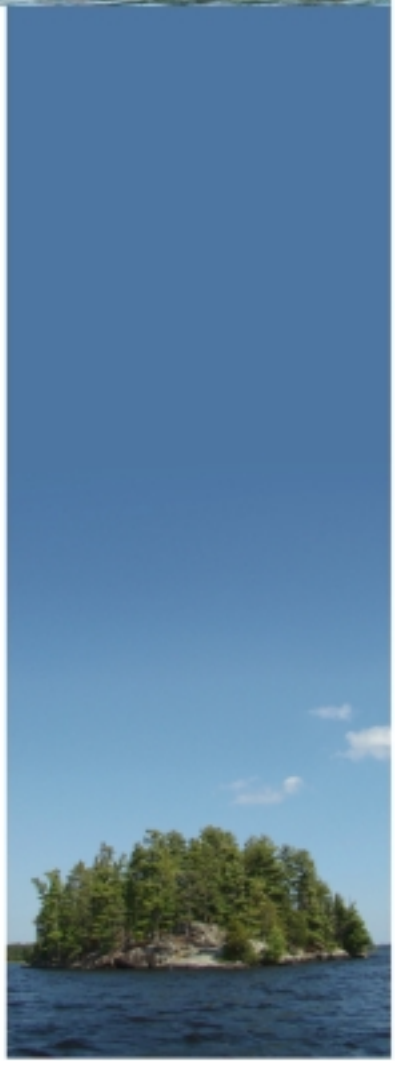
Lake of the Woods District Hospital

KENORA, ONTARIO



Third Party Report

Prepared by:

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1.0 EXECUTIVE SUMMARY

In August 2008, the North West Local Health Integration Network (North West LHIN) initiated a third party evaluation of Lake of the Woods District Hospital (LWDH) to identify whether opportunities exist for the hospital to achieve a balanced budget by March 31, 2009 and maintain a balanced operating position to March 31, 2010. The aim of the third party evaluation was to identify strategies that could be implemented by LWDH to achieve these outcomes.

The third party evaluation was a collaborative effort among the external Evaluation Team, LWDH and the North West LHIN. The following team members were appointed by the North West LHIN:

- Randy Penney, President and C.E.O., Renfrew Victoria Hospital (RVH) & St. Francis Memorial Hospital (Lead Reviewer);
- Paul Chatelain, Vice President, Financial Services, RVH;
- Nancy Kelly-Moore, Vice President, Patient Care Services, RVH; and
- Julia Boudreau, Vice President, Corporate Services, RVH.

In undertaking the evaluation, the above-noted team reviewed documentation and reports provided by LWDH, the North West LHIN and the Ministry of Health and Long Term Care (MOHLTC). Over a two-day period, tours were conducted of LWDH, meetings were held and interviews were undertaken with a variety of key stakeholders as listed in Appendix A.

The Evaluation Team reviewed the following aspects of the hospital's operations:

- Leadership;
- Financial Services;
- Clinical Services; and,
- Corporate Services.

Of these four areas, this report focuses primarily on the financial opportunities that exist for LWDH.

From the review, the team concluded that the goal of LWDH to achieve and maintain a balanced budget within the timelines set out is attainable through a combination of leadership, cost cutting and revenue generation.

With respect to the issue of leadership, the review identified some key opportunities. These include a Board of Directors which, despite past challenges in its relationship with the North West LHIN, is committed to strengthening that relationship. The Board also demonstrated a commitment to ensuring that the goals of the corporation were understood internally.

Other leadership issues include the need for a comprehensive communications strategy, a review of the current appointment process of Board members, and implementation of this report's recommendations.

The review process identified a number of options related to the finances of the hospital. These include:

- Take steps to qualify for "small hospital" status;
- Maximize bed coordination;
- Develop an investment policy, and tender banking and investment services;
- Conduct a further review of the EKS benchmarking reports to identify additional efficiencies;
- Review staffing mix levels to maximize efficiencies;
- Determine the feasibility of the knee replacement program;
- Review the feasibility of offering clinical services to the community;
- Revise parking rates to market levels;
- Review "relief" budgets; and
- Investigate further utility savings through an investment to reduce energy consumption.

The "Clinical Services" section of the report reviews issues around transportation, unremunerated services, the hemodialysis program, in-patient bed utilization, performance management, and a potential partnership with the local Community Care Access Centre (CCAC).

Transportation was identified as a key issue for critically ill and medically unstable patients as well as for medically stable patients. A significant number of concerns were identified. In light of this, the report recommends the establishment of two distinct transportation committees.

In addition, it is recommended that the hospital consider reducing its offering of unremunerated services such as dentistry; take steps to capitalize on the projected significant growth in the need for hemodialysis; and that beds be staffed according to patient census. The report also suggests that centralization of staffing records and partnering with the CCAC will produce additional efficiencies and savings.

Within the "Corporate Services" section of this report, the hospital is encouraged to maintain its membership in the WSIB Safety Group. It should also circulate its absence statistics more broadly in the organization, review policies and programs related to absence and work modification models, and establish a Wellness Committee.

Additional recommendations are as follows:

- Respond to the significant out-patient demand for ultrasound work;
- Explore the feasibility of opening a sleep laboratory, and implementing echocardiography;
- Examine full- and part-time staffing ratios;
- Review the staffing and programming of the Nursing Department;
- Evaluate the productivity levels of ECG services;
- Review Diagnostic Imaging scheduling;
- Have the physiotherapist position assume an educational role in addition to its current duties;
- Analyze the breakdown of in-patient versus out-patient physiotherapy services;

- Analyze the staffing levels in the Finance/HR, Admitting, and the Nutrition and Food Services/Cafeteria Departments;
- Explore options for group purchasing; and
- Review opportunities to partner with private laboratories.

As a result of its location, LWDH faces challenges with regard to being both rural and isolated. Travel on secondary roads and weather conditions are legitimate concerns. Moreover, the demographics of the population present some unique challenges, in terms of the determinants of health of the population served. Despite these challenges, LWDH leadership team has made significant strides with respect to clinical services. The dedication and commitment of the staff and physicians to offering high quality service and to moving forward is clearly evident.

In some departments, LWDH is currently operating at an expense level that is not consistent with benchmark performance standards as compared to its peers. As well, revenue generation opportunities exist. The Evaluation Team believes that the recommendations contained in this report will allow LWDH Senior Management Team, physicians and Board of Directors to achieve and maintain a balanced budget. LWDH must recognize that it cannot be "all things to all people". LWDH leadership team is accountable for the ongoing financial performance of the Hospital and, as such, must be prepared to make the necessary adjustments throughout the year to ensure success.

2.0 INTRODUCTION

2.1 Scope of the Third Party Evaluation

In August 2008, the North West Local Health Integration Network (North West LHIN) initiated a third party evaluation of Lake of the Woods District Hospital (LWDH) to determine LWDH's ability to produce and maintain a balanced budget. The outcome of the review process was to be a written report that would contain the Evaluation Team's observations and conclusions. The report was to outline next steps, including identifying options and strategies that could be implemented by the Board, Chief Executive Officer, hospital management and medical staff to assist the hospital in achieving a balanced operating position within known planning assumptions. Further, the Evaluation Team was asked to advise the North West LHIN of any issues related to the Board, management, medical staff, operational budget or capital budget that must be addressed in order for the Hospital Services Accountability Agreement (H-SAA) to be successfully undertaken.

The on-site portion of the review was completed over two days. The statistical analysis and benchmarking were based primarily on previously completed reports (i.e., EKS Associates Inc., 2006 and 2007 benchmarking reports, North West LHIN and Ministry of Health and Long Term Care [MOHLTC] data) as well as the knowledge and experience of the third party reviewers.

2.2 Process

The third party evaluation was a collaborative effort among the Evaluation Team, LWDH and the North West LHIN. The external team members, who were appointed by the North West LHIN, were:

- Randy Penney, President and C.E.O., Renfrew Victoria Hospital (RVH) and St. Francis Memorial Hospital (Lead Reviewer);
- Paul Chatelain, Vice President, Financial Services, RVH;
- Nancy Kelly-Moore, Vice President, Patient Care Services, RVH; and
- Julia Boudreau; Vice President, Corporate Services, RVH.

The North West LHIN and LWDH provided the Evaluation Team with Terms of Reference to guide the evaluation process. For the complete Terms of Reference, please refer to Appendix B.

In undertaking this review, the Evaluation Team examined documentation and reports provided by LWDH, the North West LHIN and the MOHLTC. Tours were undertaken and meetings were held on site. In addition, numerous interviews were conducted with a range of key LWDH stakeholders including:

- Members of the Board of Directors;
- President and CEO;
- Senior Management including Vice Presidents and Chief of Staff;
- Medical Advisory Committee;
- Fiscal Advisory Committee;

- Departmental Directors/Managers from across the Organization;
- Finance and Decision Support Staff;
- Union representatives.

North West LHIN representatives and external LWDH partners including the North West Community Care Access Centre (North West CCAC), the Sunset Country Family Health Team and Comcare Health Services were also consulted.

See Appendix A for a complete list of individuals who were interviewed as part of the third party evaluation.

3.0 LEADERSHIP

3.1 Board of Directors

The Evaluation Team met with eight representatives of the Board of Directors of LWDH including the Chief Executive Officer and the Chief of Staff.

A number of the Board members are relatively new to their positions, having been elected within the last 18 months. All members of the Board are appointed at the time of municipal elections. While there are certain benefits to this process, there are also inherent risks. The threat of losing key Board members through municipal elections and the subsequent loss of knowledge and experience is significant. LWDH should consider all options to minimize this risk. The Board is encouraged to review in detail the current process of appointment and consider alternatives.

Recommendation 1:

That the current process of appointing members of the Board of Directors be reviewed and that alternatives be considered.

