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Review of the Small and Rural Hospital Transformation Fund

Final Report

March 31, 2015

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REVIEW OF THE SMALL AND RURAL HOSPITAL TRANSFORMATION FUND

Introduction to the Review

Introduction to the Review

Terms of reference

The terms of reference for our engagement are based on the requirements outlined in the request for services document RFS 2014-08-15 (the 'RFS') issued by the NELHIN on July 11, 2014[1]. As outlined in the RFS and as subsequently refined with the project steering committee, the objectives of the review were to:

1. Outline the operating environment for small and rural hospitals
2. Provide an overview of each of the initiatives funded by the Transformation Fund
3. Compare and contrast the major categories of initiatives
4. Identify lessons learned and critical success factors for transformation in small and rural hospitals, based on the projects supported by the Transformation Fund
5. Provide suggestions as to potential changes to the Transformation Fund that could be considered by the LHINs and Ministry of Health and Long-term Care (the 'Ministry')

Methodology

Our review involved the following major worksteps:

- An initial meeting was held with the project Steering Committee (comprised of representatives of three of the participating LHINs as well as a small hospital) in order to confirm our approach
- An initial meeting was held with the participating LHINS to present our approach, discuss information requirements and identify issues of relevance to the review
- An initial meeting was held with Ministry representatives to present our approach and identify specific Ministry requirements with respect to the review
- Information relating to projects supported by the Transformation Fund, including but not limited to proposals, interim status reports and project close out reports, was obtained from each of the participating LHINs and summarized to provide an overview of each initiative, including outcomes and lessons learned
- Subsequent meetings were held with the Steering Committee to review interim deliverables
- A draft report summarizing the results of our analysis and conclusions was prepared and reviewed with members of the Steering Committee. The draft report was revised based on feedback received from the Steering Committee.
- The draft report was presented to representatives of the participating LHINs and revised based on feedback received

Introduction to the Review

Restrictions

This report is based on information and documentation that was made available to KPMG at the date of this report. KPMG has not audited nor otherwise attempted to independently verify the information provided unless otherwise indicated. Should additional information be provided to KPMG after the issuance of this report, KPMG reserves the right (but will be under no obligation) to review this information and adjust its comments accordingly.

This report may include or make reference to future oriented financial information. Readers are cautioned that since financial projections are based on assumptions regarding future events, actual results will vary from the information that may be presented even if the hypotheses occur, and the variations may be material.

Comments in this report are not intended, nor should they be interpreted, to be legal advice or opinion.

Our fees for this engagement are not contingent upon our findings or any other event nor are we insiders or associated of any party participating the Transformation Fund. Accordingly, we believe we are independent and are acting objectively.

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REVIEW OF THE SMALL AND RURAL HOSPITAL TRANSFORMATION FUND

Overview of Small and Rural Hospitals

Overview of Small and Rural Hospitals

Of the 155 public, private and specialty psychiatric hospital corporations in Ontario, a total of 51 hospital corporations operating 64 sites meet the Provincial definition of a small or rural hospital:

- **Small hospitals** — hospitals with fewer than 2,700 total acute inpatient/day surgery expected weighted cases per year in any two of the previous three years
- **Rural hospitals** — hospitals located in a community with a population of less than 30,000 and greater than a 30 minute drive, at posted speeds, to a community with a population greater than 30,000

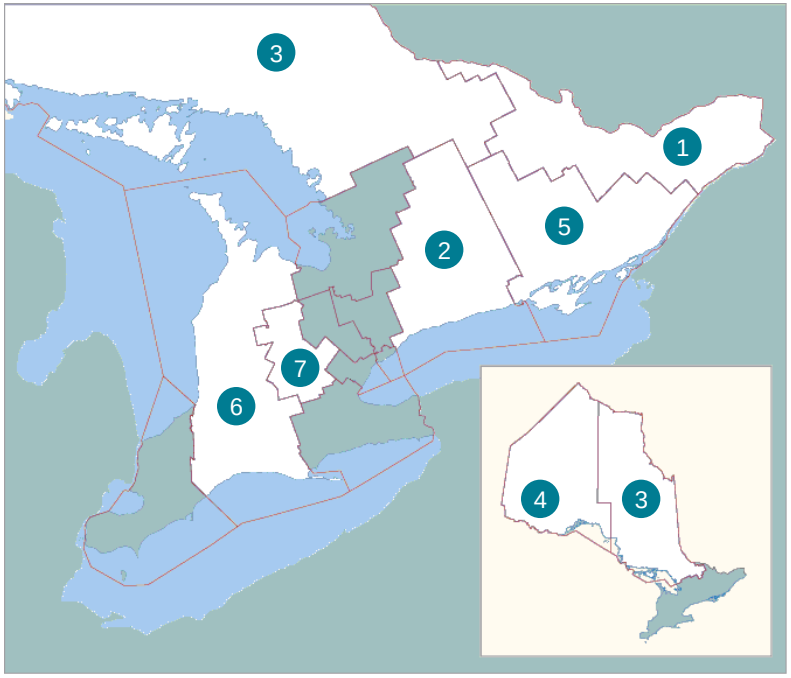
Small and rural hospitals are located within seven LHINs, with the majority located in Northern Ontario[2].

