Orillia Soldiers' Memorial Hospital

Clinical Services Plan

January 2015

Presented for OSMH Board Approval January 27, 2015

CSP Final Master Document

Table of Contents

Appendices

1. Executive Summary

High performing organizations focused on successful growth and future development are obligated to anticipate change and adapt in a timely manner to ensure long term viability.

Orillia Soldiers' Memorial Hospital (OSMH) has continually progressed through more than a century of health care evolution; from the humble beginnings of a 25-bed community hospital to the current structure providing a wide range of local and regional services to residents throughout North Simcoe, Muskoka and beyond.

OSMH will be a model of standardization, efficiency, and innovative partnerships

Recognizing the changing demographic landscape and looming financial pressures at the provincial level, OSMH has completed its most comprehensive and detailed clinical services planning exercise to date, in an effort to ensure the organization is suitably positioned to meet the acute care needs of the population it serves now and into the foreseeable future.

The genesis of this Clinical Services Plan (CSP) began more than two years ago with a thorough review of the latest program data that resulted in the creation of *Framing Future Choices*, a guidance document to inform the work that helped create this plan. The CSP is the result of multiple phases that involved stakeholders from many parts of the organization. The CSP will be a living document, and can be updated as necessary in response to imperatives faced by the hospital and the system.

There are formidable challenges to address, primarily those created by the projected spike in the senior population which, without appropriate systemic and local change, has the potential to compromise the hospital's ability to respond effectively. The anticipated growth in service demand is further complicated by the financial position of the province and the need to curb the growth of health care spending.

The province has already begun implementing changes to address these challenges. Flat-lining increases to hospital revenue while directing more money into less expensive community providers aligns directly with the strategy to move services out of hospital that don't need to be there. Even more impactful to hospitals though are the changes being implemented in the way hospitals are funded. The slice of global funding, that gave hospitals greater freedom in how dollars are spent, is getting continually smaller as the province opts for more specific funding methodologies that ties revenue directly to quality and volume.

Rapid change is the clear expectation being placed on all hospitals, especially with leverage created by the return to a majority government in the 2014 Ontario election.

OSMH strongly values and actively participates in the work of the North Simcoe Muskoka LHIN through the development of its Care Connections – Second Curve initiative, with an eye to aligning our services with our hospital and healthcare partners throughout the region. OSMH is also a strong supporter of Health Links and we look forward to working in support of this initiative along with other pending changes that will create opportunities for hospitals.

Among identified strengths, OSMH provides an array of core hospital services such as emergency care essential to serve our local community. As outlined in the pages to follow, the CSP has identified three key areas of clinical focus for OSMH which will include; acute care for complex conditions, women and children's health, and mental health.

These services will be fully supported by the necessary diagnostic, allied health and surgical care to facilitate positive outcomes and optimal transitions back home or into other more appropriate health care settings.

We will consider expansion of services when need is identified and funding is available, and we will continue to work closely to establish partnerships with other hospitals.

OSMH will be a model of standardization, efficiency, and innovative partnerships in clinical and non-clinical aspects of community hospital care.

Key to our success will be building on our own strengths in existing programs, continuing to develop our strong links to primary care, and nurturing the high levels of engagement by physicians and staff at every level of the organization.

The CSP is a guidance document that will be instrumental in future strategic, operational and capital planning, specifically as we work to define both the core and regional services that OSMH must focus on to meet our vision of A Healthier Future.

2. Objectives

The objectives of OSMH's Clinical Service Plan are intended to:

- Articulate organizational priorities that will focus resource priorities
- Align with the North Simcoe Muskoka Local Health Integration Network (NSM LHIN) Vision for "One System" and NSM LHIN Second Curve Priorities
- Delineate OSMH Programs and Services as closely as possible to the NSM LHIN Desired Future State levels of care, specifically:
    - **Local (Core) Services**. The NSM LHIN defines this as the spectrum care that is likely to be provided in all sub-LHIN planning areas, for example primary care. At OSMH we have previously used the term "Core" to describe most of the services we provide at this level.

    - **Regional Specialized Services**. The NSM LHIN recognizes this level of care as likely being provided at only a few sites in the LHIN, for example orthopedic surgery. Many of the services we currently provide are at this level.

    - **Provincial Specialty Services**. The NSM LHIN identifies a level of care that most patients will access outside our LHIN in tertiary centres, for example organ transplant. Very few, if any of the services we currently provide are in this category.

3. The Planning Environment

Orillia Soldier's Memorial Hospital is impacted by significant change underway in the Ontario healthcare environment and in the demographics of the patients served by hospital programs. The planning environment has changed significantly over the time of this project (2012-2014).

The province has significant healthcare challenges and some policy significant responses are emerging that include:

- The service delivery system was never designed and was originally oriented to acute episodes of care when the realities of today are confronting growing patient needs that are more chronic and ongoing.

- Financially, the province has an inability to sustain the historical average 7% growth rate in healthcare spending. They have addressed this by capping expenditures at 2% growth – 0% to hospitals and up to 5% in community. They have also introduced patient-based funding for hospitals which is made up of the Health Based Allocation Model (HBAM), Quality Based Procedures (QBP), and global funding. The changes in funding approaches have consequences and risks and significant new data reporting requirements.

- There is inequitable access to care as seen in wait times, timeliness of access, and availability of services. There is also significant variation in care approaches and resources utilized in providing care. There are patients that are in the wrong level of care – for example Alternative Level of Care (ALC) patients. The province has introduced legislation focused on improving quality (Excellent Care for All Act) and supporting the legislation with the development of Health Quality Ontario.

- The system struggles to measure the things that matter most – outcomes of care and measuring the full episode of care.

- Outcomes are impacted by providers from more than one organization and by the patients themselves. The province has recognized the need for locally informed change management and policy implementation and has created Local Health Integration Networks (LHINs) to support the change process. They are also establishing Health Links to address the challenges faced by the highest system users. We understand that there is no change contemplated to the labour legislation that impacts on program transfer discussions – specifically the Public Sector Labour Relations Transition Act 1997.

After four years (2010-2014) of minority rule, the province has returned to a majority government. The Liberal government has announced a strategy to guide the next four years through a stated intent for 'Ontario to provide the best health-care in the world'. The key strategies are:

- Putting patients at the centre - Right care at the right time in the right place

  This strategy can be accomplished by;

  - Ensuring coordinated, and timely access to care
  - Improving quality and outcomes through evidence-based decisions
  - Expanding home and community care
  - Strengthening primary care as well as dementia and end of life care
  - Investing wisely in hospital capital and community infrastructure
  - Improving referrals to specialists
  - Pursuing affordable drugs

- Moving forward on Accountability and Transparency

  This strategy can be accomplished by;

  - Driving accountability, transparency and quality while limiting expenditure growth through funding methods
  - Exploring laboratory improvements
  - Establishing the patient ombudsman
  - Improving air ambulance service trust
  - Pursuing more coordinated and efficient care
  - Strengthening the community sector results,

- Concluding OMA negotiations
- Accelerating the adoption of new technologies to support goals

- Collaborating on shared responsibilities across government -

  This strategy can be accomplished by;

  - Focusing on Seniors, Aboriginal health, Mental Health and Addictions Phase 2 Strategy
  - Working on poverty reduction
  - Developing community hubs to focus on health and wellness
  - Encouraging healthy living

  The immediate priorities (2014/15) include;

  - Redesigning home and community care
  - Improving integrated and coordinated patient-centred care
  - Implementing funding reform and quality improvement
  - Increasing health and wellness
  - Protecting vulnerable populations

Primary care as the foundation of the system

Attuned to the care needs of the community

The Local Health Integration Networks are viewed as key enablers for the strategy. In North Simcoe Muskoka, the NSM LHIN has been involved in a significant planning exercise to support reaching system goals. The vision for the NSM LHIN is Healthy People, Excellent Care, One System.

Care Connections Second Curve has developed a North Simcoe Muskoka Service Delivery Model that is intended to define how health service providers will move toward a single well defined system of care that delivers regional and local services and connects with provincial resources for services not offered within the NSM LHIN.

The NSM LHIN service model sees Primary Care as the foundation of the system with consistent evidence-based clinical pathways and system approaches. The new system design will be supported by incentives and disincentives to drive performance.

It is OSMH's mission 'To be a trusted provider and leader of community hospital and designated regional specialized services'. OSMH has a long history of being attuned to the care needs of the community and working in partnership with primary care to address patient needs. This partnership and collaborative approach must be expanded to include the broader health system and related care sectors.

This can be accomplished through:

a. Extensive involvement outside of the organization to influence system decisions and system development (e.g. HealthLinks)

b. Collaborative approaches/voluntary integrations to gain scale and increase quality including consideration of strategic procurement and shared services organizations

c. Leveraged acute care resources including information system resources

4. Overview of Clinical Services Planning Process

As the initial step in creating a Clinical Services Plan, OSMH contracted The Hay Group to complete a review and create a directional guidance document to ensure OSMH would provide the clinical services needed to achieve its mission, vision, and values.

This document was entitled *Framing Future Choices*. The review was conducted through a review of evidence plus stakeholder consultation. Consideration was given to existing programs and services at OSMH and within the region, strengths and areas of clinical excellence at OSMH, provincial and regional priorities, gaps or opportunities in local community-based care, evolving community needs and the potential for financial sustainability.

The document described the recommended next steps and provided a framework for the remaining work to be completed. The tabling of this document in February 2013 concluded the work done in partnership with The Hay Group.

The implementation of the clinical services planning initiative as outlined in *Framing Future Choices* commenced in June 2013. The main areas of focus were derived from the framework provided in *Framing Future Choices* and included the review of regional services, the development of a tool to use in the review, implementation and tracking of mitigation strategies and a review of funding for identified quality based programs (QBPs).

The Clinical Services Planning Oversight Committee was struck in October 2013 and continues to meet monthly to review progress on each of these dimensions and provide advice and approvals as required. The work on mitigation strategies and funding continues. The review of services initially focused on an assessment of the current state and then transitioned to an assessment of services for the future state and which now frames the OSMH Clinical Services Plan.

5. Results & Recommendations from Clinical Services Planning process

5.1 Phase 1- *Framing Future Choices* (2012)

Orillia Soldiers' Memorial Hospital (OSMH) developed the *Framing Future Choices* document (2012), as a directional guidance document to be used in strategic and operational planning of the delivery of clinical services by the hospital. Framing future choices examined the current programs of OSMH, explored the projected changes in demographics and the implications for the programs, the changes in program delivery that would mitigate the challenge of growth in demand and considered some of the significant challenges with facility accommodation. Key next steps were articulated particularly related to resource utilization. Further delineation of the future role/programs of the hospital were one of the outstanding recommendations.

Dramatic growth in the number of elderly people

Analyses of demographic factors and population projections indicate that the populations that we serve will both grow and age over the next 20 years. As a result of both, but particularly because of the dramatic growth in the number of elderly people within the communities that we serve, there will be significant growth in the need and demand for our services over this period.