Based on their previous deficit cutting experience and recovery in 2006, members of the Board have strong reservations about signing a Hospital Service Accountability Agreement (H-SAA) that will result in further staffing reductions or service cuts. Some members of the Board have indicated that they would rather resign from the Board than sign an agreement that results in any further reductions and/or cuts. They believe that the hospital is already operating as efficiently as possible. Having said that, Board members indicated to the review team that strengthening the Board's relationship with the North West LHIN is a priority, as is working with other internal stakeholders including management, staff, physicians and unions to help to ensure that this goal is understood and supported.

Recommendation 2:

That efforts be made by LWDH's Board of Directors to strengthen its relationship with the North West LHIN and to work with other internal stakeholders to ensure that this goal is understood and supported.

3.2 Corporate Communications

There was evidence from the evaluation process that there are opportunities to improve corporate communications, both internally and externally. The Board of Directors and Senior Management Team of LWDH are therefore encouraged to review all options to ensure that an effective corporate communications strategy is implemented and monitored. Options could include regular updates to the community, more frequent internal newsletters and town hall meetings for staff. The Board should also undertake a review of its media relations. Most media reports appear to be reactionary and focused on the hospital's fiscal difficulties. There are many good news stories taking place at LWDH. The Board, in concert with senior management, needs to ensure that these stories are shared with the broader public. See Appendices C, D, and E for samples of communications issued by RVH.

All internal stakeholders need to be cognizant of the corporate image of LWDH. This can be supported by improving communications and media relations and by identifying opportunities for staff engagement. Staff should be encouraged to provide input in reviewing processes and identifying opportunities for improvement.

Recommendation 3:

That an effective corporate communications strategy be implemented and monitored.

3.3 Steering Committee

The review team suggests the immediate establishment of a Steering Committee to oversee the successful implementation of the recommendations made in this report. The Steering Committee should include representatives from senior management and the Board of Directors of LWDH and be chaired by the North West LHIN. LWDH and the North West LHIN are encouraged to agree upon the Terms of Reference for this Steering Committee as well as on timelines for implementation.

Recommendation 4:

That a Steering Committee comprised of representatives of LWDH's Senior Management Team and Board and chaired by the North West LHIN be established to oversee the successful implementation of the recommendations contained in this report.

4.0 FINANCIAL SERVICES

4.1 Statement of Operations – March 31, 2008

LWDH has a $41 million operating budget. Last year, the hospital reported a small deficit of $51,860 but only a $24,564 deficit before building amortization. According to LWDH, the deficit can mostly be attributed to higher than normal occupancy levels, an increase in Alternative Level of Care (ALC) days and an increase in sick time. The financial position of the hospital fluctuates from year to year based on one-time funding from the MOHLTC (i.e., a $608,122 surplus reported in 2006/07 and a $906,470 deficit in 2005/06).

Some observations from 2007 to 2008 are as follows:

- There was a reported decrease in "non-resident of the province" revenues of 10%;
- There was a reported decrease in preferred accommodation and chronic co-payment revenues of 4%;
- There was a 60% increase in investment revenues;
- There was an 8.5% increase in salaries, wages and employee benefits due to high occupancy levels (90% to 100%), contract settlements and salary grid movements;
- There is no evidence of reductions in nursing hours when the census is down;
- There was a 16.8% increase in medical staff remuneration (offset by revenue);
- There were increased sick leave and overtime costs; and
- "Up-staffing" is commonly utilized to deal with increased volumes.

4.2 Statement of Financial Position – March 31, 2008

LWDH has good working capital as indicated by its positive current ratio of 1.35:1. It also has no debt instruments and is affiliated with a very successful Foundation.

The cash-to-investment ratio is approximately 7:1, which is very high. LWDH chooses to invest in cash due to the fact that the bank offers a greater return (prime less 2%). However, excess cash could easily be transferred to a long term investment paying a higher rate. For example, RVH's long term investments (equity portfolio) earned 7.99% in the first quarter of 2008 and 13.82% since its inception. For RVH, other benefits have included a generous sponsorship ($5,000) to the hospital's annual golf tournament, elimination of bank fees and sponsored lunches with education seminars on retirement investing for hospital employees.

4.3 Current Year 2008-09

LWDH has revised its projected deficit to $178,000 ($148,000 before building amortization) as of July 2008. This is a significant improvement from the original $503,152 deficit projected in the Hospital Annual Planning Submission (HAPS). At the end of July 2008, the hospital has reported a small surplus of $55,014. While it is noted that the savings have been generated during the summer months and may not be sustainable to year end, by implementing some of the recommendations detailed in this report, the goal of a balanced budget appears to be achievable.

The 2009-10 projected deficit has also been revised to $566,012 from $894,161 based on current year adjustments, among other factors.

Some observations noted from the HAPS submission include:

- Loss of rental revenue is projected due to the Central Ambulance Communications Centre (CACC) tenants moving in October. The building is then being decommissioned.
- OHIP and other patient revenues are budgeted to increase by only 1% in 2008-09 despite inflation of 2% and increases to Diagnostic and Therapeutic services (1.41 FTE's). This could be attributed to the forecasted decrease in CT scans; however, there is no reduction in expenses or volumes. Medical staff fees and other expenses are budgeted to increase.
- There was staff overtime and costs incurred to implement the Wait Time Strategy (WTS), the Enterprise Master Patient Inflows (EMPI) etc. (Reference: LWDH response to 2008/2010 HAPS questions – question 5.)
- A .50 FTE Physiotherapist was hired for WTS (knees).
- Chronic Minimum Data Set (MDS) and Mental Health MDS-RAI reporting are done by a full-time Registered Nurse.
- A significant amount of medical staff remuneration is paid through the hospital's global funding.
- Relief staffing for vacation, sick and education leave is budgeted throughout many functional centers in the hospital, including administrative and support areas.

4.4 Potential Revenue Opportunities

As stated earlier, opportunities exist to generate increased revenue to assist in the balancing of LWDH budget. These include the following options:

Reduce Weighted Cases to Meet Small Hospital Funding Definition:
In 2003, the Joint Planning Policy Committee (JPPC) revised the definition of small hospitals. These hospitals face many challenges that 'larger' hospitals do not. These challenges include the following:

- **Diseconomies of scale** (i.e., low patient volumes and varied occupancy rates);
- **Remoteness** (i.e., significant distance to nearest tertiary centre);
- **Isolation** (i.e., being the primary provider of health care within a geographic area);
- **Lack of community resources** (resulting in a higher proportion of ALC days and readmission rates);
- **Special needs populations** (e.g., populations with relatively low primary health status)[1].

As a result, based upon 2005/2006 data, hospitals would be classified as "small" if they had less than or equal to 2,500 equivalent weighted cases.

Base funding adjustments of approximately 1% of global budgets have been awarded to small hospitals over the past few years. LWDH would be classified as a small hospital and be eligible for this funding adjustment if its weighted cases were reduced by approximately 300/year. LWDH should review all activity currently taking place in its O.R with this in mind.

[1] JPPC Small Hospitals Sub-Committee, 1998.

Recommendation 5:

That LWDH consider a reduction in weighted cases in order to qualify for small hospitals funding.

Maximize Bed Coordination – Chronic and ALC- with Preferred Accommodation:
Patients are often admitted and placed into private and semi-private rooms based on availability and not necessarily by patient request. When this is the case, the hospital cannot bill patients for the room differential. However, effective bed coordination will allow these preferred beds to become available for patients with insurance coverage. This also applies to insured chronic and ALC patients who, if placed into a preferred room, will see the insurance company pay the room differential.

During the on-site evaluation, it was revealed that LWDH does employ this practice and it is recommended that an aggressive approach in bed coordination continue to be taken in order to optimize preferred accommodation revenues.

Recommendation 6:

That LWDH continue to review bed coordination practices and maintain an aggressive approach in this regard.

Interest Revenue – RFP for Long-Term Investments:
As stated earlier, LWDH invests in cash due to the fact that the bank offers a greater return. However, excess cash could easily be transferred to a long term investment paying a higher rate. RVH's long term investments have paid high dividends and for RVH, other benefits have accrued. A copy of RVH's bank tender document is included in Appendix F.

Recommendation 7:

That LWDH develop an investment policy and tender its banking and investment services to maximize its return on investments.

4.5 Potential Expense Reductions

EKS Reports:
There were two hospital-wide cost/efficiency comparison benchmarking reviews performed by EKS Associates, one in June 2006 and one in November 2007. While many recommendations from the first report were implemented, there are still some outstanding issues left unaddressed from the latter report. Many functional centres at LWDH were at or above the median for 2006/07. The Evaluation Team was not able to fully ascertain what recommendations were implemented, due to time constraints.

Recommendation 8:

That LWDH undertake a further review of the EKS Associates benchmarking reports to identify any additional potential areas of efficiency.

Staffing Mix Levels:
A review of the hospital's staffing budgets for 2008/09 indicates high RN to RPN ratios on many in-patient units. The percentage of nurses employed full-time is also 70%. Although this is in congruence with the MOHLTC performance target, it is nonetheless costly. Many small hospitals do not guarantee full time employment due to fluctuations in patient volumes.

Recommendation 9:

That LWDH review the staffing mix levels throughout the organization with the aim of maximizing efficiencies.

Knee Replacements – Volumes:
LWDH is funded for 55 primary knee replacements for 2008/09. At the end of August 2008, only five had been performed. LWDH will have to return this one-time (WTS) funding to the MOHLTC. It is questionable whether $6,885 per knee covers the full operating cost of the surgical case and rehabilitation. Further, the hospital incurs the cost of additional staff in physiotherapy as well as the operating room. LWDH should perform an in-depth costing of these cases to determine if it is feasible to continue with this service. While this is a beneficial service for the community, the organization needs to examine the full operating costs and factor in volume required for critical mass.

