

Third Party Validation Report

Final Report

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2018/19 Health Sciences North (HSN)

Balanced Budget Plan

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I. Executive Summary

In response to a request from the North East LHIN (LHIN), a third party review team (the “Team” or “Review Team”) was assembled in May 2018 to validate the 2018/19 Health Sciences North (HSN) balanced budget plan (BBP).

HSN had completed a thorough balanced budget plan. The Team reviewed this plan as well as all other available documentation. This other information included the Ministry of Health and Long-Term Care (MOHLTC) Hospital Information Tool (HIT) tool and the Ontario Cost Distribution Model (OCDM), as well as analysis from the North East LHIN. We have analyzed documentation provided by both HSN and the North East LHIN. We have also held interviews with key leaders both inside HSN, and across the larger health system community in the North East LHIN.

The HSN budget plan for 2018/19 will not achieve a balance at the bottom line, or Generally Accepted Accounting Principles (GAAP) balance, but the plan is to reduce the run-rate down to a \$4.9M deficit in 2018/19, and then achieve a balanced position by 2019/20. We have only reviewed proposed plans for 2018/19. Based on our review, it is clear that HSN is taking a much more rigorous internal approach to its budgeting process than it has in recent years, aiming for a balanced position after 2 years. In addition, not only was the internal process rigorous, but the budget process and the proposed outcomes received not unanimous, but considerable support from HSN staff, doctors, unions and the Board.

The Review Team also assessed HSN’s engagement of health system partners in the development of its budget. We found that there are different perspectives as to the thoroughness of this consultation and information-sharing, but we believe that HSN needs to do a better job in engaging partners and the North East LHIN in the development of its budget, so that strategies are developed in partnership with and giving consideration to the impact on the health system.

We found that HSN is performing well on key benchmarking metrics such as cost per case where their costs are at what the government model projects. Not all departments were benchmarking well, and HSN is targeting many improvements in this budget exercise. We have identified a few other opportunities. Being efficient is commendable, however it also means that there are few opportunities for financial improvement, without innovative approaches.

The Team has provided recommendations to the LHIN regarding our observations and the proposed program and service changes. We feel some of the program and service changes proposed by HSN should be supported. We also feel that other program and service changes should be rejected or modified. In some cases, we have recommended that the LHIN provide HSN with additional funding to allow other options to be explored for some of these programs and services.

All 23 recommendations and 31 actions are accompanied by the appropriate background rationale, justification and timeline.

HSN has significant debt and working capital problems, which will make it very challenging for HSN to return to a sustainable path forward. This shortfall is despite HSN having received funding from the provincial government to reduce its negative working capital position, which they almost did in 2016/17. HSN has now not fulfilled its obligations to the province, which is concerning, but today we do not see a simple path to address working capital without a fulsome review of HSN's financial resources positioned against the demand that HSN faces as the leading acute referral centre in northeastern Ontario.

During the course of this review, we received confirmation that additional funding has been made available to the North East LHIN by the ministry. This funding influenced our recommendations. As noted earlier, several of our recommendations are that the LHIN should fund some of the programs and services that were originally intended to be cut, even if one-time to allow for time to explore options this fiscal year.

Appendix A contains a complete listing of all of our 23 recommendations and 31 actions.

II. Methodology and Approach

Overview

Over the course of 5 weeks, the Team reviewed the 2018/19 HSN balanced budget plan (BBP), including an analysis of the process used by the HSN Board of Directors and Leadership Team to develop the budget.

This review was designed to provide the North East LHIN with an assessment of:

- The steps and actions and financial rigor that were undertaken by HSN to complete the BBP (Section III, A);
- Engagement of community partners and the LHIN by HSN in the development of the BBP (Section IV, A);
- The Balanced Budget Clinical Reductions (Section IV, B, C & D)
 - Assess the hospital and health system impact that may result from the implementation;
 - Determine if the changes should be supported, rejected or reconsidered;
 - Consider options or alternatives to the suggested program and service changes to minimize the negative impact to the broader health care system;
- Opportunities for further improvement:
 - Clinical Services, Medical Programs and Services as an outcome of the BBP assessment (Section V);
 - Non clinical functions (Section VI) as an outcome of the BBP assessment;
- Risks (Section VII);
- HSN's 2018/19 budget, and a projected forecast for year-end and recommended funding (Section VIII).