Funding for hospital services will not allow OSMH or any other local hospital to provide all of the acute care services that communities will need in the future. It will also be necessary to re-examine and change how we deliver services. It is anticipated that decisions about what services OSMH will start, stop, maintain, expand, integrate or transition will have to be made.

OSMH has already begun the task. Implementing new processes and streamlining existing ones to improve our efficiency using LEAN strategies to identify and eliminate waste is used routinely at the hospital. We are making changes to ensure that we are maximizing the scope of practice of our health care professionals. These are efforts we need to continue to focus on.

In order to chart the best course for the future, there are a number of priorities that we cannot compromise on when making our decisions.

First, above all else, it is a priority that care provided at OSMH support our mission of being "a trusted provider and leader of community hospital and designated regional specialized services". The hospital must understand what services are critically required to deliver on this mission. In addition to outlining core community hospital services, OSMH must also confirm and validate which of its clinical services are recognized as regional specialized services. Enhancements to clinical services, or the addition of new clinical services, should not be made at the expense of existing clinical services that are central to the achievement of the hospital's mission.

Second, OSMH must be fiscally responsible. We are required to operate with a balanced budget; therefore we should not plan to provide services that we cannot afford. We will first need to secure additional funding before we initiate any enhancements or expansions to our current scope of services.

Fiscally responsible and use our available resources to provide acute care

Third, we have a responsibility to use our available resources to provide acute care services. We must do the best with what we have, work as efficiently and effectively as possible, and ensure that we are investing in those services that are best provided by an acute care hospital.

Finally, while we believe our primary responsibility is to offer clinical services that are aligned with our mission, we acknowledge that we may also need to demonstrate leadership in finding new ways of doing things that are less hospital centered.

OSMH has previously identified the following services as core community hospital services: Emergency, Level 1 Intensive Care Unit (ICU), General medicine, General surgery, Anaesthesia, General paediatrics, Low risk obstetrics, Crisis mental health, Diagnostic/therapeutic/support services required for delivery of core services.

This report also recommends that OSMH develop a clinical service evaluation and prioritization tool in order to guide future decisions. It should develop this tool based on criteria such as: health needs of our population, sustainability, availability elsewhere, quality and safety of the service, implications of not providing the service such as interdependencies.

More analysis and explanation of this phase is provided in the body of Framing Future Choices (refer to Appendix 3)

5.2 Status Update on Identified Mitigation Strategies

In all of our cost centers, OSMH continues to target achievement of the 25th percentile in comparison to our benchmark hospitals across Ontario, and we continue to experience success in many areas. We will continue to use performance based funding into the future. There has been significant achievement in addressing the identified mitigation strategies in Framing Future Choices, made possible through the strong commitment of clinical and administrative staff. The commitment is continued and being closely monitored by through the Hospital's Utilization Committee. See Mitigation Scorecard in Appendix 65.

5.3 Phase 2- Program Current State Assessment

The review of regional services as described in *Framing Future Choices* became more commonly referred to as the current state assessment. Four teams of program directors and program medical directors were established to complete reviews on a mix of services. The assessment tool utilized fourteen weighted factors which assessed the alignment of the scope of services (service strength) against the assessed needs (sustainability). These factors are more fully described in Appendix 3, Tables 3 and 4. Each service was reviewed and given preliminary ratings by staff in Decision Support and Finance on seven of the fourteen factors. The services were then reviewed by the service manager and the clinical chief or physician delegate who provided additional information relevant to each of the fourteen factors.

Using all of the information provided through these sources, each service was then assessed and assigned ratings by the teams of program directors and medical program directors. These four teams then presented their ratings and evidence of justification to all of the assessors with additional representation from Decision Support, Finance and Senior Management who collectively established the final rating for each factor for every service.

The results were plotted on a matrix of sustainability and service strength and provided a relative assessment of all services (see Appendix 6, Current State Assessment Briefing Note).

The results of the current state assessment demonstrated that our services are clustered rather than distributed, even though their individual strengths and limitations vary. It's in the review of the assessment of individual factors that leaders can develop an understanding of whether or not the limitations can or should be mitigated and where opportunities exist for future growth and investment.

The recommendations from the current state assessment are described in Appendix 6 . It was proposed and accepted that the clinical services prioritization/decision making tool be used by each program and service leadership team to analyze and recommend what would be needed to strengthen their programs and services and that the analyses be presented to the Clinical Services Planning Oversight Committee. The assignment of this work launched the future state assessment which resulted in the development of the proposed strategic clinical choices for OSMH described in the next section.

5.4 Phase 3 – Clinical Service Profile

OSMH ORGANIZATIONAL PRIORITIES

OSMH will sustain its Mission "to be a trusted provider and leader of community hospital and designated regional specialized services". The following priorities will inform decision making and resource allocation:

Health Care Professions Education and Training

Standardization Efficiency Innovative Partnerships

Enhanced Primary Care Capacity

Strong Regional Leadership

Advanced technology Interprofessional teams Purpose built facilities

Optimize care transitions into the community

1. OSMH will <u>build upon its current strengths</u> locally and as a regional leader in the health system of the future. This includes
   - enhanced primary care capacity as demonstrated by the strong presence of family physicians in hospital activity, and the relationship with the Family Health Team and Health Links.
   - strong regional leadership in Kidney Care and related services such as Diabetes Care
   - outstanding care and service for women and children in a regional model of excellence in Obstetrics Gynecology and Paediatrics
   - focus on the needs of vulnerable populations in our community
   - Senior Friendly Care
   - Schedule 1 Mental Health and related services
   - Efficient high quality surgical services in regional collaborative models
2. The hospital of the future will focus on intensive episodes of inpatient and outpatient care that require advanced technology and expert interprofessional teams to be in "purpose built" facilities at the same time with the patient for interventions that address patients' specific circumstances. At OSMH this includes acute medical, surgical and mental health conditions for the patients we serve.
3. Anesthesia, intensive care (adult and neonatal), diagnostics, allied health supports and rehab services will be maintained and enhanced in ways that facilitate flow and outcomes for acute medical, mental health and surgical care, and to optimize continuity of care into the community.
4. Patient conditions that span more than a few days or weeks will be managed by collaborating with primary care, specialists and other community partners in models that are not hospital centric. OSMH will not be a place where people reside for weeks or months in the chronic phase of their condition.
5. Expansion of services will occur when funding drivers align with the needs of the populations we serve and our organizational priorities. Partnerships with other hospitals to create regionalized services with one program at multiple sites and with common wait list management will be the norm. OSMH will not be a site for complex tertiary medical and surgical services.
6. OSMH will continue to provide education and training experiences for health care learners.
7. OSMH will be a model of standardization, efficiency, and innovative partnerships in clinical and non-clinical aspects of community hospital care.

OSMH CLINICAL SERVICES PROFILE

OSMH AREAS OF CLINICAL FOCUS

The Clinical Areas of Focus emerged during the strategic consensus day and the strategic choices planning day. Refer to the Current State Assessment on page 36 and 37 to see the relative attractiveness, sustainability and unit strength of the areas of focus. The areas of focus are aligned to OSMH current strengths and leadership, as well as the MOHLTC provincial directions and LHIN priorities.

Acute Care for Complex Conditions

This includes medical, surgical, diagnostic and therapeutic interventions and will accommodate the need for increased access to hospital care for seniors as well as serving the acute needs of patients presenting to Emergency, and others that we serve.

Women and Children's Health

This includes a regional role for Level 2 Obstetrics, women's urogenital health, specialty Paediatrics and Level 2 Neonatal Intensive Care.

Mental Health

This includes Schedule 1 psychiatric care. This does not include the Tertiary and Forensic Mental Health Care provided by Waypoint.

How to Read the OSMH Clinical Services Profile table:

Our planned program and service profile is described below using the categories Local, Regional Specialized, and Provincial Specialty as described in the NSM LHIN Future State Second Curve Planning framework.
In the table below, OSMH current clinical services are itemized in the left hand column. In the middle column, potential enhancements for hospital services are listed. In the right column, ideas for new models of care, or to share or transfer activity to community based and partnership models are listed.

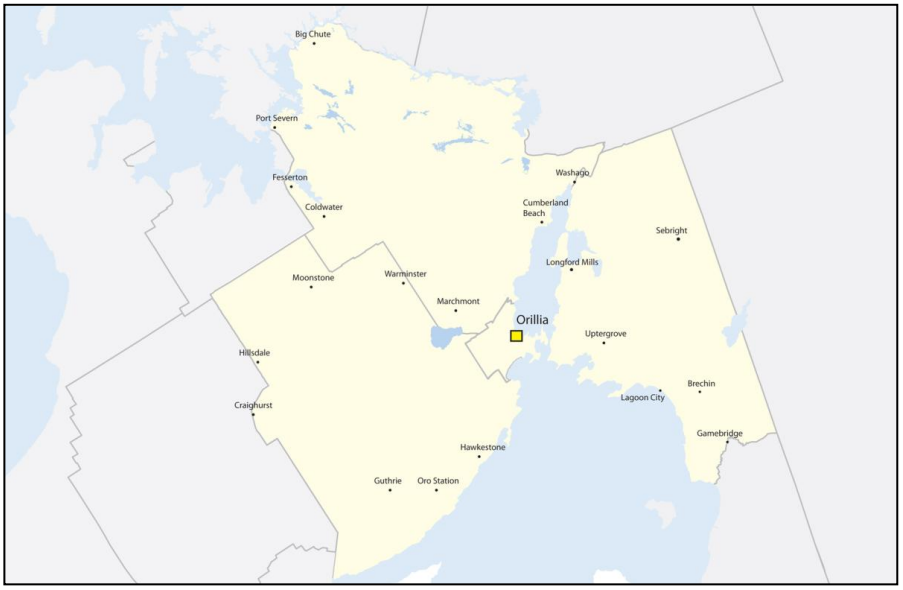
Those services and programs identified by *italics* in the left column of the table below, may not match the organization priorities as outlined above, and in the future, patients requiring these services might be served in new models of care.

All potential service enhancements, increased community capacity and new models of care are conceptual, and have been derived from many sources, references[App 8] and dialogue throughout the CSP planning process.

LOCAL (CORE) HOSPITAL SERVICES

OSMH provides a wide array of local services that are considered core to the function of a local health system. Some of our local services may not align with the organizational priorities above.

A larger version of the map to the right appears in Appendix 9 (Local and Regional service area Maps) of this document.