LHIN	Hospital Corporations	Hospitals
1. Champlain	8	8
2. Central East	2	2
3. North East	17	20
4. North West	10	12
5. South East	3	3
6. South West	10	17
7. Waterloo Wellington	1	2
Total	51	64

During the 2014 fiscal year, Ontario's small and rural hospitals[3]:

- Operated and staffed almost 2,000 inpatient beds
- Provided more than 570,000 inpatient days of care of all types (acute, CCC, ELDCAP)
- Received 765,000 emergency room visits
- Received just over $1 billion in revenues from all sources
- Employed 7,200 full-time equivalent staff

Small and rural hospitals by LHIN



Overview of Small and Rural Hospitals

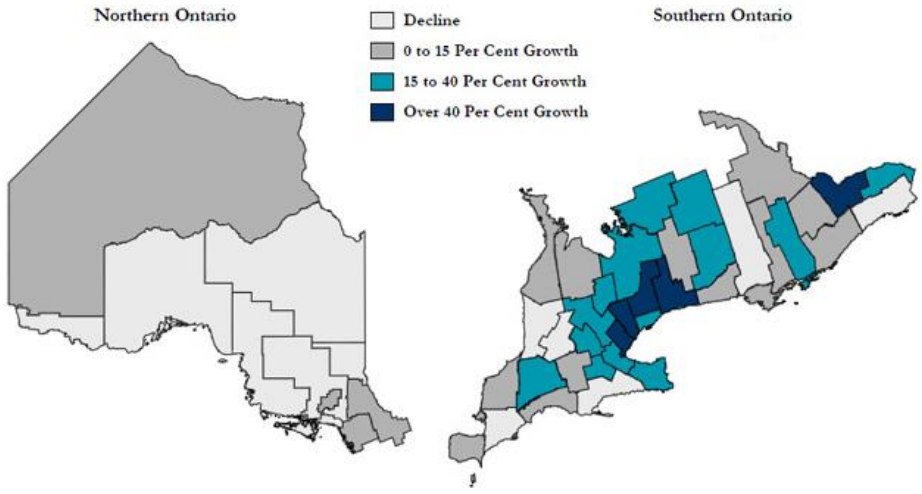
As part of our review, we have undertaken some analysis relating to the operating environment and financial performance of small and rural hospitals in Ontario, in some cases including a comparison to larger urban hospitals. As summarized on the following pages, the results of this analysis highlight a number of factors that are problematic from the perspective on longer-term sustainability.

Long-term population trends are not positive for rural and small town Ontario

Over the last two decades, 36 of 64 small and rural hospitals have witnessed negative to no growth in the population levels of the communities they serve (see Appendix A). Population projections prepared by the Ministry of Finance indicate that this trend is expected to continue for certain regions of the Province, specifically portions for Northern, Eastern and Southwestern Ontario where population levels are projected to either decrease or fall well below projected population increases in Central Southern Ontario.

Concurrent with stagnant to falling population levels, a number of the communities served by small and rural hospitals are also facing a gentrification of their residents, with the overall age increasing significantly above the Provincial average. The combination of little to no population growth (or even negative growth) and increasing aging of residents has the potential to challenge small and rural hospitals in a number of ways:

Projected population change – 2012 to 2036[4]



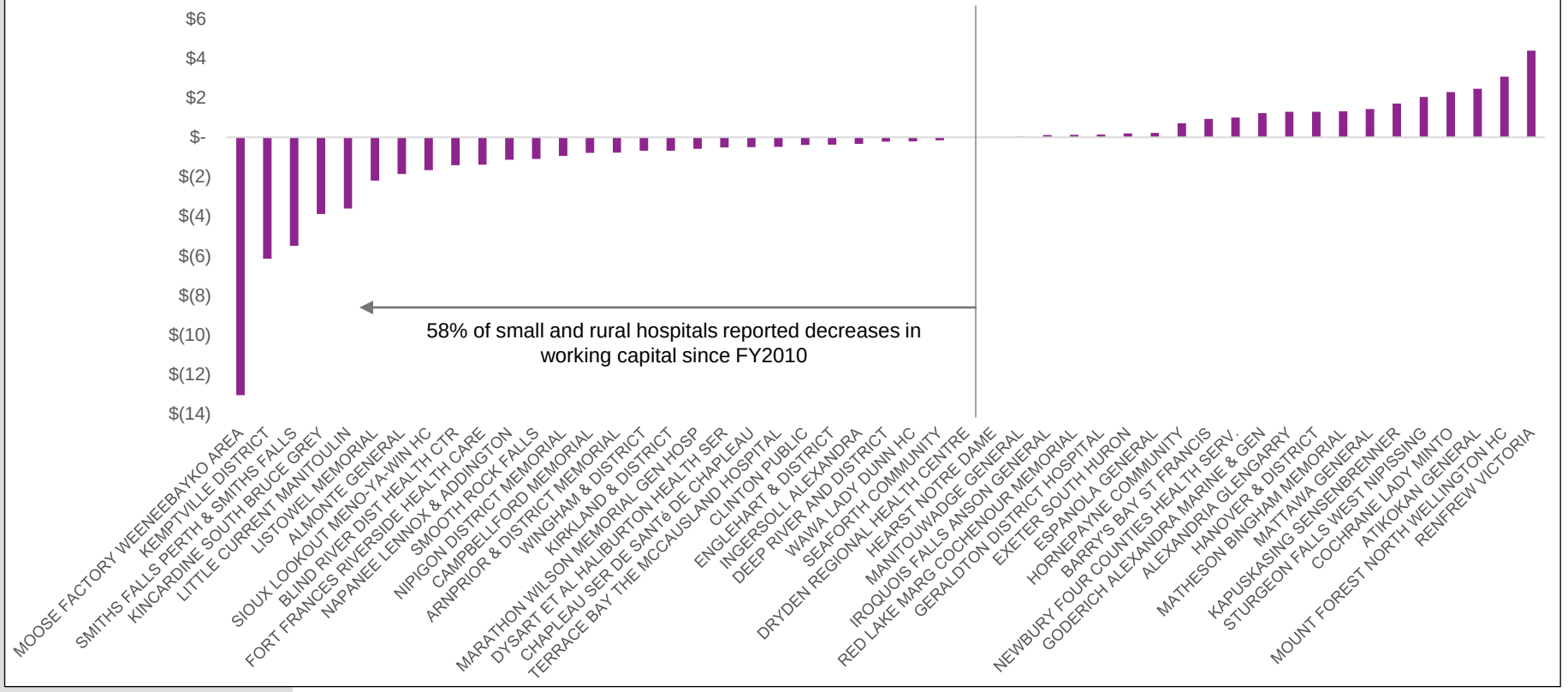
- As the Province continues to prioritize healthcare investments, the tendency may be for funds to flow to high growth areas of the Province (i.e. Central Southern Ontario), notwithstanding the fact that we understand that small hospitals (but not rural) will continue to be excluded from Health System Funding Reform ('HSFR') for the near future. The movement of funds to address growth pressures may result in continued constraint on funding increases for small and rural hospitals, which have generally experienced 1% increases in Provincial base funding and a median increase of 2.6% in total Provincial funding[5].
- Decreasing population levels may impact the ability of small and rural hospitals to raise local funds for major capital projects, including facility redevelopment and major medical equipment purchases. The absence of so-called local share capacity may result in an overall decline in efficiency and capabilities for small and rural hospitals due to the inability to finance required infrastructure investments through their own funds.
- The increased aging within the communities they serve will likely lead to operational impacts on small and rural hospitals, including increased emergency room visits for chronic conditions and higher levels of ALC patients. However, initiatives such as HealthLinks are intended to address primary care delivery and may mitigate the impact of increased aging on small and rural hospitals.

