list-style-type: none"> ▪ Registration?? Needs more discussion and review
Processes	<ul style="list-style-type: none"> ▪ Release of Information ▪ Chart Processing ▪ Production of Some Reports ▪ CIHI/MOH/LHIN Reporting ▪ Consolidation /Analysis ▪ Data Quality ▪ Physician Chart Completion ▪ Access to Care Reporting – EDRS, WTIS, CCO, CIRT 	<ul style="list-style-type: none"> ▪ MIS Reporting ▪ Chart and Form Management (i.e. form design) ▪ Specialized Reporting Requirements <ul style="list-style-type: none"> ○ Finance ○ Board of Director ○ Hospital Performance Management ○ <i>These functions may ultimately evolve into an integrated approach but for starting purposes, it would be out of scope for at least the first “phase”</i>

Common Health Records Charter

Vision

Develop a standardized information management process between the three hospitals that reduces duplication, focuses on the optimal efficiency of resources and ensures data quality and consistency across the region.

Deliverables

- Governance Model
- Workload / Process Review
- Technology Assessment and Plan
- Physical Plant / Logistic Model
- Human Resource / Workforce Transition
- Support and Service Model
- Transition and Implementation Plan

Expected Improvements

- Financial
- Reduction in Growth Factor
 - Cost per coded record
 - Average cost per dictated minute

- Quality
- Coding Turn-Around Times
 - Data Quality Audits
 - Error / Rejection Rates

Common Health Records Charter

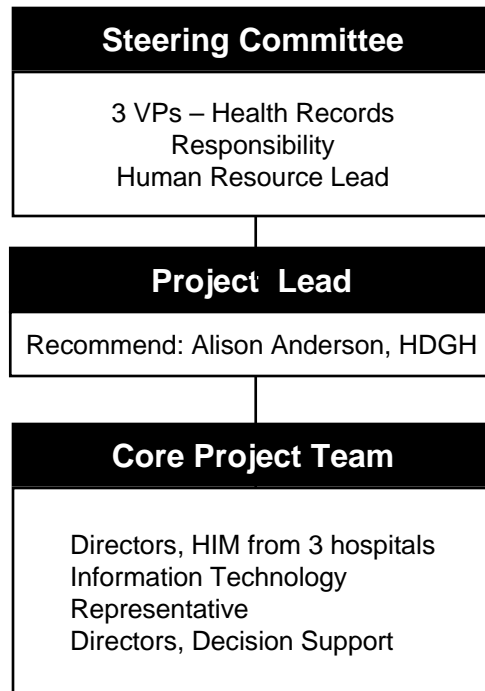
Risk Assessment

- Human Resource Implications
- Physicians and Change Management
- Financial investment requirements – short term costs for long-term pay-off
- ROI feasibility?
 - Need to invest in technology to enable integration



Common Health Records Charter

Proposed Structure & Timelines



Timelines:

Business Planning – 6 – 8 months

“Phase 1 Integration” – LDMH and HDGH – 10 – 12 months

“Phase 2 Integration” – 12 – 18 months

Requirement for ability to meet timelines – organizational
commitment