CURRENT LOCAL SERVICES	POTENTIAL HOSPITAL SERVICE ENHANCEMENTS	POTENTIAL FOR ENHANCED COMMUNITY CAPACITY OR PARTNERSHIPS
Ambulatory Clinics (Outpatient Department) *Adult Diabetes Education Clinic (Local and regional)* *Anesthesia Procedural Clinic (nerve blocks)* *Cardio-Pulmonary Diagnostics* *ENT (procedures)* *Family Practice (procedures)* *Fracture Clinic (follow ups)* *General Surgery (procedures)* *Gynecology (colposcopy, LEEP, other procedures)* *Internal Medicine (bone marrow bx, paracentesis, thoracentesis)* *Oncology Satellite Clinic* *Ophthalmology (laser, injections)* *Plastics (procedures)* *Transfusion Clinic (blood products, phlebotomy)* *Urology (catheter changes, vasectomies)*	Ongoing analysis and evaluation for appropriate utilization and scope of activity.	Hospital/Physician/Private Partnerships that combine offices and clinics for interprofessional care of **patient conditions**
Anesthesia	Respond to changes in Birthing, Surgical and other programs	
Level 1 (Low Risk) Birthing Family Medicine Midwifery	Full scope of Family Medicine Obstetrics & Midwifery Practice	

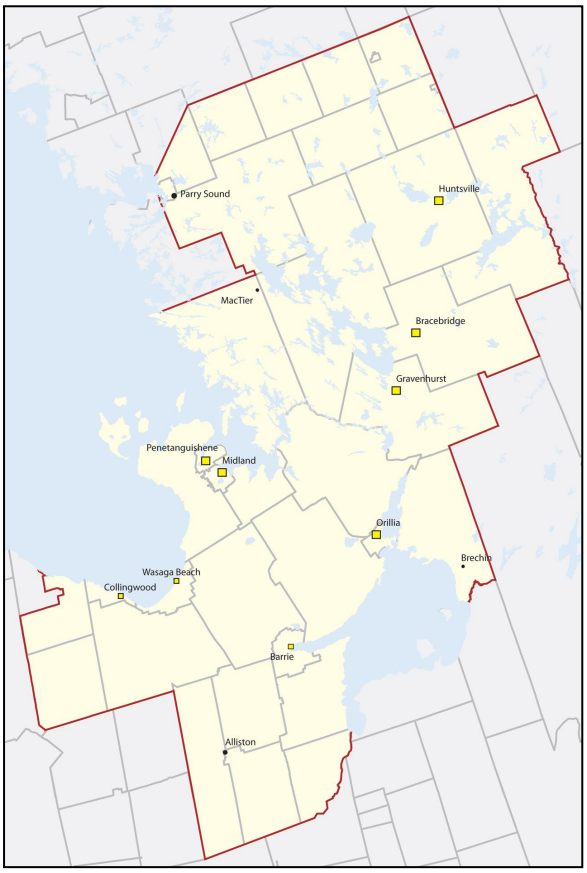
CURRENT LOCAL SERVICES	POTENTIAL HOSPITAL SERVICE ENHANCEMENTS	POTENTIAL FOR ENHANCED COMMUNITY CAPACITY OR PARTNERSHIPS
Corporate Support Services Administration, Bed Allocation, Chaplaincy, Pastoral & Spiritual Care, Clinical Nutrition, Communications, Community Relations, Decision Support, Dietary Food Services, Discharge Planners, Evening Coordinators, Facilities (Biomed, Housekeeping, Maintenance, Security, Finance, Foundation, Health Records, Human Resources, Infection Control, Information Technology, Library, Materials Management, Medical Affairs, Occ Health & Safety, Patient Navigators, Patient Registration, Performance Excellence, Pharmacy, Social Work, SPD, Staffing Office, Stores, Telemedicine, Utilization, Volunteers	Corporate Support Services need to be taken into account with any change in Clinical Services, and are listed in this plan for completeness and as a reminder of the many key corporate functions that are critical for patient care programs. Data quality enhancement with enhanced Decision Support for clinical and administrative data. Ethics program is underdeveloped for the complexity of activity we anticipate in the future. Organizational Development is not a program at OSMH and will become more of a need.	Combined corporate support functions with other organizations. Shared resources such as ethicist, Organizational Development and others for the NSM LHIN or for multiple organizations
Critical Care • See Regional Role below	Continue Level 3 closed unit staffed with intensivists 24x7	
Diagnostics & Therapeutics Local: Xray, Ultrasound, Bone Mineral Density CT Scan Echocardiography Mammography • **See Regional Role below**	Expand to meet needs of clinical programs and areas of focus, within available resources	
Family Medicine Emergency General Medical Care Palliative Care	Medicine Rapid Assessment & Consultation Unit Enhanced Family Medicine MRP Model	Student Health Services at Post Secondary Institutions Enhanced Primary Care in Long Term Care & Retirement Homes Residential Hospice
General Internal Medicine *****Medical subspecialties provide regional access, see below.		

CURRENT LOCAL SERVICES	POTENTIAL HOSPITAL SERVICE ENHANCEMENTS	POTENTIAL FOR ENHANCED COMMUNITY CAPACITY OR PARTNERSHIPS
General Surgery	Maintain current service focused on community need Post surgical home follow up	Endoscopy Services out of hospital
General Paediatrics* *Many Paeds services are Regional Specialized, below	Maintain current service focused on community need	
Lab & Pathology	Expand to meet needs of clinical programs and areas	
Mental Health Crisis Care* *Many other MH services are Regional Specialized, below	Maintain current service focused on community need	
Rehabilitation *Cardiac Outpatient* Musculoskeletal Inpt/*Outpt* *Pulmonary Outpatient* Rehab Day Hospital Speech & Language Stroke Inpt/*Outpt*	Functional Restoration and Education Focus- cross organizational focus on "up and out", independence, self-management skills, "back to life" philosophy. Align with Rehab Alliance Full implementation of Senior Friendly Hospital Initiatives Weekend/holiday CCAC,PT,OT,SLP	"Live Well" partnerships with municipal recreation facilities, community centres, pools & tracks for comprehensive pre and post-acute episode conditioning and recovery for all chronic conditions, including peer teaching and support groups linked to clinical resources. Housing alternatives for complex needs

REGIONAL SPECIALIZED SERVICES

OSMH provides many Regional Specialized services which serve the broader catchment areas north, east and west of Orillia. **Those identified by *italics* in the left column of the table below, may not match the organizational priorities as outlined above, and in the future, patients requiring these services might be served in new models of care.**
Any change in services currently provided by the hospital would require careful analysis using the OSMH Clinical Services Evaluation Matrix and guidelines such as the Ontario Hospital Association Framework for Redistribution of Services[Ref 11 App8]

A larger version of the map to the right appears in Appendix 9 (Local and Regional service area Maps) of this document.



CURRENT REGIONAL SPECIALIZED SERVICES	POTENTIAL ENHANCEMENTS	POTENTIAL NEW MODELS OF CARE
Anesthesia *Procedure Clinic*		Some pain relief procedures can be done in outpatient ambulatory settings outside hospitals. (Pain Clinics)
Level 2 Birthing Obstetrics	Maternal-fetal medicine partnership with tertiary centre	
Complex Continuing Care Inpatient	Convert some CCC beds to Acute	Housing alternatives for complex needs
Critical Care Level 3		Enhanced response to smaller NSM LHIN hospitals in regional model with other Level 3 ICUs
Diagnostics & Therapeutics MRI Nuclear Medicine Ontario Breast Screening Program (OBSP)	Enhanced Cardiac Diagnostics in partnership with a Regional Cardiac Centre Interventional Radiology Enhanced Vascular Access	
Medicine *Adult Diabetes Education* *Bronchoscopy/Endoscopy* Gastroenterology General Internal Medicine Geriatrics • Geriatric Day Hospital • *Integrated Regional Falls Prevention Program (IRFP)* Nephrology • Chronic Kidney Disease Clinic • Dialysis (inpt, outpt, home) Respirology *Sleep Medicine*	Acute Care of the Elderly (ACE) Inpatient Unit Complex Medical/Mental Health Inpatient Unit Expanded volunteer supports to elderly patients Expanded role for Regional Kidney Care satellites Stroke Care Program • Neurologist	More advanced Community DEC Enhanced Geriatric Outpatient Services Hospital/Physician/Private Partnerships that combine offices and clinics for interprofessional care of patient conditions (eg. Better Breathing Program, Falls Assessment, Dizzy Clinic, Gut Clinic, Headache Clinic, Nephrology Clinic, Sleep Clinic) Home sleep studies More Telehomecare
Mental Health Adult Psychiatry *Community Mental Health Service* *"Meeting Place"* Sexual Assault Domestic Violence Treatment Clinic Schedule 1 Inpatient Care &	Child and Adolescent MH– Partner or satellite with RVRHC program Add physicians with Addiction Medicine training to Credentialed Staff	Addiction Medicine Focused GP at Family Health Team LGBT Trans Medicine Clinic Complex Medical/Psychiatric Inpatient Care Unit

CURRENT REGIONAL SPECIALIZED SERVICES	POTENTIAL ENHANCEMENTS	POTENTIAL NEW MODELS OF CARE
Outpt Clinics to support Sched 1		
Neonatal & Paediatrics Inpatient specialized paediatric care ***Outpatient Programs***: *Asthma Clinic* *Breastfeeding Clinic* *Childhood Obesity Clinic* *Children's Therapies (Botox, Feeding Problems, PT, OT, Orthotics)* *Complex Children Navigation Program* *Genetics* *Neonatal Follow up* *Orthotics* *Paed Diabetes Clinic* Paed Oncology Clinic POGO	Complex Medical/Mental Health Paediatric eg. Eating Disorders Add Behavioural, Mental Health in regional model	Hospital/Physician/Private Partnerships that combine offices and clinics for interprofessional care of patient conditions
Surgical Services *Bronchoscopy/Endoscopy* *Dental* Gynecology • Outreach to GBGH *Ophthalmology* • *Cataract Surgery* • *Laser Clinic* • *Other eye surgery* Orthopedic • Fracture Clinic • Joint replacement • Trauma (long bones) Otolaryngology (ENT) • Outreach to MAHC Plastics • Hand trauma • Wound Care *Thoracic (outpt assessment and follow up clinic - outreach from Southlake – Dr. Toth)* Urology • Outreach to GBGH *Vascular (outreach from RVRHC)*	Support for implementation of QBPs Cancer Diagnostic Assessment Program (DAP) 3rd Orthopedic Surgeon if WTIS and QBP funding supports Foot & Ankle focus Permanent recruitment of 2nd Plastic Surgeon to join Regional model Focus on vascular access for renal patients Kidney Stone Clinic	Women's Uro-Genital Health Clinic Move dental out of hospital Single site Vision Care Program for NSM NSM LHIN Nurse led ROP exams (retinopathy of prematurity) Multi-site single surgical programs Osteoporosis Collaborative Hospital/Physician/Private Partnerships that combine offices and clinics for interprofessional care of **patient conditions** FHT Wound Care service by plastic surgeon

PROVINCIAL SPECIALTY SERVICES

OSMH is not positioning itself to be in the business of Provincial Specialty Services. Access to this level of service for people in the catchment area of OSMH will require us to provide pre and post intervention investigations, care, and follow up. We will need strong partnerships with tertiary care centres that can provide these services. Our role is to refer and repatriate appropriately.