Overview Small and Rural Hospitals

The financial position and performance of several small and rural hospitals has deteriorated in recent years

While most small and rural hospitals have been successful in achieving balanced budgets, an analysis of reported financial information indicates that the majority of small and rural hospitals (56%) have experienced a decrease in their reported working capital since the 2010 fiscal year, with 28% of small and rural hospitals reporting negative working capital as at March 31, 2014. Continued decreases in working capital can arguably be considered as indicative of a long-term sustainability challenge due to the ongoing erosion of financial reserves.

Change in Reported Working Capital – FY2010 to FY2014 (in millions)[6]

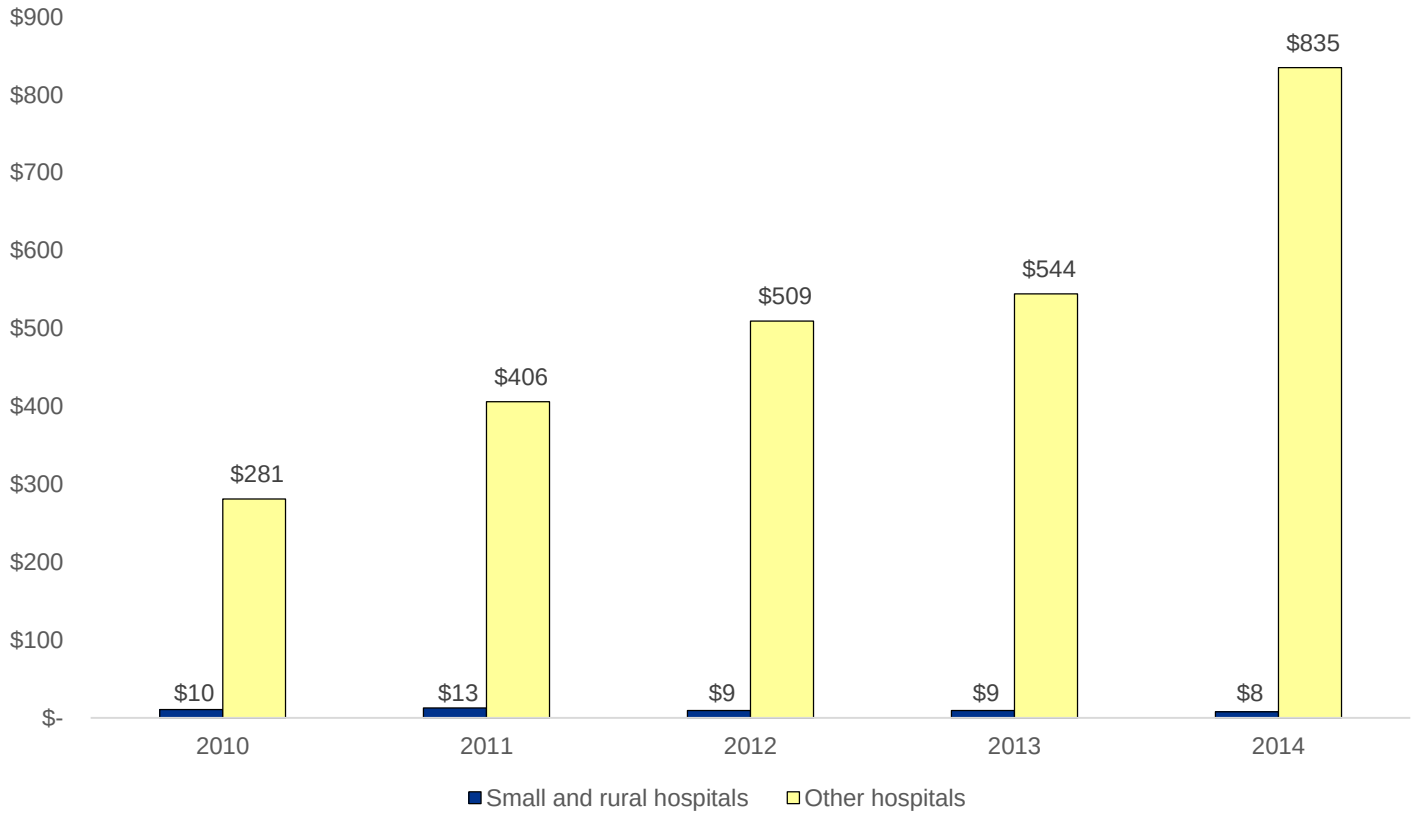


Overview of Small and Rural Hospitals

The financial performance of small and rural hospitals appears to have not kept pace with larger hospitals in recent years

The decrease in the reported working capital for the majority of small and rural hospitals appears to mirror the general trend in total margin[7], which was decreased overall for small and rural hospitals during the period 2010 to 2014. In comparison, the total reported margin for all other Ontario hospitals increased almost three-fold during the same period. From an operational perspective, we consider this to be significant as the absence of increased margins for small and rural hospitals likely limits their ability to address key investment requirements involving either capital expenditures or significant operational transformations.