The original project scope of the review is attached as Appendix E. Staying within the boundaries of the project scope meant that a clinical review of programs and services was not completed. However, in the course of our review, we did encounter clinical programs and medical services operating in a manner that are negatively impacting HSN's financial position, and we question whether it is the highest level of care for patients. In these circumstances, we have only made recommendations where patient flow and efficiency can be improved. We expect patient care to benefit, but we recommend that HSN develop a culture of bringing in the appropriate clinical expertise to examine these issues.

In addition, based on the short time frame for the budget review, we know that there are areas which will require additional review and analysis following the completion of the Team's work. These areas are noted throughout the report and within the recommendations.

Approach

The Team reviewed all documentation prepared by HSN in the development of its budget and conducted interviews with a number of key stakeholders (please refer to *Appendix C* for a listing of stakeholder interviews). These interviews included:

- HSN Board of Directors;
- Key leaders and staff at HSN;
- HSN staff union leadership;
- HSN medical staff leadership;
- Key leaders of health service providers in the Sudbury and the North East LHIN region;
- Key leaders and staff at the North East LHIN.

Key Tasks Completed

The HSN CEO provided the team with a “HSN Budget Process” binder which included 16 documents in chronological order which helped provide background and context to the budget development process. The majority of these documents are listed in *Appendix D*. The Team reviewed the documents to gain a detailed understanding of the efforts conducted by HSN in order to produce a budget that met the Board’s 13 budget parameters and ensured the changes to programs and services limited the impact on patient care. These documents also included a 16-point financial action plan that was presented to the HSN Board by its CEO in March 2018

The Team obtained “Schedule 2” which provided a detailed financial statement of the prior year actual results for each line item, the 18/19 budgeted amount and the planned savings. The rationale for the savings and their impact on patient care, operations and the community was evaluated.

The Senior Vice President, Patient Experience and Digital Transformation provided the Team with a listing of 145 initiatives that management had considered and evaluated in determining the ultimate budget plan. The Team reviewed each of the initiatives. Our focus was to assess achievability and to identify the reduction initiatives with the most significant perceived impact on patients.

At the request of the LHIN, HSN also produced a document called the “Pressures Relief Package” which identified the most important services to maintain if the LHIN provided funding. This list of 22 cost saving initiatives include some which have already been implemented/reduced.

We also reviewed analysis the LHIN had prepared, as well as functional centre benchmarking data that HSN created from provincial hospital MIS trial balance data provided by the LHIN. This data was important to HSN in identifying functional areas where the hospital was overspending relative to their peers.

Where the benchmarking demonstrated that HSN is above the 50th percentile, further evaluation was performed. The Team obtained the department review Question and Answer documents that had been created for each department as part of the review

process. The Team reviewed budget strategies that are already or are proposed to be implemented, as well as potential cost savings that had been identified but chosen not to be implemented by Senior Leadership. In addition, risks that were identified by budget owners relating to potential cost savings that the Hospital chose to tolerate or mitigate were discussed with Senior Leadership.

The Team evaluated the possibility of re-creating the benchmarking post budget plan implementation, however, this re-creation was not possible. The benchmarking analysis system requires a full trial balance to be uploaded and would have required a significant amount of work for HSN to complete to produce a “potential future trial balance”. It was agreed with HSN that the amount of work required would not produce a sufficient benefit for our review, or for the hospital.

HSN provided the Team with all their analysis of the HBAM funding, Health Based Allocation Model (HBAM) Inpatient Grouping (HIG) case costing, and Quality Based Procedures (QBP) case costing documents enabling us to verify and assess impacts and opportunities. These were not all directly used in the budget development process however this demonstrated a level of diligence implemented by HSN regarding data analysis and decision making.

Outcomes of the Team’s analysis are described throughout the remaining sections of this report.