MEDICAL SUB-SPECIALTY CARE	
Advanced Cancer Care Advanced Cardiac Care Allergy & Immunology Infectious Disease	
SURGICAL SUB-SPECIALTY CARE	
Bariatric Head & Neck (complex) Cardiac Colo-Rectal (complex) Craniofacial/Maxillofacial Gynecologic Oncology Hepatobiliary	Neurosurgery Oral Surgery Paediatric Thoracic Transplant Urology (complex) Vascular
TERTIARY MENTAL HEALTH SERVICES	

6. Funding Model Considerations

The new hospital funding approach used by the Ministry of Health and Long-Term Care provides funding to support hospital programs in five ways, although it should be noted that these methods do not currently apply to *all* hospital revenue. Definitions of the five methodologies are listed in footnotes. These funding approaches apply to different programs and expose the hospital/programs to different challenges and risks.

Percentage of funding received by OSMH	Funding methods	Programs/Services
23.6%	**Health Based Allocation Model (HBAM)**[1] • Difficult to predict year by year impact due to the nature of the formula as a comparative, sharing approach • Essential that the cost/weighted case is efficient relative to peers • HBAM comparison applies to all services (including Quality Based Procedures, *see QBP below*) therefore if overall hospital cost/case is inefficient, this will negatively impact QBPs, even where costs are in line.	• All hospital clinical services that generate weighted cases*. ** A weighted case is a case with an assigned Resource Intensity Weight (RIW). The RIW measures the intensity of resources used (based on patient diagnosis, surgical procedure performed, etc.) as well as the case mix group assigned to the individual patient.* *Cost per Weighted Case is an indicator that measures the cost associated with caring for a standard acute patient. Direct costs reflect expenses incurred in the departments providing service to the patient. Indirect costs are an allocation of administration and support expenses such as housekeeping and health records.*

[1] **Health Based Allocation Model**–"pie sharing" formula used to allocate about 40% of the provincial hospital sector budget based on the relationship of a hospital's actual rates and volumes and expected rates and expected volumes relative to other hospitals in Ontario. Excludes Quality –Based Procedure Activity and Funding. (approximately25.3% of 14/15 forecast MoH revenue)

22.0%	**Quality Based Procedures (QBP)**[2] • Cost/episode is likely to continue to tighten, making it essential for hospitals to seek on-going improvements in processes and supply management • Hospitals will likely soon be required to report on quality indicators relating to QBPs, with potential for funding adjustment for quality metrics that are not achieving standard • QBPs may continue to increase in number and therefore the proportion of budget perhaps crowding out services that continue to be funded out of global budget.	• Total hip and knee replacement • Cataract surgery • Hip Fracture • Chronic Obstructive Pulmonary Disease • Congestive Heart Failure • Stroke (Ischemic/Hemorrhagic) • Tonsillectomy • Hyperbilirubinemia • Chemotherapy • Chronic Kidney Disease • Endoscopy
2.9%	**Specialized funding**[3] • Programs are expected to be fully funded within the envelope provided • Specialized reporting is often required	• Genetics • Breast screening • Integrated Regional Falls Program • Community Mental Health Services • Diabetes Education Program
5.9%	**One time performance based funding**[4]	• Wait-Time funding

[2] **Quality Based Procedures("QBP") –**funding provided for an approved volume of specified procedures linked to a specific episode of care. In the case of chronic kidney disease QBP funding is to services associated with a bundled payment for the annual costs of delivering services to an individual patient.(approximately 22.0% of 14/15 forecast MoH revenue)

[3] **Specialized funding**- Specifically funded programs and services are funded based on a prescribed budget, funds not spend in the prescribed manner outlined in the pre-approved budget will be recovered.(approximately 2.9% of 14/15 forecast MoH revenue)

[4] **One-time performance based funding –**results based funding set annually to reduce wait-times for diagnostic services (CT/MRI) and for services delivered in the Emergency Department.(approximately5.9% of 14/15 forecast MoH revenue)

		• Pay for Results funding
38.9%	**Global budget**[5] • Decreasing proportion of hospital budget even though it supports critical hospital functions	• Emergency • Birthing • Critical Care • Laboratory • All support services • Mental Health • Medicine • Surgical • Paediatric • Inpatient when not funded as QBP • Clinics and Rehabilitation when not funded as part of a QBP

[5] **Global Budget** – envelope funding , not tied to delivery of specific services or expenditures, global funding is subject parameters outlined in the Hospital Services Accountability Agreement ("HSAA")(approximately 38.9% of 14/15 forecast MoH revenue)

Risks created by Funding Models	Management Strategy

HBAM is difficult to predict until funding is announced	• Plan programs with an HBAM hold back with scale up of activities post announcement
	• The hospital will be particularly reliant on elective surgery to allow for in-year adjustments
	• Apply needs/capacity assessment to:
	  ○ identify alignment of services that might improve HBAM
	  ○ inform opportunities to increase OSMH revenue through program transfer

QBPs with long wait times	• Negotiate for increased volume or consider single waiting list for the service (not a wait-list by surgeon)
QBPs where the hospital cannot provide the service with funding available	• Consider alternate service provision through application of Needs/Capacity Assessment Tool
Specialized program funding no longer covers full cost	• Re-design program model/service levels or scope to fit within funds available or stop providing the service • Apply Needs/Capacity Assessment Tool to inform opportunities to increase OSMH revenue through program transfer

Global Budget shrinkage	• Develop shared service approaches for support services (e.g. IT)
	• Decrease physical plant in operation
	• Decrease energy and waste costs
	• Increase efficiency of support services and clinical services funded under global budget
	• Apply Needs/Capacity Assessment Tool to:
	  ○ reduce scope, transition, or stop providing clinical programs
	  ○ inform opportunities to increase OSMH revenue through program transfer

Funding model review	• A review of the funding model is underway and continuing changes/adaptations are anticipated but it is not anticipated that we will return to the previous model of hospital funding.

7. Conclusions and Next Steps

The Clinical Services Plan (CSP) as presented here is intended to be a guidance document to be used in strategic, operational and capital planning. The phases of the project have allowed the organization to benefit from outside perspectives and internal perspectives from many stakeholders. The plan will support the organization to build on previous accomplishments and strengths and to navigate the dynamic environment of Ontario healthcare and the North Simcoe Muskoka Local Heath Integration Network.

The CSP outlines that OSMH will provide care focused at two levels – core hospital services primarily serving the local catchment area and regional services that support residents and providers from a broader catchment area with more specialized services. The plan will support OSMH to make changes that may be enabled as the Government considers and funds further development of Healthlinks, changes in Home and Community Support, and development of the Quality agenda. The hospital will be able to build on the strong linkages and relationships already in place, particularly with primary care and the program strengths, and ability to adapt that are a part of our culture.

The CSP is a guidance document to be used in strategic, operational and capital planning

Cost reduction requirements will be addressed at the program level by consideration of the Unit Strength factors and the Attractiveness/Sustainability Factors used in Phase 2 and LHIN planning related to Care Connections Second Curve and may result in alternate service provision, redevelopment of the service delivery model, redefining the scope of the service or other changes that bring services more in line with the future state defined here. OSMH and other hospitals have experienced challenges with delivery of programs and services therefore all changes will be subject to further business planning or annual operational planning decision points. It will be imperative for all services to focus on program efficiency and effectiveness including partnering/integration with related players. All programs and services will need to continue to change to address the new realities.

A key next step will be considering how our strategic plan supports the program priorities and changes identified. The challenge ahead will involve adapting all of our programs and services to focus on “what needs to be done” instead of focusing on maintaining current approaches to care and services. Ensuring that OSMH delivers ever increasing value will be the key to our future success.

Value= (Quality/Cost) x patient experience

Capitalizing on strong relationships with primary care, specialist physicians, community agencies and other hospitals will allow us to create new ways to deliver needed services that utilize new tools and evidence based approaches. This will involve becoming more patient centred, more standardized in how we approach key clinical programs and delivering programs utilizing effective partnerships that follow the patient care journey. Programs that are unable to innovate and adapt will not be sustainable.

The OSMH of the future will be focused on acute care – a place where people come for short periods of intensive intervention and facilitated transition to the community. Interprofessional teams will support the most complex patients with comprehensive care plans that follow the patient into acute care and back into the community enabled by Information Technology. Programs will generally be single program, multisite across the LHIN with consistent quality measures and program supports. OSMH will provide leadership to some of the shared LHIN programs.

The plan will also support the development of a Pre Capital Submission outlining a Master Program. The Master Program is a key first step leading toward a facility redevelopment plan. The MOHLTC capital planning framework is consistent with the principle that community based care is best planned, coordinated and funded in an integrated manner at the community level specifying key points for indication of LHIN support and MOHLTC approval.

Next steps:

1. Building on the excellent work already completed or underway OSMH will continue to focus on standardization of clinical processes and supplies. This will be enabled through the work on Order Sets and further work on Quality Based Procedures costing planned for the coming year. This work will support the Electronic Medical Record implementation and the EMR will enable the implementation of the work.
2. OSMH in collaboration with the NSM LHIN will explore the government's announcement re bundled payments to hospitals for episodes of care as an adaptation/extension of QBP funding.
3. The 15/16 Annual Business Plan for OSMH will consider will proceed using the CSP as a framework to support related decisions.
4. We will continue the engagement with system partners so that they understand the direction for OSMH programs and services starting with the conversation already underway for a residential hospice in Orillia.
5. The OSMH strategic plan will be examined in fiscal 2015/16 to ensure that the plan supports the implementation of the CSP.
6. Securing planning resources to support articulation of OSMH Master Program will be a priority in 2015/16 to ensure appropriate facilities for the OSMH programs of the future.