Reported total margin – small and rural hospitals vs. other Ontario hospitals (in millions)[8]



Overview of Small and Rural Hospitals

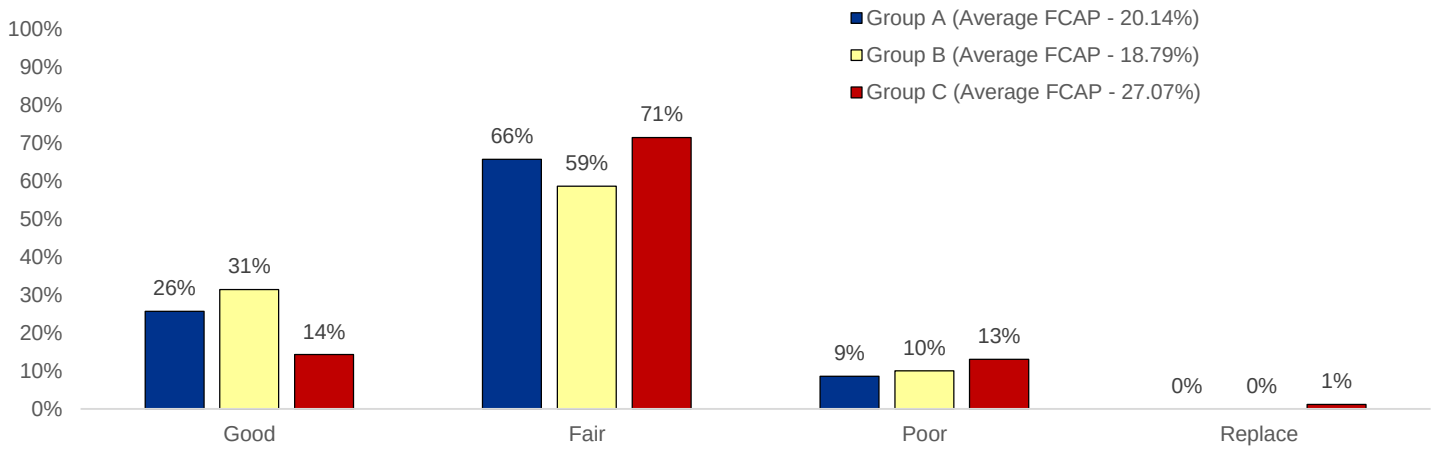
Small and rural hospitals have higher capital infrastructure deficits than hospitals in larger centres

The Ministry's Facility Condition Assessment Program ('FCAP') provides an indication as to the extent of infrastructure deficits that exist within Ontario hospitals (recognizing that FCAP only addresses facilities and not other key infrastructure components such as medical equipment). Expressed in terms of a percentage, the FCAP score delineates condition assessments as follows[9]:

FCAP Score	Condition Assessment	Description
0%-10%	Good	The facility and its components are functioning as intended; normal deterioration observed on major systems.
10%-30%	Fair	The facility and its components are functioning as intended; normal deterioration and minor distress observed.
30%-60%	Poor	The facility and its components are not functioning as intended; significant deterioration and distress observed.
60% +	Replace	The facility and its components are not functioning as intended; significant deterioration and major distress observed, possible damage to support structure; may present a risk to people or materials; must be dealt with without delay.

As noted below, small and rural hospitals have a higher infrastructure deficit than larger hospitals based on the average FCAP score, leading to a significantly lower percentage of facilities rated as good (14% vs. 26% and 31% for Group A and B hospitals, respectively). We believe this reflects in large part the lower amount of own funds necessary to support capital expenditures.

Average FCAP scopes[10]



Overview of Small and Rural Hospitals

Overall conclusions

As outlined in the Premier's mandate letter to the Ministry, the concept of '*putting patients at the centre – the right care, right place, right time*' will continue to influence the operational environment for small and rural hospitals.

While we understand that small hospitals will continue to be exempted from Health System Funding Reform, we anticipate that small and rural hospitals will see an increase in transformation activities, either in response to (i) new initiatives undertaken under programs such as HealthLinks and HealthHubs; and/or (ii) financial pressures that continue to challenge certain small and rural hospitals from the perspective of ongoing sustainability. Regardless of the reason, it appears that the need for small and rural hospitals to obtain resources to support transformational activities will likely increase, not decrease, over time. This conclusion is reinforced by several of the themes highlighted in the recent publication on Health System Transformation issued by the LHIN Leadership Council:

- Change is necessary for the Ontario healthcare environment due to a number of factors, including fiscal and demographic challenges
- Improving system integration and accessibility and modernizing home and community care are key initiatives identified in the 2014 Framework for Strategic Action
- Health innovation is viewed as an enabler of health system transformation

Discussions with the participating LHINs indicates small and rural hospitals continue to face pressures and constraints from a financial, capital and human resource perspective, a number will likely be challenged to secure the necessary capacity to undertake significant transformational activities. As a result, programs such as the Transformation Fund could potentially support system-wide changes across small and rural hospitals that would otherwise be unable to implement these changes through their own resources.

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REVIEW OF THE SMALL AND RURAL HOSPITAL TRANSFORMATION FUND

Overview of Small and Rural Hospital Transformation Fund

Overview of the Transformation Fund

Background and objectives

Established on April 23, 2013, the Transformation Fund is a four-year, $80 million program ($20 million per year) that is intended to achieve four stated objectives:

1. To demonstrate progress on moving forward with the Province's Action Plan for Health Care, including the priority of ensuring the right care at the right time in the right place
2. To enhance organizational sustainability within existing resources
3. To strengthen the linkages between small and rural hospital care and community care so that they operate as integrated networks that (i) ensure patient access to core acute services; (ii) ensure collaboration with community services; (iii) respond to community needs for post-acute and palliative services; and (iv) improve the quality and safety of services for patients while delivering good value for money within existing resources
4. To complement goals and objectives of Health Links, which are similar to the objectives noted above in terms of the focus on right care, right time, right place; financial efficiency and increased coordination