Recommendation 10:

That LWDH perform an in-depth costing analysis to determine if it is feasible to continue with its knee replacement program.

Contracted Out Services:
The hospital has marketed its clinical services such as physiotherapy, laboratory and clinical nutrition, among others in the community on a cost recovery basis. This offers a positive contribution to the community while potentially generating income from external sources.

Recommendation 11:

That LWDH undertake a review of the services that it offers to the community to ensure that the rates are sufficient to recover the cost or ideally generate a profit. Further, these rates should be reviewed and adjusted annually to recover salary and benefit increases and to ensure that staffing levels at LWDH are not higher than necessary in order to support the provision of these services to the community.

Parking Fees
Parking fees are a good source of revenue with very little overhead. LWDH currently has paid parking in place at a flat rate of $2/visit.

Recommendation 12:

That the parking rates be revised to market levels after the hospital completes its review of the parking system.

Review Current Practices, i.e., Up-Staffing, Sick and Education Relief:
A review of the hospital's detailed staffing budget for 2008/09 indicates additional relief staffing is brought in to replace employees who are on sick, education or vacation leave. While this may be imperative for some services, i.e., nursing units, a review of the need for replacing staff in non-clinical areas such as finance and health records is advisable.

Recommendation 13:

That LWDH conduct a thorough review of "relief" budgets throughout the organization, measuring the risk to project deliverables and timelines by not replacing staff when they are absent.

Energy Retrofit:
LWDH undertook an energy retrofit project in 2003 and there is an opportunity for LWDH to further review its energy consumption. A comprehensive audit of this sort could lead to investments that achieve permanent reductions in energy use, potentially resulting in significant utility cost savings. Through such a program, the Board and administration of LWDH would also demonstrate leadership to its stakeholders on energy conservation and a cleaner environment, enhancing the hospital's corporate image.

As an example of what can be achieved, RVH made a $1 million investment to reduce energy consumption. This included installing a solar wall that provides pre-heated fresh air to the operating room, updating plumbing and lighting fixtures and installing new occupancy sensors and mechanical controls that automatically adjust light, heating, ventilation and air conditioning levels. As a result of this, RVH has already enjoyed substantial annual savings in utility costs. The payback period for the project at RVH is estimated at eight years but it should be noted that the benefits are more than just financial. Most energy retrofit companies offer a variety of financing options that allow for cash flow flexibility. Please refer to Appendix G for the Energy Efficiency Award Application submitted by RVH to the Ontario Hospital Association and Appendix H for the associated media release.

Similar to the tender for banking investments, RVH has partnered with an energy firm for its energy retrofit project. This partnership has led to strong support for the hospital's annual golf tournament in addition to sponsorship for a number of staff lunches to provide education on energy conservation at work and at home.

Recommendation 14:

That LWDH investigate whether further utility savings would be achieved from a one-time investment to reduce energy consumption as described here.

5.0 CLINICAL SERVICES

5.1 Transportation

The transportation of patients is an ongoing key concern throughout the organization. A review of the documents provided indicates that, in October 2007, LWDH CEO Mark Balcaen and Board Chair Joan Reid made a presentation to the Kenora District Services Board (KDSB) outlining the issues. The problems have evolved since the transfer of responsibilities to the municipalities for this service in 1998. At present, these responsibilities and some costs, particularly in regard to non-emergent ambulance transfers (NEATS), are being downloaded to hospital operating budgets. This is due to escalating demand, service delivery costs and diminishing resources. The transportation of individuals within the health care system is a very complex issue that involves many agencies and various policies, procedures and legislation. The business of emergency medical services and non-emergency inter-facility transfers are two distinct entities that have, over the years, become perceived as one and the same.

GROUP 1 PATIENTS: Critically ill and medically unstable patients who need emergency transport.

Concerns:

- Timely transfer of critically ill patients to receiving facilities. It is 6 hours to Thunder Bay (which is in a different time zone); it is 2.5 hours out of province to Winnipeg;
- Weather conditions in the winter months which can delay transfers for hours and even days;
- Lack of critical care paramedics during all transfers;
- Increasing demands for tertiary care due to demographic shifts;
- Loss of hospital staff – physicians, registered nurses, respiratory therapists – and their expertise out of the organization for long periods of time during transfers - two to three staff members could be deployed on a single patient transfer;
- Increasing costs of overtime for staff on transfers;
- Delays in repatriation of nursing, respiratory therapists and medical staff after delivering patients to tertiary care - few modes of transportation are easily available;
- Repatriation of neonates;
- Interprovincial transportation issues; and
- Role of ORNGE as an emergency air transfer service.

GROUP 2 PATIENTS: Medically stable; non-ambulatory and ambulatory; low risk of status changing; requiring diagnostic tests, cardiac angiography etc. thus not consistent with the Ambulance Act definition of those that warrant a speedy transfer.

Concerns:

- The land ambulance returns to Kenora after dropping off patients in Winnipeg and cannot wait for hours to return patients/LWDH staff and physicians to the community. This is in an effort to maintain 911 response capability;

- Depending on the number of available vehicles, the time spent out of Kenora leaves the community of Kenora with limited ability to maintain emergency service during these non-emergent transfers;
- Lack of regulated Medical Transfer Services;
- Lack of local service providers who can carry wheelchairs;
- Lack of local service providers with attendants who are stretcher carriers;
- Vast geography;
- High volume;
- Costs;
- Air ambulance will not repatriate NEATS from Winnipeg because LWDH is within 240 kms;
- Hospitals such as St. Boniface are no longer willing to take Kenora residents into their cardiac catheterization lab unless there is an assurance that patients will be repatriated back to Kenora in a timely fashion; and
- Patient and family concerns including how to return from Winnipeg if discharged, who will pay and who will assist.

Complicating Factors: Interprovincial travel
Elective transfers causing delays
Costs to families
Costs to hospitals, affecting other patient care programs

There is a need to transfer patients by whatever means available whenever a decision is made to transfer. The private sector or a not-for-profit organization may be willing to establish a patient transfer system with the hospital as a preferred user. Early involvement in recruiting or selecting a company will allow a selection that meets local needs and standards of wait time minimums, credentials of attendants and equipment available. Unfortunately no such service exists at this time and it may take time for a service to become established and accepted by local health providers. The Board and senior management's work to date on this issue has been useful and should continue.

Recommendation 15:

That two distinct transportation committees be formed to address the concerns of both patient groups described above. The first committee should be a broad-based local community partners committee with representation from long-term care/nursing homes, First Nations, Kenora District Services Board, service clubs, volunteer drivers and others with an interest in the issue. The second committee should be a North West LHIN-wide committee for communities of practice on transportation with an interprovincial representative from the Winnipeg Regional Health Authority (WRHA) or, at least, a formal avenue to communicate information to a WRHA representative. It is also recommended that, for non-emergency transfers, LWDH review internal policies and procedures and communicate these to all stakeholders.

Goals of the Suggested Committees:

- To raise awareness of the issues among all parties including the general public through shared dialogue;
- To inventory all resources available;
- To educate all stakeholders including families, patients, physicians, etc.;
- To foster collaborative and local problem-solving;
- To obtain positive local involvement in decision-making;
- To build relationships and strengthen partnerships;
- To find opportunities for better utilization; and
- To obtain alternate service provision according to the needs of Kenora and district.

The following are recommended for Emergency Transfers:

- Raise the issue with the Emergency Services Committee, with ER physicians, clinical administration, CACC, ORNGE, etc.;
- Send reports to the North West LHIN; and
- Invite a senior representative from ORNGE to visit in order to strengthen communications.

5.2 Unremunerated Services

LWDH books dental surgeries in its operating rooms. In the case of dentistry, the fixed costs of OR utilization may be small but the operating costs such as nurses' salaries must be absorbed by the hospital from its base budget with no financial return on the investment as this is not a remunerated service for the hospital.

A Canadian publicly administered hospital only has a legal obligation to provide unremunerated services (such as dental surgery or physiotherapy for out-patients) to a person when his/her life or integrity is in danger. Another pressing legal obligation is that all hospitals in Ontario have a fiscal responsibility to balance their budgets. Ethically, reducing services that have been provided for some time will present challenges as to who is given unremunerated services and how much service is provided. LWDH has an ethics committee in place to address perspectives on these issues.

Recommendation 16:

That the following strategies be undertaken with regard to unremunerated services:

- ***Alternatives in the community should be pursued for all unremunerated services;***
- ***Any reduction of existing services needs to have a pre-existing communication strategy in place, fully discussed and approved by the Board, MAC and senior management; and***
- ***Modification should always involve face-to-face meetings with affected parties, as well as print communication.***

5.3 Hemodialysis Program

During discussions with the Board, it was a stated priority that community services not be lost. The Life Support Hemodialysis service has been in existence for many years and is a satellite of the Winnipeg Health Science Centre. Funding is provided by the Ontario Ministry of Health and is provided at the $199.50/treatment rate.* There is a nephrologist on site. The number of base funded treatments is 2,400 or approximately 16 patients. Last year the number of treatments increased to 2,940 by serving up to 20 patients during the year. Currently there are five stations in operation.

**Funding rates established by the JPPC are scheduled to increase in the near future to reflect current cost realities*

Patients are seen by the nephrologist in Kenora but are sent to Winnipeg for vascular access procedures before initiating hemodialysis, for transplant work up and for tertiary care as the need arises. Nurses receive their education in Winnipeg and technical support is provided by Winnipeg. One to two extra back-up machines should be kept. The technical recommendation is one back up for every three to four working machines but this standard should be reviewed with Winnipeg.

Growth rates and demand for hemodialysis service continues to increase by at least 10% annually. This takes into account deaths, transplants and peritoneal dialysis starts. In Ontario, the Peritoneal Dialysis (PD) Initiative recommends that 50% of new starts begin on PD so that there is a 30% retention rate on the program.