APPENDICES

APPENDIX 1 Members of the Clinical Services Planning Oversight Committee

Pat Campbell, President & CEO (Chair and Executive Sponsor)
Angie Harwood, VP People Partnerships and Planning (Executive Lead)
Leads:

- Dr. Nancy Merrow, Chief of Staff/VP Medical Affairs
- Doug Murray, VP Corporate Services and CFO
- Cheryl Harrison, VP Patient Services and Regional Programs/CNE
- Terry Dyni, Director of Community Relations

Dr. Mike Odlozinski, President of the Medical Staff Association Executive
Dr. John MacFadyen, Senior Physician Leader, Chief of Medicine
Dr. Don Sangster, Previous president of Medical Staff Association
Barbara Jones, Director Performance Excellence
Gini Stringer, Patient Advisory/Community Member

APPENDIX 2 *Framing Future Choices* document

Provided under separate cover

APPENDIX 3 Needs/Capacity Assessment Tool

Application to Clinical Program Assessment - example

Purpose: To develop a framework for the alignment of resources that would inform strategic choices within the OSMH Mission

Mission: "To be a trusted provider and leader of community hospital and designated regional specialized services"

The service choices should be tested against key questions that help to ensure that choices made bring OSMH closer to its strategic objectives while keeping within the parameters of the hospital's vision, mission and values.[6]

[6] (Ginter, P. M., Duncan, W. J., Swayne (2013). Strategic Management of Healthcare Organizations, 7th ed., Jossey-Bass, San Francisco, Chapter 6, pg. 210)

A Needs/Capacity Assessment Tool was developed to provide a framework for the evaluation of alternatives, strategic choice and opportunities. The tool provided a methodology to evaluate the alignment of the current scope of services (Internal: Service Unit Strength Factors Scoring Definitions, Table 3) with the assessed needs (External: Attractiveness/Sustainability Factors Scoring Definitions, Table 4) and to help identify potential strategies to deliver designated services on a sustained basis.

In the framework assessed need is based on the 7 external criteria that were weighted based on a survey of individuals participating in the CSP process (Table 1).

Table 1 Needs/Capacity Assessment Matrix Tool 'External' Factors and Weighting

Criteria	External: Attractiveness/Sustainability Factors	Factor Weighting
1	Referral Population	14.0%
2	Referral Population Growth	9.0%
3	Funding Methodology (Global Budget, QBP, Tech Fee, Combination)	17.0%
4	Service Alternatives	16.0%
5	Location of Alternatives	12.0%
6	Implications to the continuum of care and broader health care system	18.0%
7	Alignment with Government Direction (e.g. Care Connections, Health Links, Hospital vs. Non Hospital Services) - ref: CSP pg. 5	14.0%
		100.0%

The identification of potential strategic alternatives and choices (also referred to as "Future State") is an example of an "Adaptive Strategy" and informs adjustments in scope of services in response to factors in the external environment (Table 1). These external factors were applied to determine the potential strategic choices are the same as used in the "Current State Assessment" process and defined in greater detail in Table 3 and 4.

Strategic options are potential actions to be taken to adapt the capacity or service scope to improve alignment with external opportunities. Potential options could focus on changes to scope that effect Internal: Service Unit Strength Factors (Tables 2 and 3) provide the basis for organization's response to the assessment of need as determined by the External Factors (Tables 1 and 4) and result in better alignment of internal scope with external opportunities.

The Needs/Capacity Assessment suggests that where the External Attractiveness/Sustainability score is high and where the Internal Service Unit Strength Factors score is low there should be a relative increase in the scope of service or activities undertaken to improve strategic alignment. Conversely, when the assessment suggests that the External Attractiveness Score is low and where the Internal Service Unit Strength Factor score is low there could be a relative decrease in the scope of service. High external factor strength indicates that there is high community need

for the service. The model assumes that the Service Unit Strength Factors are the changeable factors for the organization.

Table 2 Needs/Capacity Assessment Matrix Tool 'Internal' Factors and Weighting

Criteria	Internal: Service Unit Strength Factors	Factor Weighting
1	Market Share	14.0%
2	Financial Benchmarking Performance	14.0%
3	Safe and High Quality Service Delivery – ref: Framing Future Choices, CSP pg. 5	25.0%
4	Infrastructure to Support Program - Physicians, Nurses, Other Clinical Specialists	13.0%
5	Infrastructure to Support Program - Equipment and Facilities	9.0%
6	Intrinsic Quality or Value of the Service within the Community – ref: CSP pg. 5	9.0%
7	Internal interdependency of the service with other services	16.0%
		100.0%

Table 3

Internal: Service Unit Strength Factors Scoring Definitions
Enter **Ratings** for each **Service Unit** in terms of the **Strength Factors** on a scale of 1 to 9 where

1. Market Share
definition: The Market Share (expressed as a percentage) of the service within the LHIN
Scoring Guide:
1 - the service has a very low market share (<10%) within the LHIN
5 - the service has approximately 50% market share within the LHIN
9 - the service has >90% market share within the LHIN

2. Financial Benchmarking Performance
definition: Cost of delivery per "service activity", compared to peers.
Scoring Guide:
1 - The cost per "service activity" delivered is grossly in excess compared to peers.
5 - The cost per "service activity" delivered is about average (50th percentile) compared to peers
9 - The cost per "service activity" delivered is extremely competitive compared to peers.

3. Safe and High Quality Service Delivery
definition: The quality & safety of the service delivery relative to comparable peers. Consider both quantitative benchmarking data (e.g. LOS, readmission, complications, patient satisfaction, etc…) and qualitative or intangible indicators of quality (e.g. standard of care, continuity of care etc...). Do *not* consider issues of cost ($).
Scoring Guide:
1 - The quality and safety of the service is poor, and falls below industry standard.
5 - The quality and safety of the service meets standards, or is on par with average performance among peers.
9 - The quality and safety of the service delivery exceeds best practices.

4. Infrastructure to Support Program: Physicians, Nurses, Other Clinical Specialists
definition: To maintain the current level of service, are the clinical human resources adequate in-house and readily available if needed?
Scoring Guide:
1 - Clinical human resources are inadequate and external availability is poor.
5 - Clinical human resources are adequate, with reasonable external availability.
9 - Clinical human resources are abundant, and are also externally available in abundance.

5. Infrastructure to Support Program: Equipment and Facilities
definition: To maintain the current level of service, are capital investments to equipment or facilities required?
Scoring Guide:
1 - Significant capital investments to equipment/facilities are required immediately to maintain current level of service.
5 - Moderate capital investments to equipment/facilities will be required periodically to maintain the current level of service.
9 - No significant capital investments to equipment/facilities are required at present or in the near future to maintain the current level of service.

Intrinsic Quality or Value of the service within the Community
definition: Does the community support this program as evidenced with fundraising, or advocacy? What would be the political impact of changes to the program?
Scoring Guide:
1 - There is minimal community support for the program, and the political impact of changes to the service would be minimal.
5 - There is moderate community support for the program, and the political impact of changes to the service would be moderate.
9 - There is significant community support for the program, and there would be political upheaval due to changes in the program.

Internal Interdependency of the service

definition: The degree to which the rest of the hospital would be impacted by changes (expansion/enhancement/alternate provision) of the service)
Scoring Guide:
1 - The rest of the hospital is minimally or negligibly impacted by this service, or changes to the service.
5 - The rest of the hospital is moderately impacted by this service, or changes to the service.
9 - The rest of the hospital is significantly impacted by this service, or changes to the service.

Table 4

External: Attractiveness/Sustainability FactorsScoring Definitions
Enter **Ratings** for each **Service** in terms of the Sustainability **Factors** on a scale of 1 to 9 where

Referral Population
definition: The absolute number of patients impacted by the service, weighted more heavily by vulnerable population groups (e.g. first nations, socioeconomically disadvantaged).
Scoring Guide:
1 - The number of patients served is low, and it does not serve any significant number of vulnerable groups.
5 - The number of patients served is moderate and provides some service to vulnerable groups.
9 - The number of patients served is high, and it serves a significant number of vulnerable groups.

Referral Population Growth
definition: The degree to which the referral population is projected to grow over time.
Scoring Guide:
1 - The referral population projected growth is far below average.
5 - The referral population projected growth is about average.
9 - The referral population projected growth is far above average.

Funding Methodology
definition: The degree to which the funding methodology for the service would support sustainability or growth of the service, OR the degree to which the funding methodology would enable divestment of service with minimal fiscal consequences to the hospital.
Scoring Guide:
1 - current funding does not sustain the service or allow it to grow, and/or divestment of service would have significantly positive fiscal consequences.
5 - current funding currently sustains the service, but does not allow for growth and/or divestment of service would have neutral or positive fiscal impact to the organization
9 - current funding not only sustains the service, but allows it to grow, and/or divestment of service would have major negative fiscal impacts to the organization

Service Alternatives
definition: The number of alternative service providers.
Scoring Guide:
1 - There are numerous alternative service providers available
5 - There are a few alternative service providers available.
9 - There are essentially no alternative service providers available

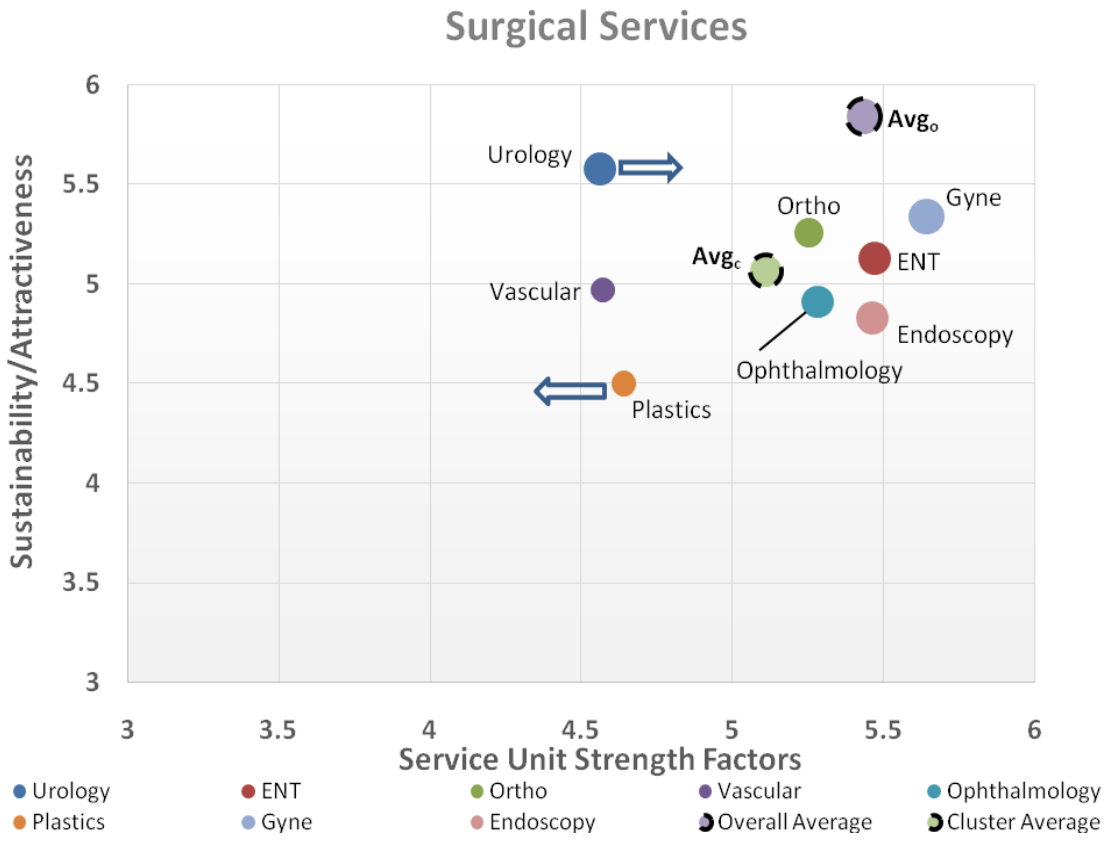
Location of Alternatives
definition: The location / accessibility of alternative service providers.
Scoring Guide:
1 - The alternative service providers available are very close, and/or would be easily accessed by our patients.
5 - The alternative service providers available are located within a reasonable distance, and would be moderately accessible by our patients.
9 - The alternative service providers available are located very far away, and/or would be poorly accessed

byour patients.