North East LHIN New System Funding Received

During the course of the Review Team’s work, we learned that the North East LHIN had received two significant injections of funding from the ministry which could enable the LHIN to work with HSN to balance its budget, minimizing the impact of any proposed program and service changes.

The LHIN received approximately \$3M in base funding from the ministry as part of a provincial package of \$40M in one-time funding for “hospitals pressures”. The LHIN also received approximately \$12M in base-funding for home and community care services, of which 75% of this amount (\$9M) is for direct home and community care services provided by the LHIN. This funding impacted the Review Team’s recommendations.

III. HSN Budget Review

The Review Team was presented with an organization facing considerable financial challenges that are impeding the successful operation of the hospital and making it very challenging to manage its debt and make new capital investments. However, in our review, we saw an organization that is beginning to take significant steps, and we believe the right steps, to address these challenges and balance its budget.

Although we saw an organization with a history of financial challenges, including the appointment of a Peer Reviewer in 2012, HSN has in recent months been applying considerable internal rigour and structure to its budgeting process, a rigour and structure that did not exist in previous years.

In our interviews with HSN leadership, we heard frequently that HSN is different. We heard that it is different due to its role as the sole teaching hospital in northeastern Ontario, the provider of a wide array of programs and services which are unique in the region, and challenges that differ from those facing large, teaching hospitals in Southern Ontario. We recognize the unique role that HSN plays in northern Ontario and would encourage HSN to continue to work with the LHIN to utilize data, benchmarking and comparator information in bringing attention to its unique position in the provincial context.

Finally, we need to note that this current balanced budget plan was developed by HSN in a very short window of time - from October 2017 to March 2018. There will be challenges and risks in implementation with community impacts and factors that have not yet shown themselves. Therefore, we have attempted to focus our assessment on the implications of the highest risk initiatives for both the community and HSN.

A. Overview of the HSN 2018/19 budget

The HSN approved 2018/19 budget which includes the following highlights:

- Increase in Fund 2 Community / Mental Health (Other Vote) funding and spending of \$9.959 M
- Increase in Acute Care, Cancer and Nephrology spending of \$3.155M,
- \$11.2 M in reductions, including \$8.432 M already reduced in Support and Clinical Support departments.
- Resulting in a \$4.890M deficit,

Budget Area Increases and Decreases

Within HSN's 2018/19 approved budget, programming is separated into four broad areas: Acute Care, Cancer and Nephrology; Other Clinical Areas and Health Promotion; Clinical Support; and Support. Within these areas, there are 31 programs

in total. A comparison of 2017/18 actuals to 2018/19 approved budget showed the following:

Table 1 - Programming Budget				
Area	No. Programs	Expenditure Reduction No.	Expenditure Increase No.	Net Amount
Acute care, Cancer and Nephrology (Table 2)	7	3	4	\$3.155M
Other Clinical Areas and Health Promotion (Table 3)	4	2	2	\$0.096M
Clinical Support (Table 4)	7	4	3	(\$1.104M)
Support (Table 5)	13	12	1	(\$7.328M)
Total	31	21	10	(\$5.181M)

This analysis clearly highlights the bias towards support cuts over clinical cuts as Clinical Programming costs were budgeted to increase \$3.155M and support areas planned to incur \$8.432M in reductions.

A summary of the net savings and investments of budget changes by Clinical area is below:

Table 2 - Programming Budget Detailed	
Program	Change Year over Year
Surgical	(\$679,630)
Medicine	\$1,082,088
Critical and Emergency Care	\$1,200,939
Cancer Centre	(\$564,537)
Nephrology	\$(680)
Cardiac Outpatient Centre	\$277,089
Quality Based Procedures and Priority Program Funding	\$1,840,000
Total	\$3,155,269

The table below depicts the net savings and investments in Other Clinical Areas, Health Promotion.

Table 3 - Other Clinical Areas, Health Promotion Budget Detailed	
Program	Change Year over Year
Community Care and Rehabilitation	\$757,149
Mental Health and Addictions	\$293,976
NEO Kids and Family	(\$395,812)
Senior Care Transitions	(\$559,292)
Total	\$96,021

The table below depicts the net savings and investments in Clinical Support Areas.