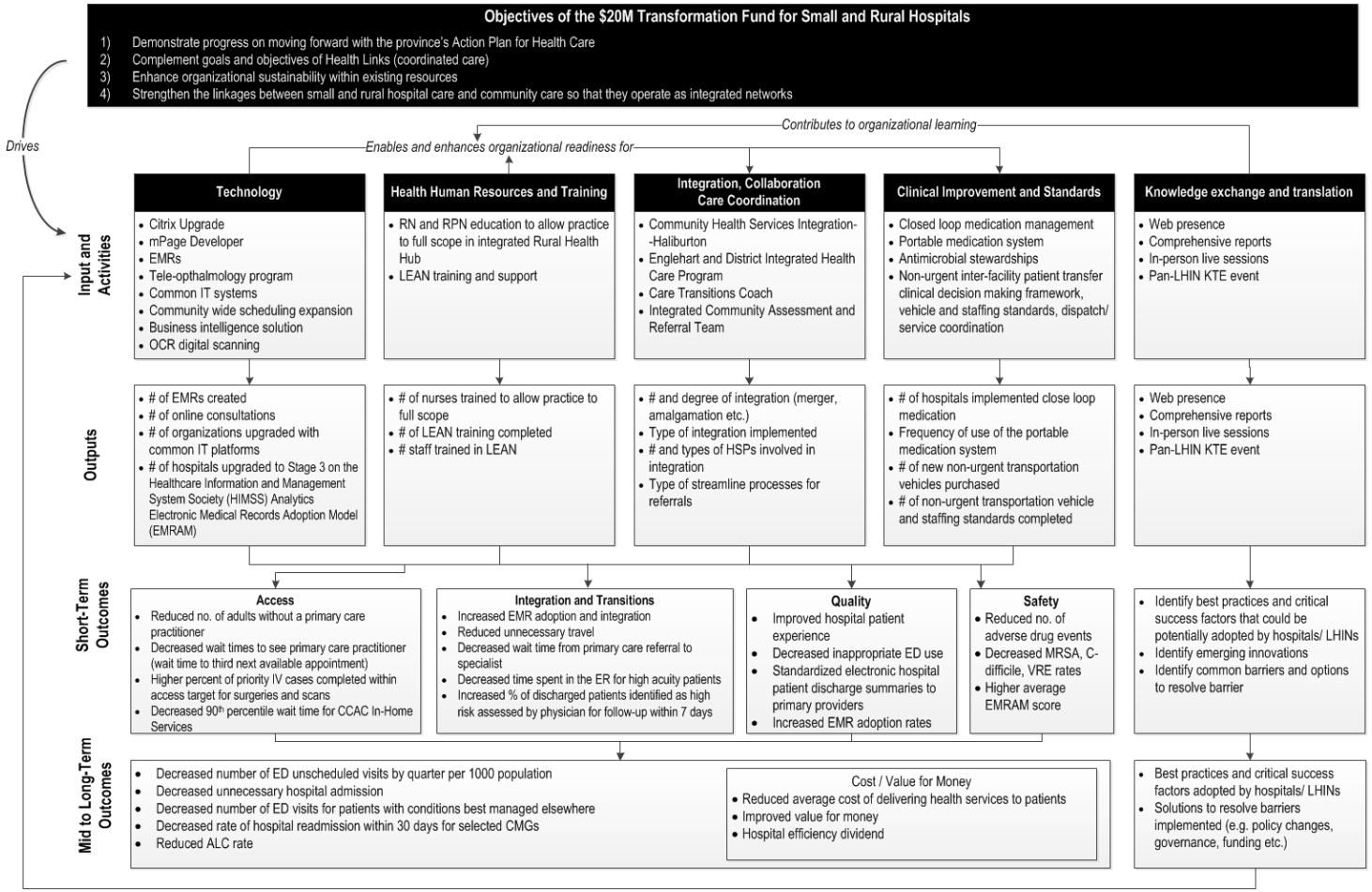
Eligible Transformation Fund projects can fall into one of five categories:

- Technology
- Health human resources and training
- Integration, collaboration and care coordination
- Clinical improvements and standards
- Knowledge exchange and translation

Based on our review of projects supported to date, we note that in certain instances, a single project may involve multiple categories. As noted later in our analysis, investments in technology are sometimes made in support of integration, collaboration and care coordination.

In order to demonstrate the linkages between the Transformation Funds objectives, activities and outcomes, the Ministry has developed a draft logic model for the program, which is presented on the following page.

Overview of the Transformation Fund



Overview of the Transformation Fund

Funding allocations and investments

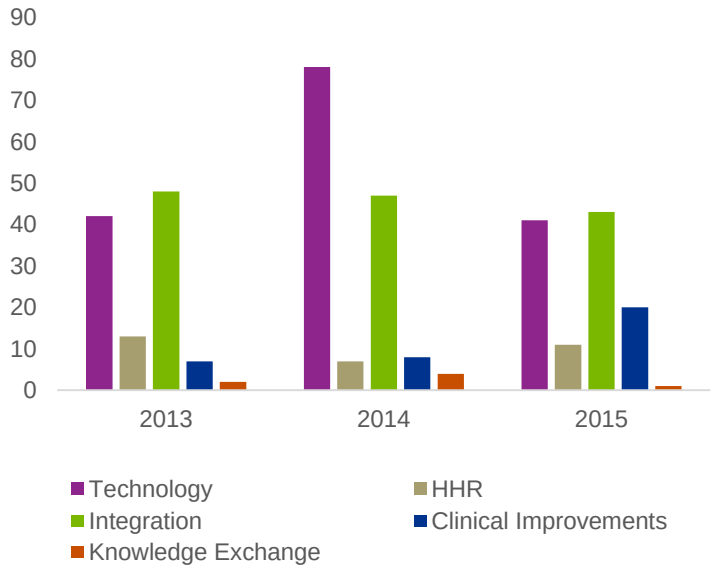
Since its inception, the Transformation Fund has supported a total of 373 separate projects[12,13], including 116 projects identified to date for the 2014-2015 fiscal year. Overall, the total investment made in small and rural hospitals through the Transformation Fund has amounted to $61.2 million.