Implications to the continuum of care and broader health system (External Interdependency)
definition: The degree to which the rest of the LHIN/region would be impacted by changes (expansion/enhancement/ divestment) of the service.
Scoring Guide:
1 - The rest of the LHIN/region is minimally or negligibly impacted by this service, or changes to the service.
5 - The rest of the LHIN/region is moderately impacted by this service, or changes to the service.
9 - The rest of the LHIN/region is significantly impacted by this service, or changes to the service.

Alignment with Government Direction
definition: The degree to which the LHIN and/or Government supports the growth or maintenance of a service.
Scoring Guide:
1 - The LHIN/government would be significantly opposed to growth/maintenance of a service.
5 - The LHIN/government would be indifferent to growth/maintenance of the existing service.
9 - The LHIN/government is significantly supportive of growth/maintenance in the service.

APPENDIX 4 Sample Assessment incorporating Clinical Services Needs Capacity Assessment Tool



*size of dots reflects the size of the referral population

Figure 1 Needs/Capacity Assessment Matrix Score for Surgical Program in "Current State" assessment.

(Avg_c is the average for the cluster, Surgical Services, Avg_o is the overall average). Size of the bubble is correlated to referral population.

While the scores on the matrix are clustered closely together the assessment indicates that there is a potential opportunity to increase the scope of urology to better align with the assessed opportunity. Adaptive scope adjustments could include assessment of activity, volumes, equipment investments, OR time allocation and physician and staff recruitment planning.

The need to provide for an increase in the scope of urology could be addressed through adjustments in the scope of plastic surgery which has a relatively lower score for External Attractiveness/Sustainability. Adjustments in the cluster should also consider where the

program is positioned in comparison to the overall average as there may be opportunity for scope changes in other services that would result in even greater alignment with opportunities.

Once an assessment has been done under the model a final check using the table below would help to refine the rationale for proposing changes to the program or service. This would be incorporated in the operational planning/business planning proposal for final consideration.

Linking Strategy with Current State Assessment ("Situational Analysis")		**Yes/No**
1	Addresses an External Factor/Issue	
2	Draws on Competitive Advantage or Fixes a Competitive Disadvantage	
3	Fits with Mission, Vision, Values	
4	Moves the Organization Toward the Vision	
5	Achieves One or More Strategic Goals	

Limitations of the Needs/Capacity Assessment Tool

The assessment could be applied to all services not just Regional Specialized Services. Core/local services have not been assessed against the model. Efforts were taken to validate the weighting and scoring criteria, however the level of precision of the tool is not clear.

The weighting of criteria engaged direct service providers to weight both the external need and internal strength factors. The tool might be improved through greater participation of other stakeholders, particularly in the discussion and weighting of the external assessment criteria.

The process required the dedicated effort of many participants including Program Managers, Directors and Medical Directors and Senior Administrators, this required a great deal of time, discussion and analysis.

APPENDIX 5 Mitigation Strategies Scorecard

SOLDIERS' MEMORIAL HOSPITAL

Mitigation Strategies Dashboard
Fiscal Year 2014/2015

Mitigation Strategies Summary - Framing Future Choices

Mitigation Strategy Outcome Measure/Indicator	Detail	Annualized Data	2014/2015 Q1		Q2		Q3		Q4		YTD (Sep)*	Adjusted Forecast	Year End Target	
Reduce ALC														
Average Number ALC Beds (Census - Acute & Post Acute)*	20	26.9	25.8	R	29.2	R					27.5	n/a	20.0	n/a
ALC Rate in Acute Care (Coded)	4	22.0%	29.7%	R	21.8%	R					26.0%	n/a	18.5%	n/a
Meet Best Quartile LOS Targets														
Total Conservable Days in Acute Care	2	5865.9	1039.8	G	1182.4	R					2222.2	n/a	3835.9	n/a
% Unplanned Readmission Rates < 28 Days in Acute Care	5	4.7%	4.8%	Y	5.2%	R					5.0%	n/a	4.7%	n/a
Strategy to Reduce CTAS 4 & 5 ED Visits														
% CTAS 4 ED Visits	10	53.4%	51.5%	Y	51.8%	Y					51.6%	n/a	49.4%	n/a
% CTAS 5 ED Visits	15	2.5%	1.8%	G	1.9%	G					1.8%	n/a	2.6%	n/a
Reduce CTAS 4 & 5 Visits (Budget Initiative)	7	29626	7447	R	7932	R					15379	n/a	25399	n/a
Transfer Outpatient Services to Community/Other Venues														
Outpatient Clinic Volumes (monitoring)*	14	69828	17023	G	16358	G					33381	n/a	73409	n/a

Reduce FY 10/11 ALC Rate in Acute Care of 21% by 50% in FY 15/16 to a rate of 8.7%.

Reduce FY 10/11 Acute Care Patient Days of 45,269 to 42,575 in FY 15/16 with concurrent increase of Separations from 7,366 to 8,437.

Reduce FY 10/11 CTAS 4 ED Visits by 25% and CTAS 5 ED Visits by 50% by FY 15/16.

No target stated in Clinical Services Plan.

Grey shaded cells indicate the use of preliminary data which will be validated upon completion of data quality audits.

Light blue shaded cells are indicators also monitored on Corporate Utilization Scorecard.

*YTD - September 2014

Dashboard developed to monitor and measure the Mitigation Strategies referenced in the Framing Future Choices - A Clinical Services Plan for OSMH.

Potential Indicators To Be Removed:	
Patient Satisfaction - Would You Recommend?	Monitored on QIP Dashboard & Corporate Balanced Scorecard
Achieve Best Quartile Day Surgery Targets	
Day Surgery Volumes	Monitored bi-weekly by Surgical Program
% Day Surgery of Total O.R. Cases (monitoring)	Potential to move to Program-level monitoring
Reduce Medicine Admission Rate	
% Met Admission Criteria (Medworxx)	Aligns with Medworxx indicators currently presented by Patient Flow at UMC
% Admits Through CDU	Monitored monthly by ER (compliance indicator for CDU operation)
ALC Designation < 48 hours of admission	Monitored on H-SAA

APPENDIX 6 Current State Assessment Briefing Note

OSMH Briefing Document

Date: May 28, 2014
Topic: Clinical Services Planning Current State
Submitted by: Cheryl Harrison, VP Patient Services
Nancy Merrow, Chief of Staff, VP Medical Affairs
Situation: The Clinical Services Plan for OSMH Current State Assessment is being presented for consultation.

Background:

In February 2013 the hospital finalized the document "Framing Future Choices - A Clinical Services Plan for Soldiers Memorial Hospital". Data to inform the document was provided by The Hay Group.

From this document, one of the steps required to proceed with planning was to design and implement a clinical services prioritization/decision making tool for ongoing evaluation of clinical services, based on the prioritization framework and criteria outlined in the document. This tool has been used to produce the Current State. The tool was used by a multi-disciplinary group of assessors (raters) that included Program Directors, Program Medical Directors, Managers, Decision Support, and clinical content advisors for each of the programs (Chiefs, Leads or delegates).

30 programs and services were assessed and assigned numerical ratings from 1-9 based on ratings of 14 weighted attributes. Final ratings were plotted on a 3 x 3 matrix, illustrations attached.

Assessors diligently applied their knowledge, opinions, clinical and planning expertise to their work over an extended period of time, and were able to achieve consensus on the final ratings. Participants recognized limitations in access to data and information to inform the rating process.

Assessment

- The Current State Analysis has been produced using a tool created from criteria in the Framing Future Choices document, and the best data available to us.
- The Current State is presented to inform dialogue about the Future State we create for OSMH.
- Other factors in addition to the Current State Assessment will be taken into account as we face the choices ahead.

Recommendations and Next Steps

1. That the Current State be received, and any feedback collected by Cheryl Harrison and Nancy Merrow to report to the Clinical Services Planning Oversight Committee.

2. That during the next few months the information from the clinical services prioritization/decision making tool be used by each program and service leadership team* to analyze and recommend what would need to be in place for them to be rated in the higher on the 3x3 matrix. That the analyses be presented to the Clinical Services Planning Oversight Committee.
3. That the NSM LHIN Care Connections Second Curve Planning document and other provincial or system wide initiatives be used to inform planning of the future state. (currently expected to be available in late summer 2014).
4. That the OSMH Budget planning cycle be taken into account (ideally would have CSP by early October 2014)

*program/service leadership team is considered to include Managers, Chiefs, Medical Leads, Program Medical Directors, and Directors.

Clinical services prioritization/decision making tool attributes

7 Service Unit Strength Factors:

1. Market Share, Factor weight 14%
2. Financial Benchmarking Performance, Factor weight 14%
3. Safe and High Quality Delivery of Care, Factor weight 25%
4. Infrastructure to Support Programs – Physicians, Nurses, others, Factor weight 13%
5. Infrastructure to Support Program-Equipment and Facilities , Factor weight 9%
6. Intrinsic Quality or Value of the Service within the program, Factor weight 9%
7. Internal Dependency of the services with other services and programs. Factor weight 16%

7 Attractiveness/Sustainability Factors:

1. Referral population served by the Service Unit, Factor weight 14%
2. Referral population growth, Factor weight 9%
3. Funding Methodology (Global budget, QBP, Technical fees) Factor weight 17%
4. Number of Service alternatives, Factor weight 12%
5. Location of alternatives, Factor weight 12%
6. Implications to the continuum of care and broader system, Factor weight 18%
7. Alignment with government direction (e.g. Care Connections), Factor weight 14%

The final consensus ratings were plotted on a 3x3 matrix as illustrated below.