Table 4 - Clinical Support Budget Detailed	
Program	Change Year over Year
Pharmacy	(\$740,346)
Medical Imaging	\$375,132
Laboratory	(\$718,628)
Nursing Administration	\$568
Genetic Counselling, Medicine Lodge	\$18,143
Breast Screening	(\$27,456)
Ethics, Spiritual and Religious Care	(\$12,333)
Total	(\$1,104,921)

The next table below depicts the reductions in non-clinical support areas. These HAVE already been implemented:

Table 5	
Non-clinical Support Areas	Savings
Support Services	\$1,006,000
Information Technology	\$604,000
Facilities Management	\$854,000
Corporate Support Services, Material Management	\$3,000
Medical and Academic Affairs	\$455,000
People Relations and Safety	\$524,000
Decision Support, Health Information Systems	\$238,000
Administration	\$206,000
Finance	\$309,000
Research	\$1,393,000
Organizational Excellence & Patient Relations (Quality & Patient Safety)	\$944,000
Marketed Parking and Rent Activities	\$727,000
Communications and Community Engagement	\$66,000
	\$7,328,000

Remaining budget strategies

Following is a summary of what has been implemented, and what is proposed, less what we are proposing that the LHIN invest in.

	Already Implemented	Proposed Clinical Reductions	Proposed LHIN Investment	Net Reductions to Occur
People	50	106	35	71

A. Evaluation of HSN Budget Development Process

The Budget Process

In order to obtain an understanding of the HSN budgeting process and evaluate whether an appropriate approach was taken in its development, the Review Team met a number of times with key HSN budget owners including the HSN CEO and senior leadership team, as well as members of the finance and decision-support teams at HSN.

On June 15th, 2017, HSN released its 2016/17 financial statements showing a \$7.12M deficit (1.54% of \$462.35M revenue). This deficit was a significant trigger for the HSN Board and leadership team as under its Hospital Service Accountability Agreement (H-SAA) with the North East LHIN, HSN is required to balance each year.

Based on our assessment, we believe that the deficit was generated in part, because of a decision made by the former HSN CEO in April 2016, to adopt a 36-month “rolling forecast methodology” to replace the traditional April to March fiscal year budgeting approach. The Board has advised us that they did not really like this but did not stop it. Other factors contributed to the deficit, including changing the accounting for research funding, restructuring and increased occupancy.

A rolling forecast can be a good financial planning and analysis tool but is not an effective tool to understand the organization’s year-end position, which is critically important for both hospital budgets and LHIN reporting, which operate on a fiscal year from April to March. We believe that the rolling forecast created the need for year-end injections of one-time funding in order to improve the year-end position of HSN.

We believe that the Board of Directors bears a certain amount of responsibility for allowing the change to a rolling forecast to be made without sufficient oversight to both ensure its success and be in a position to accurately forecast a year-end position.

On October 2nd, 2017, a new CEO was hired by the Board. He was presented with a deficit of \$5.3M for the first five months of the fiscal year. On October 6th, 2017 he made the decision to revert to a traditional April to March budget methodology and asked the Chief Financial Officer (CFO) at the time to develop such a budget for the remainder of the 2017/18 fiscal year.

In November 2017, the CEO worked with the Board to develop 11 budget parameters which HSN’s Board reviewed and added an additional 2 parameters. The 13 parameters approved by the Board included “the recommended 2018/19 budget shall be balanced, unless the CEO is of the view that a modest deficit no greater than 1% of total revenue is necessary and/or appropriate, with a plan to restore a balanced budget no later than 2020/21”.

In November and December 2017, the Chief Nursing Executive completed several budget meetings with the clinical program leaders where opportunities for financial improvements were identified based on benchmarking. In January 2018, the Chief

Operating Officer instituted a budget committee including six Vice Presidents and Associate Vice Presidents, the Chief Information Officer (CIO), the Directors of Finance, Decision Support, Material Management, and Human Resources, six accountants and a Human Resources Advisor.

The purpose of the budget committee was to develop and manage HSN's annual budget process in accordance with Board approved budget parameters. It met on six occasions between late January and mid-February 2018 to recommend a 2018/19 budget within the budget parameters to the Senior Leadership Committee and CEO.