As noted on the following page, 94% of the Transformation Fund support was used to in three of the five potential categories:

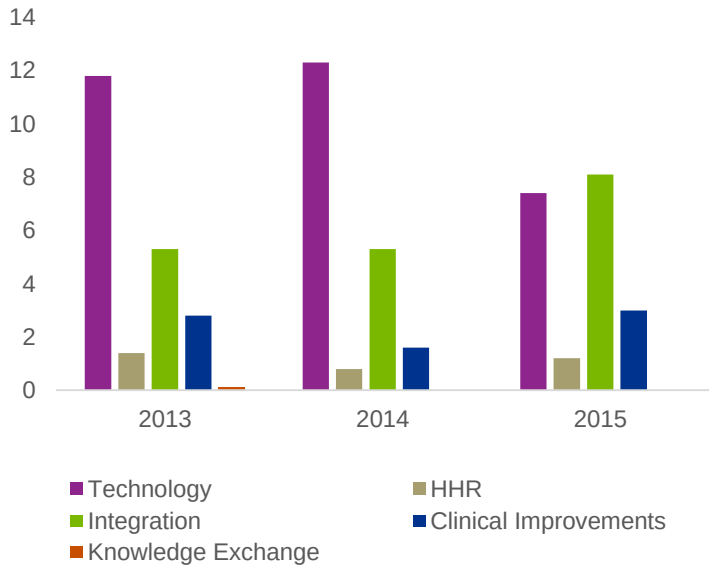
- Technology initiatives (161 projects, $31.5 million);
- Integration, collaboration and care coordination (138 projects, $18.7 million); and
- Clinical improvement and standards (35 projects, $7.4 million).

The significance of these three categories is consistent across all of the participating LHINs, with the Central East LHIN and North East LHIN having the highest number of projects involving integration, collaboration and care coordination.

Number of Projects Funded



Project Funding (in millions of dollars)



Overview of the Transformation Fund

2012-2013 Projects[15] (Funding in thousands)	Technology		Health and Human Resources Training		Integration, Collaboration and Care Coordination		Clinical Improvement and Standards		Knowledge Exchange and Translation		Total	
	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding
Waterloo Wellington	1	$84	1	$119	2	$200					4	$403
South East	9	$639	1	$125							10	$764
Central East					26	$1,022					26	$1,022
North West	2	$140	2	$451	8	$2,787			1	$55	13	$3,433
Champlain	1	$2,753	1	$200	2	$285	2	$550			6	$3,788
North East	21	$3,559	4	$424	9	$828	3	$365	1	$50	38	$5,226
South West	8	$4,639	4	$130	1	$167	2	$1,920			15	$6,856
Total	42	$11,814	13	$1,449	48	$5,289	7	$2,835	2	$105	112	$21,492

2013-2014 Projects[15] (Funding in thousands)	Technology		Health and Human Resources Training		Integration, Collaboration and Care Coordination		Clinical Improvement and Standards		Knowledge Exchange and Translation		Total	
	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding
Waterloo Wellington	2	$161	1	$265			1	$50			4	$476
South East	13	$956	2	$167	3	$100	1	$65			19	$1,288
Central East	4	$413	1	$112	2	$175			1	$10	8	$710
North West	3	$857	1	$27	2	$2,729	1	$142	1	$15	7	$3,623
Champlain	1	$2,970	1		2	$125	2	$138			6	$3,233
North East	41	$3,378	1	$200	38	$2,155			1	$10	63	$5,743
South West	15	$3,525					3	$1,242	1	$10	19	$4,777
Total	79	$12,260	7	$771	47	$5,284	8	$1,637	4	$45	145	$19,997

[10] Source – Information provided by participating LHINs.

Overview of the Transformation Fund

Current year activities

A total of $20 million in funding has been approved for projects during the 2014-2015 fiscal year by the seven participating LHINs. As noted below, projects approved for the 2015 fiscal year follow the traditional focus on technology, integration and clinical improvement.

2014-2015 Projects[16] (Funding in thousands)	Technology		Health and Human Resources Training		Integration, Collaboration and Care Coordination		Clinical Improvement and Standards		Knowledge Exchange and Translation		Total	
	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding	Projects	Funding
Waterloo Wellington	1	$10	2	$315	1	$151					4	$476
South East	7	$635	3	$197	5	$198	4	$258			19	$1,288
Central East					12	$720					12	$720
North West	2	$504	1	$160	6	$2,198	2	$912			11	$3,774
Champlain	1	$1,934	1	$50	2	$1,120	1	$120	1	$10	6	$3,234
North East	24	$1,860	2	$90	16	$2,735	10	$821			52	$5,506
South West	6	$2,500	2	$380	1	$1,000	3	$860			12	$4,740
Total	41	$7,443	11	$1,192	43	$8,122	20	$2,971	1	$10	116	$19,738

Individual project descriptions

We have included as appendices to our report details relating to individual Transformation Fund projects, as follows:

- Appendix B provides a listing of projects undertaken during the 2012-2013 fiscal year
- Appendix C provides a listing of projects undertaken during the 2013-2014 fiscal year
- Appendix D provides a listing of projects approved during the 2014-2015 fiscal year
- Appendix E includes case studies involving individual projects that are intended to facilitate knowledge transfer among small and rural hospitals.

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REVIEW OF THE SMALL AND RURAL HOSPITAL TRANSFORMATION FUND

Observations and Items for Consideration

Observations and Items for Consideration

Based on the results of our review, we make the following comments and observations concerning the Transformation Fund.

1. Outcomes and achievements of objectives

The draft logic model has identified a number of intended outcomes from the Transformation Fund, which are intended to fulfill short and long-term objectives for the enhancement of access, integration and transitions, quality and safety.