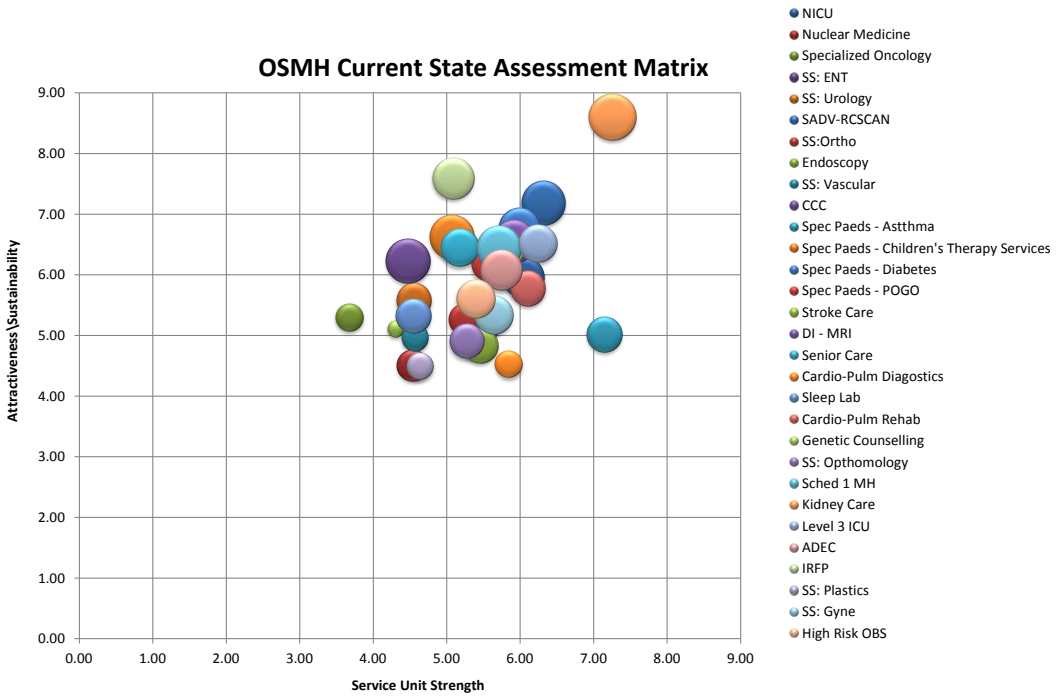
Participants' feedback and lessons learned from the process:

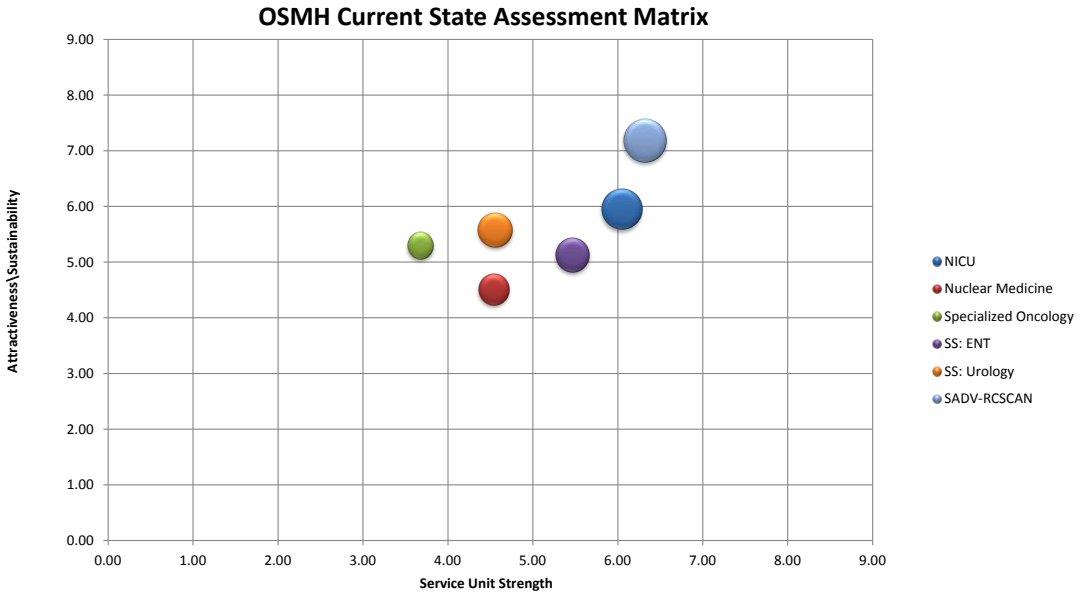
- Data provided by Decision Support and Finance was limited to financial, referral and market share data available to OSMH from primarily coded dated
- Market Share data was not always adequate to assign a rating
- A clear definition of the scope of services (i.e. what was in, or out of the assessment) was needed both for decision support and finance to pull data, as well as the assessors. This was noted to be a limitation for surgical and specialty clinic ratings
- Benchmarks hospitals for some services for comparison purposes required updating
- There is limited financial and clinical data at a specialty level for surgery

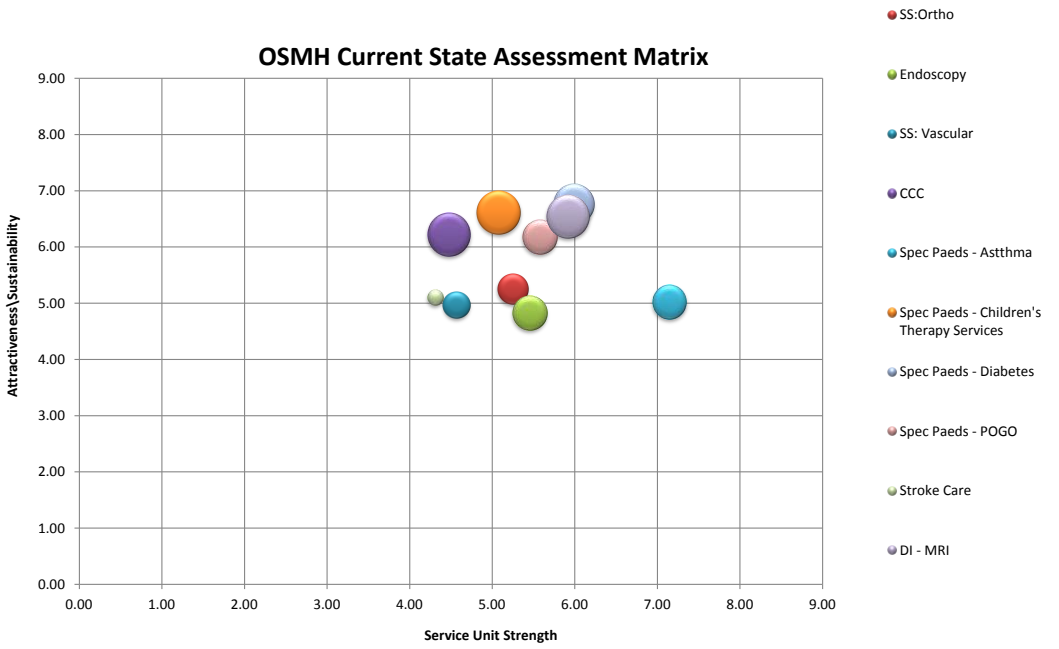
- There is a lack of LHIN data available to describe outpatient services, such as ADEC and Cardio-Pulmonary Rehab. In addition, the measure of alternative services is impacted by the fact that they are not necessarily equivalent which requires judgment be applied in establishing the rating
- "Grade D" consensus was the most commonly used tool (evidence being inadequate, a rating is recommended by consensus)
- There are several services where there were significant differences in the ratings for components of the services which required the selection of a rating in between the two values. This occurred in Seniors Care (Geriatric Day Hospital versus Soldiers 2), SADV versus RCSCAN and in Cardio Pulmonary Rehab. There is limited information about definition and scope of services, financial and clinical data at a specialty clinic level. This made rating challenging
- Some groupings included outpatient services and others did not which impacted on the scope under assessment
- Each service having been reviewed and given preliminary ratings by decision support and finance on 7 of 14 factors, was then reviewed by the service manager as well as reviewed by the clinical chief or physician delegate. Each service was then assessed and assigned ratings by dyad assessor of program manager and medical program director who presented their ratings and its evidence of justification to all the assessors, with representation from decision support, finance and Senior Management over two eight-hour days.
- For the process to work well, the review must be fluid and timely to allow for decision-making using common references and most current evidence.

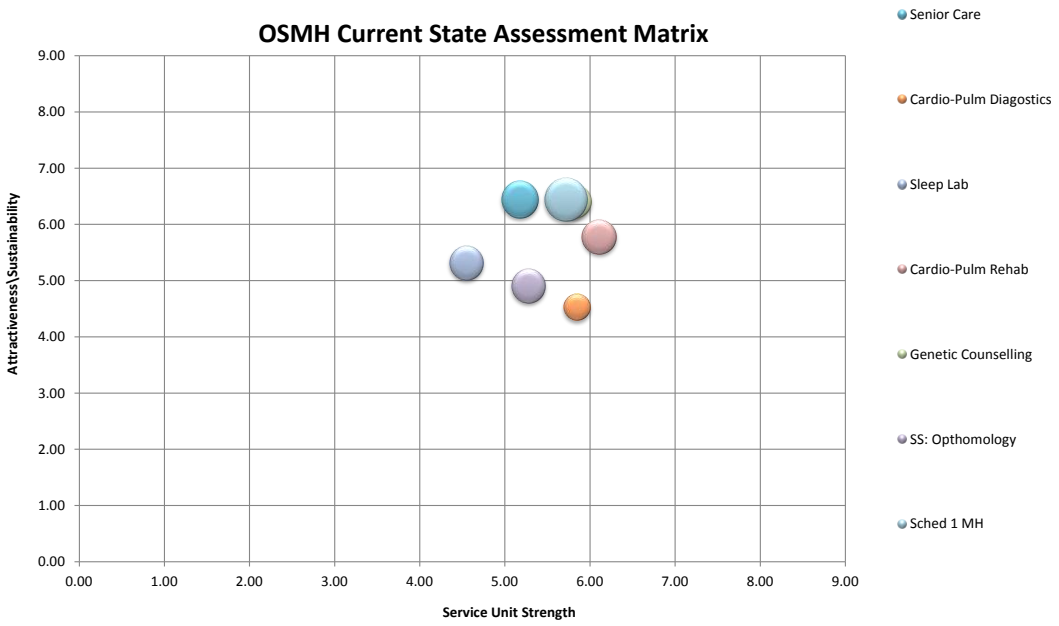
Participants' Recommendations for Future State Assessment:

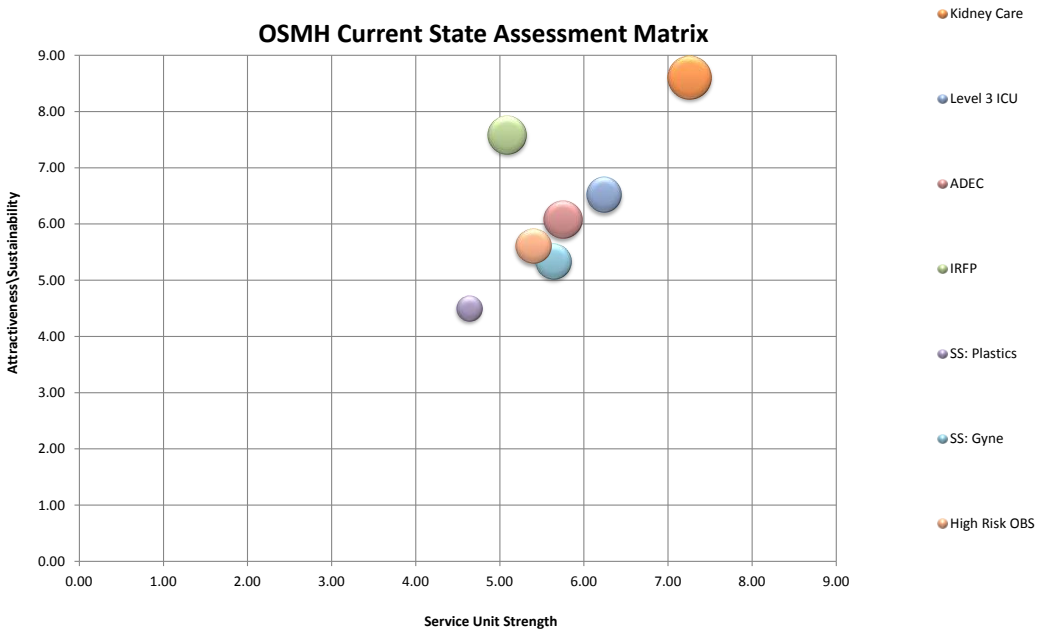
- Recommend that we include CKD and DI perspectives in the future assessment for the Vascular Surgical Service
- Consider quantifying interdependencies with a numerator/denominator approach with adjustment for size of service
- Definitions on Clinical Services Assessment tool have been reviewed and tested multiple times. They continue to vary between quantitative measurement and qualitative assessment. Further clarity (ie, within the LHIN limits) may be warranted if use for future state.


OSMH Current State Assessment Matrix
Attractiveness\Sustainability
Service Unit Strength
0.00
1.00
2.00
3.00
4.00
5.00
6.00
7.00
8.00
9.00
NICU
Nuclear Medicine
Specialized Oncology
SS: ENT
SS: Urology
SADV-RCSCAN
SS:Ortho
Endoscopy
SS: Vascular
CCC
Spec Paeds - Astthma
Spec Paeds - Children's Therapy Services
Spec Paeds - Diabetes
Spec Paeds - POGO
Stroke Care
DI - MRI
Senior Care
Cardio-Pulm Diagostics
Sleep Lab
Cardio-Pulm Rehab
Genetic Counselling
SS: Opthomology
Sched 1 MH
Kidney Care
Level 3 ICU
ADEC
IRFP
SS: Plastics
SS: Gyne
High Risk OBS

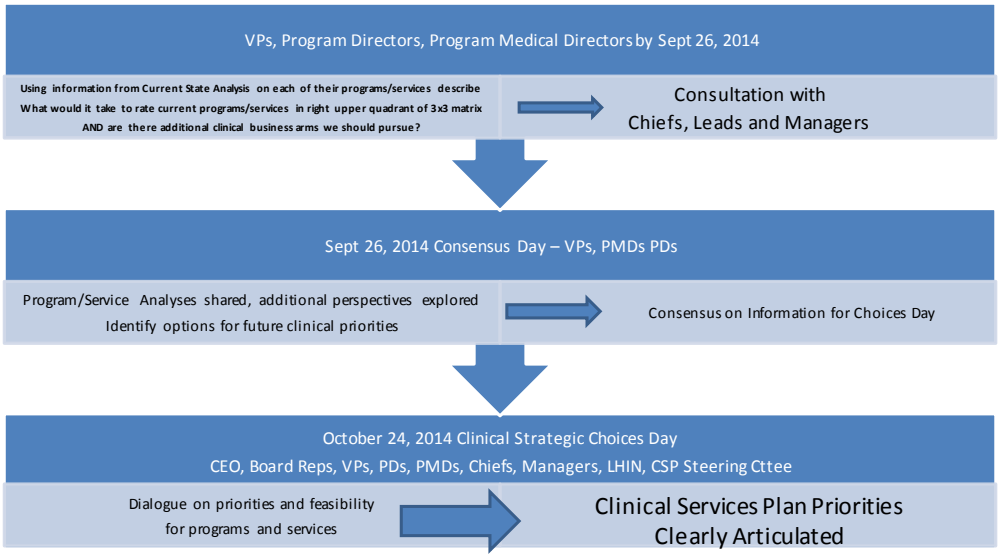

OSMH Current State Assessment Matrix
Attractiveness\Sustainability
Service Unit Strength
0.00
1.00
2.00
3.00
4.00
5.00
6.00
7.00
8.00
9.00
NICU
Nuclear Medicine
Specialized Oncology
SS: ENT
SS: Urology
SADV-RCSCAN


OSMH Current State Assessment Matrix
Attractiveness\Sustainability
Service Unit Strength
0.00
1.00
2.00
3.00
4.00
5.00
6.00
7.00
8.00
9.00
SS:Ortho
Endoscopy
SS: Vascular
CCC
Spec Paeds - Astthma
Spec Paeds - Children's Therapy Services
Spec Paeds - Diabetes
Spec Paeds - POGO
Stroke Care
DI - MRI


OSMH Current State Assessment Matrix
Attractiveness\Sustainability
Service Unit Strength
0.00
1.00
2.00
3.00
4.00
5.00
6.00
7.00
8.00
9.00
Senior Care
Cardio-Pulm Diagostics
Sleep Lab
Cardio-Pulm Rehab
Genetic Counselling
SS: Opthomology
Sched 1 MH



Next Steps for Future State Clinical Services Planning



APPENDIX 7 Strategic Choices Planning Report

Provided under separate cover

APPENDIX 8 References

1. Centre for Addictions and Mental Health Medical Psychiatry Alliance http://www.theglobeandmail.com/news/national/60-million-slated-for-newly-created-psychiatry-alliance/article16542521/

2. Emerging Technologies – Disrupt or be Disrupted – from IT Challenge to business imperative Price Waterhouse Cooper http://www.pwc.be/en_BE/be/publications/2014/emerging_technologies.pdf

3. Health Quality Ontario Common Quality Agenda http://www.hqontario.ca/Portals/0/Documents/home/hqt2013-common-quality-agenda-en.pdf

4. MOHLTC Action Plan http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/

5. MOHLTC Assess & Restore Guideline http://www.health.gov.on.ca/en/pro/programs/assessrestore/docs/ar_guideline.pdf
6. MOHLTC Mental Health Strategy http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf

7. MOHLTC Minister's Mandate Letter – Premier Wynne to Dr. Eric Hoskins https://www.ontario.ca/government/2014-mandate-letter-health-and-long-term-care

8. MOHLTC Quality Based Procedures Initiative http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding_qbp.aspx

9. MOHLTC Seniors Strategy http://news.ontario.ca/mohltc/en/2012/05/ontario-helping-more-seniors-live-at-home-longer.html

10. NSM NSM LHIN Integrated Health Service Plan http://nsmNSM LHIN.on.ca/goalsandachievements/ihsp.aspx

11. OHA-OMA Framework for Redistribution of Services https://www.oma.org/Resources/Documents/HSFRFramework.pdf

12. Provincial Council for Maternal Child Health Integrated Complex Care Strategy for Medically Fragile/Technology Dependent Children http://www.pcmch.on.ca/search_page/complex%20children

13. Redefining Health Care: Creating Value-based Competition on Results, Michael Porter http://www.amazon.ca/Redefining-Health-Care-Value-based-Competition/dp/1591397782

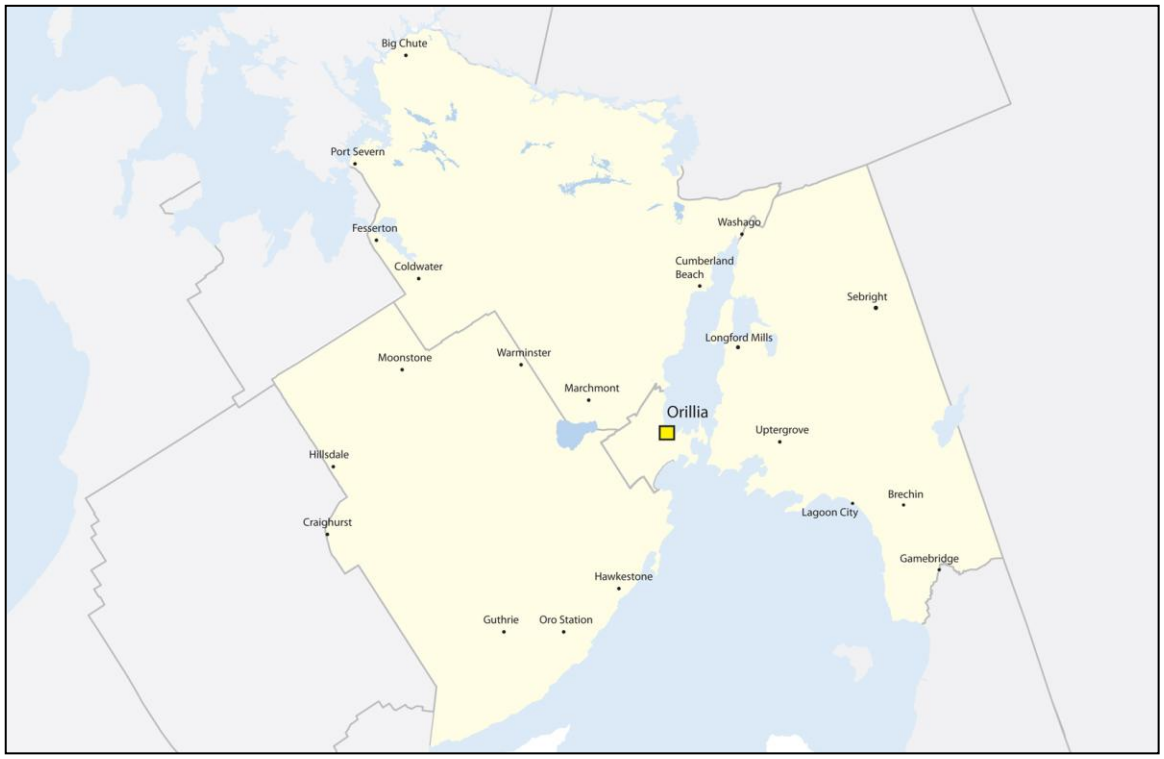
14. Rehabilitative Care Alliance Ontario http://rehabcarealliance.ca/about-us

15. Senior Friendly Hospitals Toolkit http://seniorfriendlyhospitals.ca/

16. The Innovator's Prescription, Clayton Christensen http://www.amazon.ca/s/ref=nb_sb_noss?url=search-alias%3Dstripbooks&field-keywords=innovators%20prescription

APPENDIX 9 Local and Regional service area Maps

Local Map (as referenced on page 12 of this document)



Regional Map (as referenced on page 14 of this document)