Recommendation 17:

That LWDH Board and Senior Management Team establish processes to target growth in key program areas. This will enable these programs to be operationally efficient and meet clinical thresholds for delivery of quality outcomes. There should be a dialogue with Winnipeg Health Science Centre, the Ontario Ministry of Health, Priority Programs Branch and the North West LHIN to review program growth for the population served now in pre-renal clinics and future projections. Approval for 100% funded growth needs to be assured in advance and plans developed by LWDH, with appropriate North West LHIN and MOHLTC approvals in place to have the physical resources to respond.

It is likely that treatments will exceed 3,000 in 2009/10.

The average chronic hemodialysis treatment takes 4-4.5 hours to complete. Current staffing in the unit allows for 2 RNs on 12 hour shifts, Monday to Saturday and 1 RN on an 8 hour shift Mondays, Wednesday and Fridays. There is also a part-time clerk assigned to the unit. Approximately 30 hours of RN care is provided on Mondays, Wednesdays and Fridays to 10 patients on 2 shifts. Approximately 22.5 hours of RN care is provided on Tuesdays, Thursdays and Saturdays to 8 patients on 2 shifts. **Total nursing hours for 18-19 patients is 157.5 hours/week or 8.2 hours per patient/week (2.7 hours/treatment)**.

Recommendation 18:

That steps be taken to ensure that revenue and expenses are more closely matched. As part of this, there should be a review of the space needed for the program and staffing levels including number of hours of care/patient and the service delivery model.

To address growth projections in Kenora, LWDH Senior Management Team will need to assess the auxiliary space required for treatment provision for a five to 10 year projection. The addition of a sixth station now will allow for 10% annual program growth and enhanced revenue opportunities. It will also ensure a more cost effective staffing model for care delivery. Six stations would allow up to 36 patients to dialyze in the unit in future. Adjustments need to be made for storage of supplies at maximum occupancy.

Recommendation 19:

That the hospital purchase additional hemodialysis machines after communication with Winnipeg regarding infrastructure capability.

With 6 stations operating on 3 shifts, 3 times/week (Mondays, Wednesdays, Fridays), 18 patients can be dialyzed. Under this scenario, the RN staffing could be shifted to 2 RNs on 12 hour days, and 2 RNs on evenings Mondays, Wednesday and Fridays. This translates to 37.5 hours/day for 3 days or **112.5 RN hours/week versus 157.5 RN hours/week under the current staffing model**.

Other combinations can be configured with the stations being used for only 2 shifts i.e., 12 patients dialyzing Mondays, Wednesdays and Fridays and 6 patients dialyzing on Tuesdays, Thursdays and Saturdays or 15 patients Mondays, Wednesdays and Fridays and 5 on Tuesdays, Thursdays and Saturdays. While this is not as cost effective, it may need to be implemented because some patients have organized their work schedules around these times. For 2 patient shifts on 6 stations for a total of 12 patients, the staffing could be realigned to include 2 RNs on 10 hour shifts after discussions with the Ontario Nurses Association (ONA).

These staffing suggestions would also free up capacity to accommodate visitors in the summer months to increase funded volumes or make up for patient treatments lost due to hospital admissions out of Kenora. This model also provides flexibility to accommodate extra treatments if and when needed for patients.

The common staffing for chronic hemodialysis patients at regional centres where patients often have higher acuity is 1 nurse to 3 patients. Novice nurses may be assigned to only 2 patients until they gain competency in needling patients. Often the units operate 3 shifts/day. Patient starts are staggered at 20 minute intervals in order to allow three patients on each shift. In addition many units utilize RPNs or technical aides to start machines and run the disinfect cycles at the end of the patient treatment. Some reinvestment of the RN savings into RPN hours for technical support could be implemented for coverage at lunch and suppertime. The addition of RPNs would allow some assistance with nursing and technical functions in the unit. This could be an alternative to attrition or in addition to clerical support.

5.4 In-Patient Bed Utilization

Adult Medicine/Pediatrics/CCC:
On this unit, there are 10 Complex Continuing Care (CCC) beds, 14 Medical beds and 4 Pediatric beds.

- Occupancy on the Medical beds is 90% YTD
- Occupancy on the CCC beds is 97.7% YTD
- Occupancy on the Pediatric beds is 28.3% YTD

While the desire of the organization to keep the beds available for pediatric patients is reasonable, it is not necessary to keep them staffed 100% of the time. It may be possible to use the float position to staff according to need when pediatric patients are admitted.

Recommendation 20:
That beds be staffed according to patient census.

The staff mix should be reviewed to take into account the number of patients whose outcomes are known and who are medically stable and who could therefore have their care provided by an RPN.

If both the ALC length of stay and the number of ALC patients continue to grow, this adult medical unit would be an appropriate location to accommodate ALC patients. They could then benefit from the rehabilitation and/or recreation programs for the CCC patients, the staffing mix could be adjusted and staff could be educated in geriatrics geared to meet patients' needs.

For 24 patients, 3 RNs and 3 RPNs on days, and 2 RNs and 1 RPN on nights would provide a 1:4 patient ratio on 12-hour days and 1:8 on 12-hour nights. The PSW position and extra RN position can be floats to assist with sick calls, vacation relief hours, transport etc.

ICU:
The Board and Senior Management Team have given consideration to a new model of care in the ICU (i.e., ICU 'light'). Maintaining an ICU at LWDH is necessary due to ER volumes, the surgical program, psychiatric program and the geographic isolation that delays transfers. Due to geography and health conditions, it appears that there will always be a need, at the very least, to stabilize and transfer vented patients. Weather conditions in winter months mean that patients could spend their entire time on a ventilator in LWDH ICU. As such, it is necessary to maintain the skills of RNs and RTs in the care of these patients. The staff has participated in the critical care coaching team strategy in order to ensure a high quality service to the community and this is to be commended.

Currently the ICU has 4 beds. The occupancy level is 60.7%. This equates to an average of 2.4 beds although it is recognized that this number can be higher or lower at any time. It is currently staffed with 2 RNs, thus the worked hours/patient day will be significantly higher than the peer average.

Recommendation 21:

That LWDH consider decreasing the number of ICU beds to three, thereby increasing occupancy and decreasing case costs. In addition, a review of the staffing model in the ICU with the decreased number of beds should be undertaken.

By combining the nursing staffing with Medicine/Surgery, the second ICU nurse position could be maintained and redeployed as a float nurse (ACLS certified) to assist with break coverage in the ICU or when acuity rises. The float could assist with assessments of patients on telemetry and transition patients to the medical unit. Nursing administration has already put an RN float position in place to maximize efficiency. This is particularly important in an environment of nursing shortage to respond to illness and vacation relief and peak periods in workload. The current budgeted FTEs are 8.75. The budgeted FTEs could be reduced to 4.8 FTEs with one RN 24/7 in a three bed unit. The reallocation of staffing costs and workload to medical will merit further review to see if savings can be achieved there. As noted, a 24/7 float RN position who is ACLS certified could assist in ER / Medical Surgical, in the ICU and with critical care transfers. It will be important to review processes to ensure centralization of staffing information to avoid duplication when float nurses are available.

Recommendation 22:

That the top ten clinical diagnoses be reviewed along with the admission and discharge criteria for the ICU and that these are known and communicated to all stakeholders to ensure optimum utilization and length of stay.

Psychiatry:

While the average occupancy rate in Psychiatry to the end of July is approximately 50%, the staffing should match the occupancy and patient acuity. Currently, 4 staff members are scheduled on days for an average of 8-10 patients and three staff on nights.

Recommendation 23:

On this unit, in the emergency department and facility-wide, that all staff members take a non-violent crisis intervention course and continue to maintain updates due to the potential for violence. In-house staff expertise could be developed.

Obstetrics:

The decision to locate medical beds onto this unit has had a positive impact on efficiencies and RN utilization. Obstetrics will always remain a difficult service to staff efficiently due to erratic and non-predictable service volumes but it is a valued and needed service for isolated communities. The decision to co-locate medical beds will allow its continued viability for the community. The use of midwives is commendable.

Medical Surgical Unit 3 East:

Occupancy is 87.9% YTD and staffing matches the occupancy level. A total patient care model has been in effect for a number of years and bed utilization is on track.

5.5 Processes for Managing Performance

The use of float pools for staffing at LWDH is an efficient practice. Many of these hours can be reallocated from vacation, stat and illness budgets. Processes need to be reviewed to ensure centralization of staffing information to avoid duplication and unnecessary overtime when float nurses are available for vacation, sick time and fluctuations in acuity. Centralized record keeping and schedules would assist in this regard.

Recommendation 24:
That processes be reviewed to ensure centralization of staffing information to avoid duplication and unnecessary overtime when float nurses are available.

5.6 North West CCAC / LWDH Partnership Opportunity

Currently some visits to the emergency department are for administration of IV antibiotics and dressing changes. These are nurse-intensive visits and often occur due to lack of service or interruptions in the provision of community services through the North West CCAC. It is recommended that LWDH track the number of times CCAC is unable to provide service in the client's home, resulting in either a hospital admission or repeated returns to the ER. This information may already be included in the proposal developed by LWDH staff and currently before the North West LHIN. A partnership with CCAC and its service providers to establish a nursing clinic on an out-patient basis on-site or nearby with the goal of decreasing ER visits and in-patient admissions and maximizing the efficiency of the CCAC service provider is endorsed. Often in rural and remote areas, there are long distances travelled between clients for community nursing visits so this proposed partnership would be mutually beneficial and save costs by increasing efficient use of nursing resources.

Recommendation 25:

That LWDH consider a partnership with CCAC and its service providers to establish a nursing clinic on an out-patient basis onsite or nearby to decrease ER visits and maximize CCAC efficiency.