The CEO identified four main areas of concern with the presented budget:

- a proposed reduction of 300 surgery blocks;
- an assumption that one-time severance costs would be funded by the ministry/LHIN;
- a very ambitious reduction in sick and overtime costs without adequate contingency; and
- proposed bed closures.

It was determined that detailed departmental reviews were required to identify alternate/additional saving opportunities.

In March 2018, 22 departmental reviews were held involving most members of the Senior Leadership Committee, the Finance Director and two accountants. Ten questions were sent to each Director. The CEO chaired each review.

We reviewed the outcomes of these reviews to identify if inconsistencies between what the departments raised existed compared to the actual proposed savings. The strategies identified by departments were consistent with proposed savings which demonstrates that the proposed savings were determined based on a sound approach.

On March 8th, 2018 the CEO consulted the Chief System Planning and Performance Officer at the Ontario Hospitals Association to validate provincial funding, collective bargaining and pay equity assumptions.

On March 14th, 2018 the Senior Leadership Committee held four budget consultations with the Medical Advisory Committee, the Patient and Family Advisory Council, the Fiscal Advisory Committee and Directors.

Throughout March 2018, the Senior Leadership Committee spent many hours on several occasions deliberating and subsequently finalizing the recommended budget. The recommended budget showed a \$4.901M deficit (1% of \$479.22M). This budget was made possible by significant proposed reductions in several areas but also investment in other areas.

Functional Centre Benchmarking

One of the methods for determining the areas where savings opportunities existed and reductions were necessary was through engagement of the Decision Support staff and utilizing their benchmarking data and insights. HSN's decision support department obtains the MIS Trial Balance data for all hospitals across the province from the North

East LHIN Director Hospital Sector, between 3-4 months after it has been submitted to the ministry. The HSN Director Decision Support has developed a database where this data can be stored and an interface that allows for efficient and effective benchmarking exercises.

The Team was provided with benchmarking for 70 functional centres, which accounts for all the Fund Type 1 hospital activity. Due to the varied nature of how hospitals account for certain expenses, HSN removes “Medical Staff Remuneration” and “Equipment Expenses” from their benchmarking. For each functional centre, HSN may have selected different hospitals to benchmark against depending on their suitability for comparison to HSN. For example, for “General Administration” HSN benchmarks against 17 hospitals, for “Staff Recruitment and Retention” HSN only benchmarks against five other hospitals.

HSN used this benchmarking to identify functional centres where opportunities for cost reductions existed, particularly areas where costs were higher than the 50th percentile. HSN presented these figures internally showing the required savings to reduce HSN’s costs per functional centre down to the 50th percentile. In many areas, it was identified that HSN’s costs were lower than the 50th percentile, however, costs were still reduced in some of these areas.

HSN prioritized the functional centres where costs could be reduced quickly without impacting patient care. Laundry, for example, was a functional centre that benchmarked very poorly, primarily due to process issues. Specifically, staff placed laundry in cupboards in individual patient rooms. Laundry will now be placed in one location within wards thus significantly reducing these transportation costs.

Diagnostic Cardiology was a functional centre which also benchmarked poorly. Changes to reduce costs in 2018/19 by \$232,500 have been proposed to this functional centre, however, this will not reduce costs to the 50th percentile. HSN states that in order to ensure cost reductions occur in a manner that will not impact patient care, strategic planning is required surrounding Diagnostic Cardiology prior to further cuts.

We found that one of the limitations of functional centre benchmarking is that HSN’s budget is never created or presented in the same format. There are over 70 separate budgets that roll up into the annual budget. It is therefore very challenging for HSN to accurately identify the effects their proposed cuts have on benchmarking until they have been made and the financial data has borne out. Management should ensure that when provincial hospital data is made available that they complete this benchmarking.

HIG Case Costing Benchmarking

Using Case Cost data for Ontario Hospitals obtained from the ministry, HSN’s Decision Support group has developed a benchmarking interface for HIG weighted cases. They are able to compare direct costs, indirect costs, cost per case, length of stays (LOS) and resource intensity weightings (RIW) from any hospital in the province that completes the procedures. Similar to the above functional centre benchmarking, HSN is benchmarking case costs using hospitals that are similar to themselves. They can

use other hospitals for benchmarking to identify potential trends, for example, that economies of scale drive down cost per HIG weighted cases.