As documented in Appendices B and C, our review of available documentation relating to the projects undertaken through the Transformation Fund in the 2013 and 2014 fiscal years indicates that the ***intent*** of the projects appears to be consistent with the outcomes and objectives identified in the Transformation Fund logic model, recognizing that a number or projects are "early stage" and as such, a clear attainment of the intended objectives cannot be determined at this time. Other projects, particularly those involving technology and training, appear to demonstrate the achievement of intended outcomes (which the logic model identifies as a precursor to the achievement of objectives). We do note, however, that for certain projects, it appears that the desired mid to long-term outcomes have already been achieved. For example:

- The Champlain LHIN has indicated that the Home First project, initiated in the 2012-2013 fiscal year, has contributed towards decreases in ALC rates of between 40% to 83% for four of the eight participating hospitals from December 2012 to December 2013[17]. During the same period, 86% of patients discharged with enhanced services are still at home 90 days post-discharge, achieving the Transformation Fund's outcome of decreased rate of hospital readmission within 30 days[17].

As discussed later in our report, our analysis of projects undertaken through the Transformation Fund was influenced by the extent of available documentation relating to the projects, which varied considerably. In certain instances, our conclusions reflect the intended outcomes of projects as they are based on proposals and other planning documents as opposed to documents outlining actual results. In order to facilitate future evaluations, the Ministry and participating LHINs may wish to consider establishing a formal reporting mechanism for project outcomes and achievements.

Observations and Items for Consideration

Based on the results of our review, we make the following comments and observations concerning the Transformation Fund.

2. Logic model considerations

Given the draft nature of the logic model for the Transformation Fund (see page 15), the Ministry and participating LHINs may wish to consider the following revisions:

- **Aggregation of activities and outputs** – We note that the draft logic model contains very specific activities with respect to the Transformation Fund, such as the naming of specific integration projects (e.g. Community Health Services Integration – Haliburton, Englehart and District Integrated Health Care Program) or specific training activities (e.g. LEAN training and support). Given that the intended role of the Transformation Fund is to support these types of broad activities across the seven participating LHINS, consideration could be given to presenting more generalized inputs and activities that allow Transformation Fund participants additional latitude as to how the intended outcomes are achieved.
- **Revise logic model for knowledge exchange and translation** – We note that the input and activities listed under knowledge exchange and translation are the same as the outputs. Given that activities under this category should describe how the knowledge is assembled rather than the end presentation materials, consideration could be given to revising the wording surrounding knowledge exchange and translation. We also note that the mid to long-term outcome for knowledge exchange and translation is the adoption of best practices and critical success factors by small and rural hospitals and the participating LHINS. In our experience, there is a considerable span between best practice identification and best practice adoption and as such, consideration could be given to intermediate steps such as generating awareness and buy-in.
- **Aggregation of outcomes and alignment with other programs focused on small and rural hospitals** – Consistent with our comments concerning activities and outputs, we note that the draft logic model outlines a number of specific outcomes In addition, we note that the achievement of certain objectives may be influenced by other Provincial initiatives directed towards small and rural hospitals, including Health Links and Health Hubs.

  In order to facilitate future evaluations of the Transformation Fund, as well reflect the potential for other initiatives to contribute towards the attainment of the outcomes, consideration could be given to revising the logic model by (i) aggregating outcomes into less specific categories, so as to allow for a less prescriptive approach to determining the benefits and outcomes of the Transformation Fund; (ii) aligning outcomes with future initiatives focused on small and rural hospitals. We note that the draft logic model has outcomes that are consistent with Health Links but as future initiatives are introduced (e.g. Health Hubs), the addition of new outcomes should be considered.

Notwithstanding the potential for the aggregation of activities, outputs and outcomes, individual projects should have specific performance indicators established by the LHIN and participating hospitals that align with the broader categories identified in the logic model. For example, a project involving a regional pharmacy initiative could have more specific performance indicators such as (i) a reduced number of adverse drug events (consistent with the broader outcome of enhanced patient safety); and (ii) operating cost reductions of $x (consistent with the broader outcome of reducing the average cost of delivering health services to patients)

We have included on the following page a potential logic model that reflects the comments noted above.

Observations and Items for Consideration

Objectives of the $20M Transformation Fund for Small and Rural Hospitals

1) Demonstrate progress on moving forward with the Province's Action Plan for Health Care
2) Complement goals and objectives of Health Links (coordinated care)
3) Enhance operational sustainability within existing resources
4) Strengthen the linkages between small and rural hospital care and community care so that they operate as integrated networks

	Technology	Health Human Resources and Training	Integration, Collaboration and Care Coordination	Clinical Improvement and Standards	Knowledge Exchange and Translation
Inputs and activities	• Support the implementation of technologies and/or the development and deployment of new tools intended to facilitate enhanced integration, collaboration and clinical improvements and standards	• Undertake training and develop programs to enhance patient safety and/or clinical and non-clinical effectiveness and efficiency	• Build capacity within small and rural hospitals for integration, collaboration and care coordination • Establish working groups for the identification and implementation of coordination opportunities	• Identify and implement opportunities for enhanced clinical care and patient safety	• Identify, appraise and validate best practices and innovative approaches to transformation • Establish and operate information dissemination mechanisms
Outputs	• No. of EMRs created • No. of online consultations • No. of organizations upgraded with common IT platforms • No. of hospitals upgraded on the HIMSS Analytics EMRAM	• No. of training programs completed	• No. and degree of integration and collaboration projects undertaken	• No. of clinical and patient safety initiatives undertaken	• Web presence • Comprehensive reports • Presentations (in person and webinars) • Pan LHIN KTE events

Outcomes

- Reduce the time from primary care referral to specialist consultation
- Reduce the number of 30-day re-admissions to hospital
- Reduce the number of avoidable ED visits for patients with conditions best managed elsewhere
- Reduce time from referral to home care visit
- Reduce unnecessary hospital admissions
- Reduce hospital ALC rate
- Enhance the hospital patient experience
- Enhance patient safety measures
- Reduce the average cost of delivering health services to patients
- Contribute towards the attainment of priorities identified in LHIN strategic plans

Observations and Items for Consideration

3. Documentation and performance measurement

In its funding letter to participating LHINs, the Ministry has identified specific documentation requirements intended to support knowledge transfer and exchange activities, including:

- **A visible, publicly-accessible web presence** - Based on a review of LHIN websites, we note that all seven participating LHINs have published information relating to the Transformation Fund, although the level of detail will vary by LHIN.
- **An inventory of projects submitted and funded** - All participating LHINs provided KPMG with summaries of projects funded for each of the 2013, 2014 and 2015 fiscal years.
- **One or more in-person live sessions** - The *Small Hospital Knowledge Transfer Web Conference*, which included presentations by all participating LHINs was held on March 25, 2014. In addition, there is evidence that participating LHINs have conducted knowledge sharing sessions within their small and local hospitals. For example, the NE LHIN had presented at the ONA Northeast Annual Conference in April 2013, while the Champlain LHIN presented to the Champlain Alliance of Small Hospitals in 2014.