6.0 CORPORATE SERVICES

The Evaluation Team met individually with several department managers; as well as with the Local President of the ONA and the CUPE RPN bargaining units along with the Recording Secretary of the CUPE Support Staff bargaining unit and members of the Fiscal Advisory Committee. In addition, several reports (including statistical, financial, salary, staffing, WSIB and sick time information) were made available to the Evaluation Team.

From these sources of information, issues relating to Corporate Services can be grouped into the following categories: human resources; opportunities for revenue generation and opportunities for cost savings.

6.1 Human Resources

In light of the hospital's financial situation, a preliminary review of WSIB and sick time statements was conducted. LWDH received a rebate from WSIB (based on its NEER experience) in two of the last five years. The claims experience and statistics relating to WSIB absences in the current year appear reasonable. The challenges faced by a hospital of this size are recognized as is the potential devastating cost of one claim which may have impacted on the hospital's past ability to achieve rebates. As an option to further improve its OH&S program and capture WSIB rebates, LWDH is encouraged to maintain its membership in the OHA-sponsored WSIB Safety Group as a means of benchmarking and networking with other health and safety professionals, as well as to benefit from group rebates.

Recommendation 26:

That LWDH maintain its membership in the OHA-sponsored WSIB Safety Group.

LWDH shared its quarterly reporting system for absence statistics which is used to track "absence days" related to modified work, WSIB and sick time (full-time and part-time). The Senior Management Team is commended on the quality of this report and is encouraged to broadly circulate this report to the unions, the Fiscal Advisory Committee, the Personnel Committee of the Board and all staff.

Recommendation 27:

That LWDH circulate its absence statistics report broadly throughout the organization.

The sick time experience at LWDH has been at or near the Ontario Hospital Association average number of sick days/employee for the last several years. LWDH administers both an Attendance Management Program (AMP) and a Modified Work Program. The HR Manager indicated a desire to undertake a review of the AMP. There may also be an opportunity to conserve paid modified work days by reviewing whether modified work is fully managed by departmental managers and is time limited. Some departments have a higher use of modified days and these areas need to be analyzed first.

Recommendation 28:

That the Human Resources Department of LWDH undertake a review of the following policies/programs: modified work, return to work/work hardening, accommodation and attendance management in order save absence days across the organization and achieve an improved attendance record.

Another approach to improving the absence experience at LWDH is to implement a comprehensive Wellness Program for staff. LWDH has already implemented several excellent activities in this regard (i.e., healthy eating options in the cafeteria/vending machines, one full-time physiotherapist dedicated to staff health and a shared gym with the psychiatry program). Staff indicated that there is a desire for more Wellness Programs (i.e., staff lounges, quiet areas, improvements to cafeteria menu, enhanced communication across the organization, activities to improve morale, etc.).

Recommendation 29:

That LWDH establish a Wellness Committee with extensive employee representation to identify and implement further staff Wellness Programs. This could be a joint responsibility of the Occupational Health and Safety Nurse and the Staff Physiotherapist. It is vital that LWDH identify champions across the organization and throughout all levels of the hospital to develop and implement programs of interest. The Ontario Hospital Association has developed many resources in regards to staff wellness. A related initiative is to establish a tuition assistance fund through coffee/drink sales (or other sales) in the cafeteria, as the RVH has done. This will ensure that education funds are available to staff across the organization in all disciplines.

In terms of labour relations, LWDH has received few grievances from its unions. There was a surge of grievances during the restructuring exercise in 2006 which illustrates the fact that the current situation needs to be managed differently. By improving communication strategies as noted earlier, staff will become more engaged in the requisite changes and will assist in reviewing processes and identifying further opportunities for efficiencies.

6.2 Opportunities for Revenue Generation

There are opportunities for additional revenue generation across several departments.

There is a significant labour market shortage of ultrasound technologists. LWDH has done a good job in terms of cross-training its x-ray technologists and it should continue to seek opportunities to respond to the available volume of out-patient ultrasound work (current waiting time is 2 months) in order to maximize out-patient revenue. A related cost saving measure would be to conduct a call-back analysis of the ultrasound technologist position to determine whether this service is needed after hours.

Recommendation 30:

That LWDH identify the means of responding to the potential out-patient volume of ultrasound work.

LWDH Senior Management Team should undertake a review of services and job functions in the Respiratory Therapy Department in order to optimize out-patient revenues (i.e., business case for implementation of plethysmography service). Part of the time of the clinician in the Respiratory Therapy Department is devoted to the hospital capital equipment acquisition process. LWDH should explore another option for this duty, as well as ensure that all options and efficiencies related to capital group purchasing are explored.

Recommendation 31:

That LWDH review services and job functions in the Respiratory Therapy Department in order to optimize out-patient revenues including establishing a plethysmography service.

LWDH does not have a sleep laboratory. The experience of the RVH is that this service generates significant revenue for the hospital. None of the hospitals in the immediate area offer this service; hence, the catchment area would likely be sufficient to support the program. LWDH will have to consider staffing mix and number of beds to maximize revenues.

Recommendation 32:

That LWDH explore the possibility of establishing a sleep laboratory program.

LWDH should also explore all possibilities for implementing echocardiography to enhance out-patient revenue.

Recommendation 33:

That LWDH explore the possibility of implementing echocardiography.

6.3 Opportunities for Cost Savings

The Evaluation Team reviewed staffing level reports across the organization. Based upon information provided in the EKS Associates Inc. reports (2006 and 2007) as well as on comparisons with activity/staffing levels at RVH, there appear to be opportunities for savings in several departments.

Generally, there is a high proportion of full-time to part-time staff in some departments i.e., diagnostic imaging, select nursing units, finance, switchboard and laundry. While this may be a retention/recruitment strategy, further review is nevertheless advisable.

Recommendation 34:

That these full-time: part-time ratios discussed above be examined at every opportunity in order to capture savings related to benefits, as well as to benefit from flexibility in staffing levels, etc.

The potential for efficiencies may also exist in the middle management structure within the Nursing Department, warranting a review. This review should include all positions including the volunteer coordinator, secretarial support to nursing administration, the MDS coordinator

and the discharge planner. The review should also include the nursing supervisors in light of the recommendations put forth in this document regarding staffing changes in the ICU and the fact that they no longer have a clinical role.

Recommendation 35:

That the Senior Management Team undertake a review of the Nursing Department in terms of the following: scope of responsibility; the number of staff reports; and, the number of programs managed.

The annual volume of ECGs in 2007/08 was 5,234. This is comparable to the number of ECGs performed on an annual basis at the RVH. At LWDH, a full-time ECG technician is employed but it is unclear who is completing ECGs after regular working hours. At the RVH, ECGs are completed as part of the daily workload in the Diagnostic Imaging Department by x-ray technologists already on duty and on call after hours.

Recommendation 36:

That productivity levels in ECG services be evaluated, taking into account the potential re-alignment of duties with Diagnostic Imaging Department or tying in with this report's recommendations about Respiratory Therapy and/or Sleep Lab Service.

LWDH has already embarked on a plan in the Diagnostic Imaging Department to train all x-ray technologists in CT. There is currently a very short wait time reported at two days for CT scans; hence, there may be an opportunity to decrease the hours on this service and provide all evening/night and weekend coverage by the newly-trained x-ray technologists. It is recognized that a review of the scheduling in the Diagnostic Imaging Department will need to be done in view of WTS funding.

Recommendation 37:

That the Senior Management Team undertake a review of the Diagnostic Imaging Department as detailed above.

LWDH's commitment to staff health is apparent in the fact that it employs one full-time physiotherapist dedicated to staff treatments. Workload statistics specific to this position were not reviewed.

Recommendation 38:

That LWDH staff physiotherapist position focus not only on individual treatments but also on group education sessions for all applicable staff on musculo-skeletal disorder prevention strategies. It is further recommended that this position be reviewed to determine its fit with staff wellness opportunities as identified earlier.

As noted in the Clinical Services discussion, further analysis is needed on the breakdown of in-patient versus out-patient physiotherapy services in an effort to potentially divert more out-patient physiotherapy services to the community. There should also be a review of case mix and workload regarding in-patient physiotherapy services. A general rule of thumb is 10

to 14 in-patients/day depending on patient case mix; and, up to 20 patients per day depending on staff mix i.e., when physiotherapy assistants are employed. The Physiotherapy Department was earmarked in the EKS & Associates reports (2006 and 2007).

Recommendation 39:

That LWDH further analyze the breakdown of in-patient versus out-patient physiotherapy services and review the case mix and workload regarding in-patient physiotherapy services.

It is unclear from the 2007 EKS Report whether staffing reductions were made in LWDH's Finance/Human Resources Department or whether the efficiencies were derived solely from a reallocation of salaries to a different cost centre.

Recommendation 40:

That the Senior Management Team conduct an analysis of staffing levels in the Finance/HR Department.

Two reports were reviewed regarding staffing in the Admitting and Communications Departments, revealing a discrepancy in the reported number of FTEs. From the review, it appears that there may be an opportunity to reduce staffing levels in the Admitting Department.

Recommendation 41:

That the Senior Management Team conduct a review of staffing levels in the Admitting Department. This review should include an examination of the role of the Manager in terms of reassigning the booking function of the visiting specialists' clinics to a lower paid classification.

The Evaluation Team also reviewed the staffing and service levels in the Nutrition and Food Services/Cafeteria Department. A more detailed analysis of this Department is warranted and should cover the following:

- Review the roles and functions of the food services supervisors, the dietary clerks and the department manager;
- Ensure that the full costs of meal preparation are charged to "other vote" programs where applicable (i.e., the hostel and the Morningstar program);
- Ensure that the cafeteria prices reflect current costs, recognizing the higher cost of transport to LWDH;
- Ensure that the actual costs of 'Meals on Wheels' meals are reflected in the meal prices; and
- Research staffing models that could be implemented (respectful of collective agreement provisions) to recognize peak periods in the kitchen (i.e., four hour shifts during peak periods rather than full shifts that likely experience downtimes).

Recommendation 42:

That the Senior Management Team conduct a review of staffing in the Nutrition and Food Services/Cafeteria Department as described above.

There may also be further potential to realize efficiencies through group purchasing.

Recommendation 43:

That LWDH ensure that all options and efficiencies related to group purchasing are explored.

6.4 Laboratory

Compared to hospitals of a similar size, LWDH's laboratory offers a wide range of services, enabling the hospital to play a regional role by providing support to surrounding hospitals.

There may be an opportunity to review the hospital's role in the provision of out-patient laboratory work. At this time, the hospital is subsidizing the cost of all out-patient work and the demand for out-patient laboratory work is growing at a pace of about 8%, well in excess of hospital funding. The hospital must consider how long it is willing to continue to subsidize all of the out-patient work.

In other communities, hospitals have moved away from out-patient community laboratory work to allow the hospital laboratory to focus on "core" hospital services. This would include in-patient, dialysis, emergency work, etc. To allow this to occur, the Senior Management Team of the hospital, with the support of the Senior Laboratory staff and physicians, should review the options for partnerships with private laboratories to decant the volume of out-patient work from the hospital. The hospital will have to factor in current revenues, expenses and future trends. Senior management will also have to play a leadership role to ensure there is no reduction in the overall quality of service for the community. Having said this, the experience of other communities suggests immediate savings could be found and future costs avoided.

Recommendation 44:

That the Senior Management Team review and capitalize on opportunities for partnerships with private laboratories to realize savings and avoid future costs.

7.0 CONCLUSION AND RECOMMENDATIONS

7.1 Conclusion

The review team acknowledges that significant challenges exist for LWDH, including being both rural and isolated, with travel on secondary roads and weather conditions key concerns. More importantly, there are significant challenges in the determinants of health for the population served.

In some departments, LWDH is currently operating at an expense level that is not consistent with benchmark performance standards as compared to its peers. It is, however, the belief of the Review Team that the Board of Directors and Senior Management Team can achieve a balanced budget. To accomplish this, it will be important for LWDH to recognize that it cannot be "all things to all people". The LWDH leadership team is accountable for the ongoing financial performance of the Hospital and, as such, must be prepared to make the necessary adjustments throughout the year to ensure success.

In light of the conviction of the Review Team that a balanced budget is achievable, the Board is encouraged to submit a full recovery plan based on the recommendations of this report and proceed with signing the H-SAA.

Recommendation 45:

That the Board submit a full recovery plan in the short term and sign the H-SAA.

These statements are made fully recognizing the significant amount of work that needs to be done by LWDH and the support that the hospital will need from the North West LHIN.

Change management in any organization is always difficult. Unlike previous cost-cutting exercises at LWDH, opportunities for enhancement of services in addition to realignment of current services exist. If the changes are well implemented, with particular attention to process, communication and transparency, the review team believes that LWDH will be a stronger organization as a result of the exercise.

This report has identified numerous opportunities for LWDH to consider. Some of these suggestions involve expansion of services and development of new programs while others involve reductions in services and programs along with productivity improvements. A major limitation of a peer review, however, is the ability to provide guaranteed dollar amounts with each suggestion. Some of the dollar amounts will be significant. In light of this, a thorough review of this report needs to be undertaken in the short term to prioritize the recommendations.

Recommendation 46:

That Senior Management and the Board thoroughly review the content of this report and develop a mechanism to rank the recommendations, prioritizing those areas identified for immediate attention. Consideration should then be given to establishing internal task forces for each recommendation whose responsibility it would be to review in detail the revenues, expenses and processes/timelines for full implementation.

7.2 Summary of Recommendations

7.2.1 Leadership

a. That the current process of appointing members of the Board of Directors be reviewed and that alternatives be considered.
b. That efforts be made by LWDH's Board of Directors to strengthen its relationship with the North West LHIN and to work with other internal stakeholders to ensure that this goal is understood and supported.
c. That an effective corporate communications strategy be implemented and monitored.
d. That a Steering Committee comprised of representatives of LWDH's Senior Management Team and Board and chaired by the North West LHIN be established to oversee the successful implementation of the recommendations contained in this report.

7.2.2 Financial Services

a. That LWDH consider a reduction in weighted cases in order to qualify for "small" hospitals funding.
b. That LWDH continue to review bed coordination practices and maintain an aggressive approach in this regard.
c. That LWDH develop an investment policy and tender its banking and investment services to maximize its return on investments.
d. That LWDH undertake a further review of the EKS Associates benchmarking reports to identify further potential areas of efficiency.
e. That LWDH review the staffing mix levels throughout the organization with the aim of maximizing efficiencies.
f. That LWDH perform an in-depth costing analysis to determine if it is feasible to continue with the knee replacement program.
g. That contracted out services be reviewed and adjusted annually to recover salary and benefit increases and that staffing levels at LWDH are not higher than necessary in order to support the provision of these services to the community.
h. That the parking rates be revised to market levels after the hospital completes its review of the parking system.
i. That LWDH conduct a thorough review of "relief" budgets throughout the organization, measuring the risk to project deliverables and timelines by not replacing staff when they are absent.
j. That any additional staff call-ins be approved by management.
k. That LWDH investigate whether further utility savings would be achieved from a one-time investment to reduce energy consumption.

7.2.3 Transportation

a. That two distinct transportation committees be formed to address the concerns of both patient groups identified in this report.

7.2.4 Unremunerated Services

a. That the following strategies be undertaken with regard to unremunerated services:
   - Alternatives in the community should be pursued;
   - Any reduction in services should have an approved communication strategy in place; and
   - Modification should always involve meetings with affected parties and print communications.

7.2.5 Hemodialysis Program

a. That LWDH Board and Senior Management team establish processes to target growth in key program areas such as hemodialysis.
b. Take steps to ensure that revenue and expenses in this program are more closely matched.
c. That the hospital purchase additional hemodialysis machines after communication with Winnipeg regarding infrastructure capability.

7.2.6 In-Patient Bed Utilization

a. That beds be staffed according to patient census.
b. That LWDH consider decreasing the number of ICU beds to three. In addition the staffing model should be reviewed.
c. That the top ten clinical diagnoses along with the admission and discharge criteria for the ICU be reviewed and that they be made known to all stakeholders.
d. In the Psychiatry unit, the emergency department and facility-wide, that all staff take a non-violent crisis intervention course.

7.2.7 Processes for Managing Performance

a. That processes be reviewed to ensure centralization of staffing information to avoid duplication and unnecessary overtime when float nurses are available.

7.2.8 CCAC/LWDH Partnership Opportunity

a. That LWDH consider a partnership with CCAC and its service providers to establish a nursing clinic on an out-patient basis onsite or nearby.

7.2.9 Human Resources

a. That LWDH maintain its membership in the OHA-sponsored WSIB Safety Group.
b. That LWDH circulate the absence statistics report broadly throughout the organization.
c. That the Human Resources Department review the following policies/programs: modified work; return to work/work hardening; accommodation; and, attendance management.
d. That a Wellness Committee be established with extensive employee representation to identify and implement further staff wellness programs along with a tuition assistance fund.

7.2.10 Opportunities for Revenue Generation

a. That LWDH identify the means of responding to the potential out-patient volume of ultrasound work.

b. That LWDH review services and job functions in the Respiratory Therapy Department in order to optimize out-patient revenues including establishing a plethysmography service.
c. That LWDH explore the possibility of establishing a sleep lab program.
d. That the possibility of implementing echocardiography to enhance revenues be explored.

7.2.11 Opportunities for Cost Savings

a. That full-time part-time ratios across LWDH be evaluated.
b. That the Senior Management Team undertake a review of the Nursing Department with respect to the number of staff reporting and the number of programs managed.
c. That productivity levels in the ECG service be reviewed and that re-alignment of duties with another department be considered.
d. That the Diagnostic Imaging Department be reviewed.
e. That LWDH physiotherapist position also focus on education.
f. That staffing levels in the Finance/HR, Admitting and Nutrition and Food Service/Cafeteria Departments be reviewed.
g. That all options and efficiencies related to group purchasing are explored.

7.2.12 Laboratory

a. That the Senior Management Team review options for partnerships with private laboratories to decant out-patient volumes from the hospital.

7.2.13 Conclusion

a. That the Board of Directors of LWDH submit a full recovery plan in the short term and sign the H-SAA.
b. That Senior Management and the Board thoroughly review the content of this report and develop a mechanism to rank the recommendations, prioritizing those areas identified for immediate attention. Consideration should then be given to establishing internal task forces for each recommendation.