In addition to these requirements, the funding letters also stipulate that the participating LHINs "*shall establish performance expectations for projects, monitor progress on these, and develop an action plan for addressing projects that are not progressing as planned*."

During the course of our review, we noted significant variations in the level of documentation maintained by the participating LHINs with respect to projects undertaken through the Transformation Fund, with no consistent format project reporting across the LHINs, including interim status reports and close-out reports. This variation in documentation is also noted within individual LHINs, with some projects having more documentation than others. Based on discussions with the participating LHINs, the absence of documentation for Transformation Fund projects was attributed to a number of factors including (i) staff turnover; (ii) insufficient resources and competing priorities within both the LHINs and the small and rural hospitals receiving the funding; and, (iii) the absence of a defined and standardized documentation format for projects.

In order to facilitate future evaluations of the Transformation Fund and enhance the degree of knowledge transfer and exchange, the Ministry and/or participating LHINs may wish to consider establishing a standard reporting template for projects that captures all necessary information at the various stages of projects, including planned milestones, expected outcomes and project progress. In addition, consideration may also be given to establishing a central repository of presentations and reports relating to Transformation Fund activities that can be accessed by all participating LHINs as well as small and rural hospitals.

In terms of reporting frequency, consideration could be given to requiring annual financial reporting by hospitals to their respective LHINs (and by LHINs to the Ministry), consistent with other programs such as HRIF, and with a deadline of May 31st in the following fiscal year. In addition to an annual reporting requirement, interim reports could be required no later than December 31st of the fiscal year in question so as to allow sufficient time to determine whether in-year funding reallocations and/or carryforwards to subsequent years are required.

Observations and Items for Consideration

Project identification and selection

Based on our discussions with the participating LHINs, we understand that the identification and selection of initiatives varied from LHIN to LHIN. In certain instances, LHINs spent an initial period of time establishing a working group comprised of small and rural hospitals, the purpose of which was to:

- Identify strategic priorities to be addressed through the projects, with the focus on enhanced collaboration and sustainability
- Assess resource requirements, including the need for project management capabilities
- Achieve buy-in and commitment from the participating small and rural hospitals
- Develop a linkage between small and large hospitals, recognizing that in certain instances collaboration would necessarily require the participating of larger hospitals

Examples of working groups established in support of the Transformation Fund include the Health Alliance (North West LHIN) and Champlain Alliance of Small Hospitals (Champlain LHIN).

Based our discussions with participating LHINs, consideration could be given to the adoption of a more structured approach to project identification and prioritization through the use of small and rural hospital steering committees, which would allow for the development of an appropriate oversight and governance model for collaborative projects, enhanced buy-in and commitment and facilitate the implementation of multi-year projects (which could address issues relating to the timeliness of funding announcements by pre-selecting projects for support). In order to avoid potential conflicts of interest for the small and rural hospitals involved in the committees, as well as to resolve instances where requests for funding conflict or exceed the amount of available funding, we suggest that the LHINs retain final approval for all funding allocations.

End Notes

1. The NELHIN is acting as the contracting agency on behalf of the seven LHINs participating in the Small and Rural Hospital Transformation Fund.
2. Ministry of Health and Long-term Care.
3. Healthcare Indicator Toolkit.
4. Ministry of Finance population projections.
5. Our review included an analysis of total MLPA funding for small and rural hospitals for the fiscal years 2010 t0 2014, based on information reported in the Allocation, Payment and Transfer System (APTS). For the purposes of our review, we have excluded Weeneebayko Area Health Authority as it transitioned from a Federal Hospital to a Provincial Hospital during this period. On average, MLPA funding for the remaining 50 small and rural hospitals increased by 3.2% annually during this period, with the median funding increase being 2.6% per year. The highest reported funding increases were for Kemptville District Hospital (17.1% per year), Sioux Lookout Meno-Ya-Win Health Centre (12.7% per year) and Blind River District Health Centre (10.0% per year), with the lowest reported funding increases reported by Renfrew Victoria Hospital (decrease in MLPA funding from $25.5 million in 2010 to $21.1 million in 2014) and South Bruce Grey Health Centre, Clinton Public Hospital and Hanover & District Hospital, each of which experienced an average annual funding increase of 1% per year from 2010 to 2014.
6. Health Indicator Toolkit.
7. Total margin is defined as revenues less expenditures for all fund types.
8. Health Indicator Toolkit.
9. Ministry of Health and Long-term Care.
10. For the purposes of our report, we have presented FCAP scores by group (A,B,C), with Group C hospitals (representing hospitals with less than 100 beds) considered to be the proxy for small and rural hospitals. Additionally, we have only considered Group C hospitals located within the seven LHINs that participate in the Transformation Fund.
11. Participating LHINs.
12. Documentation provided by the participating LHINs indicates that in a number of cases, individual projects involved multiple hospitals and other community care providers. As a result, the number of participating hospitals and other organizations is higher than the number of individual projects. Additional information concerning partnerships supported by the Transformation Fund can be found in the appendices.
13. In certain instances, projects have been funded through a phased approach with each individual phase identified as a separate project.
14. KPMG analysis of information provided by the participating LHINs.
15. KPMG analysis of information provided by the participating LHINs. Additional details concerning projects can be found in Appendix B (2012-2013 fiscal year) and Appendix C (2013-2014 fiscal year).
16. KPMG analysis of information provided by the participating LHINs. Additional details concerning projects can be found in Appendix C.
17. *Home First Rural Champlain Hospitals Project Overview*, March 20, 2014

cutting through complexity

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