APPENDICES

APPENDIX A

STAKEHOLDER INTERVIEW LIST

Board of Directors

Mark Balcaen, Secretary/Treasurer
Rev. Rod Lamb, Board Member
Marge Matheson, Board Vice Chair
Orlo Mejia, Board Member
Betty Anderson, Board Member
Jim Clarke, Board Member
Dr. J.K. MacDonald, Chief of Staff
Joan Reid, Board Chair
Debbie Baldwin, Board Member

Senior Management

Mark Balcaen, President & CEO
Cindy Gasparini, VP, Corporate Services
Lesley Brown, VP, Patient Services
Dr. J.K. MacDonald, Chief of Staff

Fiscal Advisory Committee

Mark Balcaen, Chairperson
Cindy Gasparini, VP, Corporate Services
Cheryl O'Flaherty, Manager, Health Records/Finance
Brock Chisholm, Manager, Rehabilitation
Judy Bain, RPN, President, CUPE 1781
Debra Bastone, President, ONA Local 81
Doug Kurtz, CUPE 3634, Paramedical
Lesa Sieradzki, CUPE 822, Support
Anne Sweeney, Manager, Psychiatry Services
Dr. J.K. MacDonald, Chief of Staff

Medical Advisory Committee

Dr. Sherry Reed-Walkiewicz, GP, GPI Psychiatry, President Medical Staff
Lesley Brown, RN, VP Patient Services/Chief Nursing Officer
Mark Balcaen, President & CEO
Dr. Usama Zahlan, Chief of Psychiatry
Wendy Peterson, RN, Midwife
Dr. J.K. MacDonald, Chief of Staff

Transportation

Marg Stevenson, Manager, Emergency/Dialysis/Stroke Strategy
Brent Dionne, RRT/Care, Manager, Respiratory Therapy/Cardiac Diagnostics
Lesley Brown, VP, Patient Services
Val Sinkins, ASM, CACC
Craig Marek, Central Ambulance Communication Centre
Lynn Mychalyshyn, Utilization Coordinator/Discharge Planner
Lynn Ronnebeck, Infection Control

External Partners

Randy Belair, Executive Director, Sunset Country Family Health Team
Colleen Snyder, Sunset Country Family Health Team
Marilyn Fortier, CCAC
Lisa Shaw, Dryden Private Nursing Com Care

APPENDIX B

Terms of Reference for Third Party Evaluation
Lake of the Woods District Hospital (LWDH)

Background:

Lake of the Woods District Hospital and the LHIN are required to enter into a Hospital Service Accountability Agreement (H-SAA) for the 2008 to 2010 period. The LHIN's agreement with the Ministry of Health and Long-Term Care (MOHLTC) stipulates that the LHIN must have a balanced budget provision in its agreements with public hospitals. The hospital did not submit a Hospital Annual Planning Submission (HAPS) that reflected a balanced operating position. The hospital and LHIN have been engaged in discussions with a view to find a mutually acceptable plan for the hospital to achieve a balanced operating position. The LHIN has extended the 2007/08 Hospital Accountability Agreement until the end of June in order to be able to continue to provide funding to the hospital in the absence of a signed H-SAA. As the hospital believes that it has done all that it can to achieve a balanced operating position, the hospital agreed that the LHIN would seek the opinion of an independent third party. An evaluation team will be led my Mr. Randy Penney, CEO of the Renfrew Victoria Hospital (RVH). Team members will include; Nancy Kelly, VP Patient Services at RVH, Paul Chatelain, VP Financial Services at RVH and Julia Boudreau, VP of Corporate Services at RVH.

Purpose:

To review and evaluate the hospital's assertion that it is unable to balance its budget and to produce a written report that will summarize the evaluation team's observations and conclusions. The report will outline next steps, including identifying options and strategies that could be implemented by the Board, CEO, hospital management and medical staff to assist the hospital to achieve a balanced operating position within the known planning assumptions. The evaluation process is a collaborative and supportive effort between the hospital and the evaluation team.

General Conditions of Evaluation:

1. The evaluation team will be on site at the LWDH on August 26 and 27, 2008.
2. It is expected that a final report will be available by October 15, 2008.
3. The report will be shared in its entirety with the NW LHIN.
4. The evaluation team will be reimbursed for expenses by the NW LHIN.

Hospital Role:

1. The hospital will identify an individual to be the single point of contact for the team lead.
2. The hospital will provide the team with access to Senior Management, Board members, Medical staff/Medical Advisory Committee, Unions and any other individuals/groups.
3. The hospital will provide physical space for the team and access to office equipment such as printers, phones, etc. as required.

4. The hospital will provide the team with any and all requested information including:
   a. HAPS submission.
   b. Hospital analysis documents.
   c. Detailed internal financial statements, including departmental reports, hours, variances and Board financial reports.
   d. Staffing model on nursing units and mix of professional staff.
   e. Workload/productivity reports for all departments including Nursing.
   f. Hospital foundation financial statements.
   g. Human Resources summaries including reports on sick time, overtime, NEER, grievances.
   h. All Board and Committee minutes for the past two years.
   i. The Medical Manpower Plan
   j. The hospital report prepared by Eric Sparks
   k. The most recent Accreditation report.
   l. Internal communications such as newsletters and any newspaper clippings pertinent to the hospital/financial issues.
   m. Any other pertinent information as requested.

LHIN Role:

1. The LHIN will identify an individual to be the single point of contact for the team lead.
2. The LHIN will provide the team with access to Senior Management, LHIN Board members and staff as requested.
3. The LHIN will provide the team with any pertinent documents as requested including HAPS analysis documents, HIT tool analysis, etc.

APPENDIX C

Talk it up Victoria

Renfrew Victoria Hospital | Your Community Healthcare Centre

Volume Seven, Number Two — July 2008

This issue of "Talk It Up Victoria" presents Renfrew Victoria Hospital from the perspective of some of our patients. We are proud of the quality care provided by the RVH team, as reflected in these stories. Thank you for the community support that continues to make this level of service possible for Renfrew and area!

Babies are welcomed at RVH

Bringing a new life into the world is an exciting time, and deciding where to deliver that tiny bundle of joy can sometimes be a tough task for new parents.

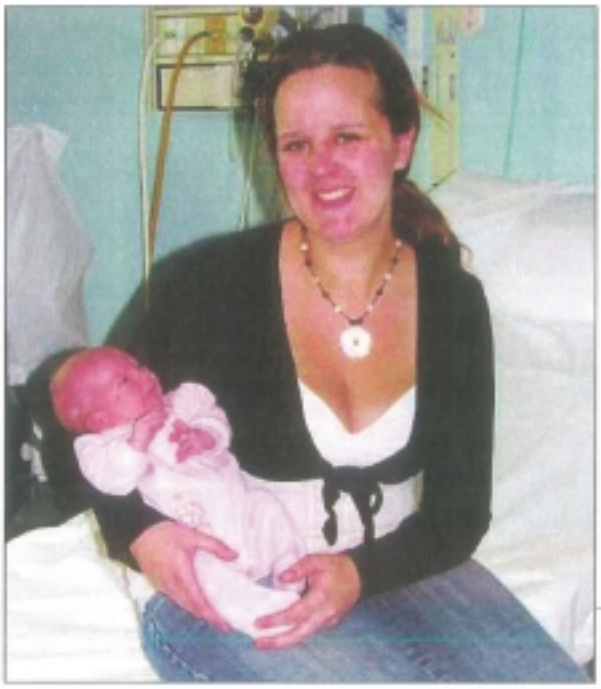
Luckily for area residents, Renfrew Victoria Hospital's obstetrics staff are prepared and thrilled to be the first ones to meet the newest citizens of the Valley.

On April 28, 2008 little Miley Davidson was added to the list of the many babies born at RVH.

A week and a half after her daughter's birth, Krista Davidson says she wouldn't have it any other way.

"I love it here," she proclaims during a return visit to the RVH cafeteria.

She's had three children in Renfrew, all delivered by Dr. Stephanie Langlois.



Miley Davidson takes a good look at the RVH obstetrics unit from the vantage point of her mom, Krista's arms.

"My biggest fear was going into labour somewhere else besides Renfrew," she says.

While it is a normal and natural process, having a baby is also an exhausting and painful experience, and Krista doesn't sugar-coat the 19 hours of labour she experienced.

"This time I was asking for drugs," she says, explaining that she used a nitrous oxide gas mask for her pain management, as RVH does not offer epidural pain relief.

Krista says the nurses were supportive and encouraging and helped her through the difficult labour to see a healthy 6 pound 5 ounce newborn make her entrance on the second floor of RVH.

And she also enjoyed the nurses in the unit offering to take the baby during the night to allow mom to get some quality rest.

Krista has a suggestion for other anxious moms-to-be who may be considering making a trip into the city to deliver, just to have that epidural as an option.

"I wouldn't even think of it. The nursing staff and doctors are so great here, I wouldn't go anywhere else."

The level of understanding and nurturing care shown by the nurses in the maternity ward is outstanding in Gemma Robillard's opinion too.

She has three children—a set of twins and "a singleton". Since multiples are considered high risk, she was not able to deliver at RVH for her first pregnancy.

"We rushed into the hospital in the city like we were supposed to do and were greeted by 'we have no room right now, hang on,' upon our arrival," she recalls.

When her third son was born at RVH last June, she was able to stay close to home and experience childbirth the way she had always thought it would be.

"It was so refreshing to have such warm, personable nurses there to help you. Everyone was beyond friendly," she says. "I was convinced by a friend to try it here, and I'm so grateful that I did. Trust me on this, I'd pick Renfrew again in heartbeat."

RVH GRAND ROUNDS

June 15 is World Elder Abuse Awareness Day and Judy Mayer of the Regional Assault Care Program at RVH is marking the designation by speaking to a variety of groups and church organizations about the hidden problem of elder abuse.

"We're talking directly to seniors themselves so they are aware and know what to do if they're in an abusive situation, and we're speaking to the community, because the more they know about it, the better," she explains.

Mayer is a patient care resource nurse and a member of the assault response team at RVH. She also chairs the Response Elder Abuse Prevention Awareness Coalition (REAPAC) of Renfrew County, a team of various service providers throughout Renfrew County who are working together to build awareness about the various forms of elder abuse. According to REAPAC, in Renfrew County it is estimated that between 600 to 1,500 seniors are experiencing or have experienced abuse or neglect in later life.

Mayer states that elder abuse is a crime that is generally not talked about or even reported to authorities. Victims are usually abused by someone they know—a friend, family member, neighbour or paid caregiver who causes some form of harm.

Mayer explains that there are different types of abuse: physical, emotional/psychological, financial, sexual and neglect.

She says that while most would think that physical abuse is predominant, "the most common form of abuse in general is financial and property management," adding that it's often a victim's own children taking advantage of money matters.

Seniors with disabilities such as mobility issues or sight loss are often at higher risk of abuse.

Older adults in families with a history of generational conflicts can be in an abusive situation and not even know it. "That's just been their life, and they don't know any different," Mayer explains.

Other risky situations involve those who are living with a spouse or child who is unable to sustain steady employment or those living with a substance abuser. Also, someone who has difficulty living with stress is "more likely to abuse an older person."

Preventing abuse starts with seniors being aware of their rights and the resources available in the community.

Much of the time people don't know where to go or what to do, but Mayer encourages anyone who needs the help to turn to the RVH response team.

"Here we have specialized registered nurses on call seven days a week, 24 hours a day," Mayer notes.

The assault care program also counsels family members and provides emotional support where needed.

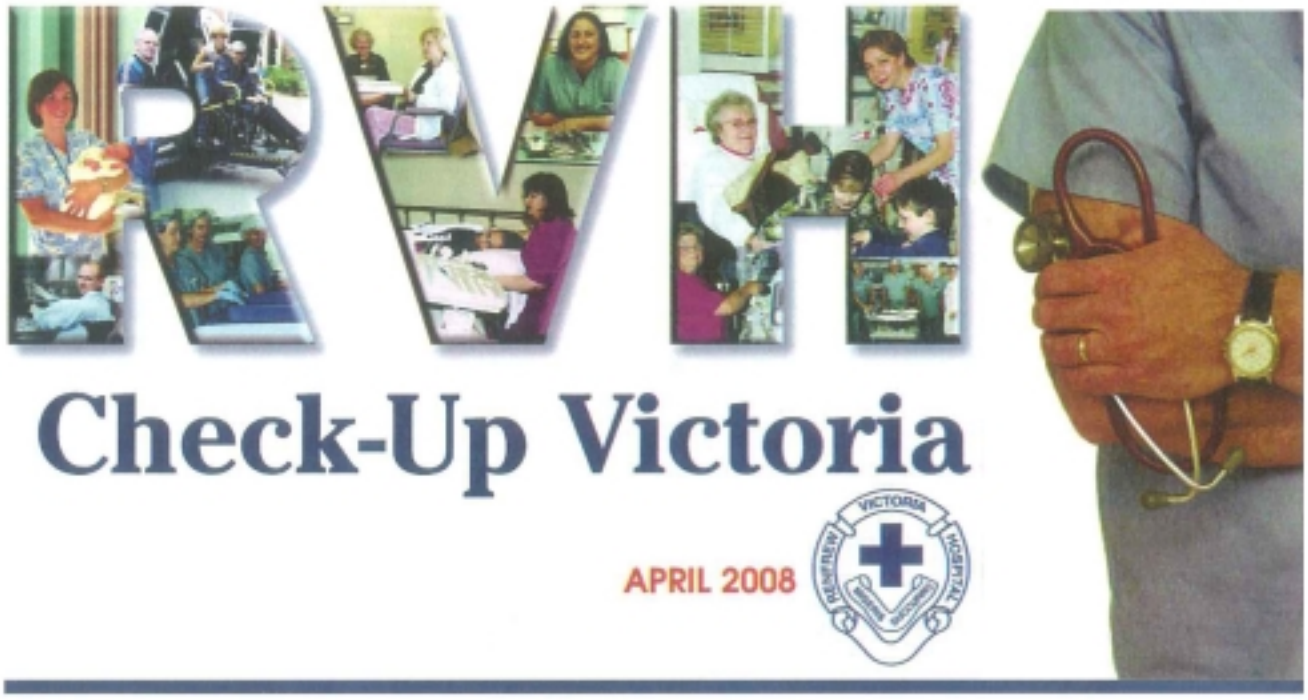
Confidentiality is assured.

Mayer herself can be reached at (613) 432-4851 ext. 224 during regular office hours. Round-the-clock response can be accessed by phoning 1-800-363-7222.

However, if there's a safety issue, Mayer advises to "go right ahead and call police. Dial 9-1-1."

Judy Mayer wants people to be aware of elder abuse and how RVH can respond.

APPENDIX E



Check-Up Victoria

APRIL 2008

Welcoming future RVHers

Not everyone in this photo is as actively involved as it would first appear. Kathryn Burwell on the left and Lynn Campbell on the right were actually at the Algonquin College Health Sciences Job Fair in Pembroke where this picture was taken. Gillian Carty and Jenny Briscoe are part of the poster display in the background.

Lynn reports that the event was well-attended by students who had lots of questions about job placements as part of their college requirements, as well as opportunities for jobs after they graduate. She and Kathryn spoke to 40 to 50 students in the registered nursing, registered practical nursing, and personal support worker programs at the college.

"We received resumes and answered lots of questions," says Lynn.

Interested in supporting the new CT or other ongoing services?

The RVH Foundation has introduced a new way to support our hospital.

A monthly donor program is now in place, offering the choice of post-dated cheques, automatic debit or credit card payments for those who prefer to spread their donations over the entire year.

Hospital staff can participate through regular payroll deductions.

The quality of care we provide, and the variety of services we offer, depend on the ongoing support of our community.

If you are interested in learning more about the new monthly donor options, or you know someone in our community who might choose this way to support our work, please contact Barb Desilets at extension 263 in the Foundation office.

APPENDIX F

RENFREW VICTORIA HOSPITAL
HÔPITAL VICTORIA DE RENFREW

499 RAGLAN STREET NORTH
RENFREW, ONTARIO K7V 1P6
TEL 613- 432-4851
FAX 613- 432-8649
www.renfrewhosp.com

March 6, 2006

Re: Request for Proposals to Provide Banking and Investment Services to the Renfrew Victoria Hospital.

Dear,

Attached you will find a Request for Proposals for banking and investment services for the Renfrew Victoria Hospital and the Renfrew Victoria Hospital Foundation. The incumbent institution is also being given the opportunity to submit a proposal.

Please inform Janet Jones by e-mail at jonesj@renfrewhosp.com of your intent to provide a quotation for these services by March 15, 2006. The deadline for the proposals is March 31, 2006.

If you require additional information please contact Janet Jones at (613)432-4782 ext 271.

Sincerely,

Janet Jones

Janet Jones, CA, MBA
Manager Financial Services

APPENDIX G

Name of Organization: Renfrew Victoria Hospital
Contact Person: Paul Chatelain
Position: Vice-President Finance
Address: 499 Raglan St. N.
City: Renfrew
Province: Ontario
Postal Code: K7V 1P6
Telephone: (613) 432-4851 x 272
Fax: (613) 433-5713
E-mail: chatelainp@renfrewhosp.com

Award we are applying for: Energy Efficiency

What did you do?
Renfrew Victoria Hospital is committed to providing high-quality care to its patients and community while offering a sustainable, healthy workplace. The hospital recently invested $1,041,000 to complete an Energy Efficiency Retrofit Project with Honeywell in support of this goal. For a small, community hospital, this was a significant undertaking.

The results have provided improved patient comfort through cutting-edge automation, improved air quality and improved lighting levels.

In addition, energy and water consumption was reduced through energy-efficient solutions designed to improve indoor air quality, reduce environmental emissions and lower utility costs.

This was coupled with a comprehensive energy awareness program developed for staff to allow them to become part of the energy efficiency solution at the hospital.

How did you do it?
A comprehensive energy efficiency project was implemented at the hospital with the objective of upgrading equipment to energy-efficient models, achieving permanent reductions in energy use resulting in utility cost savings and providing an increased level of comfort for the patients and staff.

The most unique aspect of the project was the installation of a solar wall heating system, a renewable energy alternative not typically seen in hospitals. The system provides solar pre-heated air for the new operating supply unit. Outside air is drawn through perforations in the dark, sun-warmed metal panel. A ventilation fan creates negative pressure in the wall cavity to draw air through the holes. The Solarwall heater looks like a conventional metal wall, but collection efficiency can exceed 70% at high air flow rates.

Energy-efficient lighting was installed to reduce energy consumption and provide better illumination. Upgrades included converting T-12 lamps to T-8 lamps and electronic ballasts, installing specular reflectors to redirect light and increase fixture efficiency,

APPENDIX H

News Release
(For immediate release)

Renfrew Victoria Hospital receives provincial environment award

Renfrew Victoria Hospital (RVH) has been recognized on a provincial and national level for its environmental leadership.

The local hospital received the Green Health Care Energy Efficiency Award at the Ontario Hospital Association's (OHA) annual conference in Toronto last week (November 6). The award is presented by the OHA in conjunction with the Canadian Coalition for Green Health Care to recognize leadership and excellence in reducing health care's environmental impact.

"This is a significant achievement for a small, rural hospital," comments RVH Chair Kent Tubman.

"As an organization, we have made a conscious decision to extend our commitment to quality health care into the broader realm of caring for our environment," he adds. "It is gratifying to be recognized by our peers across Ontario and Canada for the work that we're doing."

RVH Finance Chair Bill Welsh and CEO Randy Penney were on hand to accept the honour, which singles out the $1 million investment made by the hospital earlier this year to reduce its energy consumption.

"This was an investment that made sense in a number of ways," comments Welsh. "The hospital is realizing substantial ongoing savings in our energy bills, our staff and patients are enjoying the comfort of better lighting and air quality, and we were able to provide leadership in environmental stewardship."

The project included installing a solar wall that provides pre-heated fresh air to the operating room. More efficient plumbing and lighting fixtures were installed throughout the building, and new occupancy sensors and mechanical controls automatically adjust light levels, heating, ventilation and air-conditioning levels.

"It was a major project that affected every area of the hospital," says Penney, adding, "All of our staff and physicians share in this provincial honour for their commitment to making this work."

"Our board also deserves a great deal of the credit for providing outstanding leadership in this area, once again," he adds.

A letter from GE Canada, sponsor of the award, points out the significance of RVH's achievement.