Quality Based Procedures (QBP) Case Costing

HSN uses a manual spreadsheet to compare the actual costs related to each QBP to the funding rate. Each QBP has costing and volume data going back to 2014/15 so comparisons can be made, and trends analyzed. HSN uses this data to identify QBPs where the variance between actual cost and funded cost is high and try to reduce costs in these areas. For surgical QBPs in particular, HSN attempts to ensure that they are meeting volume targets.

Any case where actual cost exceeds funding, or volumes exceed funded volumes can result in pressures.

Health Based Allocation Model (HBAM) Funding vs Actuals

HSN has created a manual spreadsheet which compares the HBAM expected funding to the forecast actual costs and volumes for 2018/19 for each of the separate categories (e.g. In-patient and Day Surgery, In-Patient Rehab). This data was not used for benchmarking, but it demonstrates a level of effort performed by HSN to monitor all aspects of the funding and expenses opportunities and risks.

Clinical Savings Determination Process

The Senior Vice President, Patient Experience and Digital Transformation has created a document in order to analyze the benefits and risks of 145 potential saving initiatives that makes up the \$10.8M fiscal year proposed savings within the areas of the hospital which are under his responsibility. The document provides details of the process completed to determine each initiative.

For the majority of savings initiatives, there is a current benchmarking target where such data is available (e.g. currently performing at 75th percentile), or another performance indicator of cost per unit of service. For each of these saving initiatives, there is a target benchmark, typically 50th percentile or better.

Each saving initiative also has a rationale for change (e.g. improving efficiency, staying within funding), number of patients impacted, the risk and impact (e.g. no risk, increased patient wait, shifting work to other areas), risk mitigation, and potential alternative provider. Not all fields have been completed for all savings initiatives.

Overall, it appeared that there was a variance between the diligence applied to the decision making for some of the saving initiatives. For example, in a savings initiative for Forensic Pathology to save \$100,000 is to “constrain forensic pathology to funded costs”. There is no current benchmark or future benchmark. The risk mitigation is described as “*Provide service but ensure HSN's costs are covered. Need to determine*

the service that can be provided staying within the funding of \$400,000". This risk mitigation does not appear to be complete.

On the other hand, within one of the surgical inpatient units, a savings initiative of "change RN to RPN on 7B" to save \$60,000 annually is proposed. Based on a cost per discharge, the surgical inpatient units combined are functioning at the 68th percentile. The risk and impact is low because the hospital is expanding an RN to RPN model of care that already exists elsewhere in the hospital. HSN will use acuity-based staffing model from safer Health Care Now, staff education for RPN scope of practice and three-factor framework. This initiative appears sufficient and is a proven cost reduction model.

Overall, we evaluated these initiatives in detail through review of the departmental submissions and their support, discussions with the Senior Vice President, Patient Experience and Digital Transformation, and evaluation of benchmarking, impact on patients, labour relations, reputation and impacts on other key longer term funding such as the funding model. Specific results of the analysis and recommendations are included in the sections that follow.

Non-Clinical Savings

Most saving initiatives for departments that do not fall under the Senior Vice President, Patient Experience and Digital Transformation, have already been implemented. In order to determine the amount of non-clinical savings, the Team completed a comparison of the 2018/19 budget versus the 2017/18 actuals for the 13 non-clinical support areas which can be seen in Section III, A.

Each line of savings for the non-clinical areas were discussed in detail with the Chief Operating Officer. The rationale for the reductions was evaluated utilizing the benchmarking, and thorough review of support for the changes presented by the COO. Specific results of the analysis and recommendations are included in the Sections that follow.

Overall, we believe that the budget development process undertaken by HSN was very thorough. HSN completed a significant amount of work in a relatively short period to identify suitable strategies in order to meet the expectation of the HSN Board to have a balanced budget. Given the pace of change, there is always a risk of failure, or unintended consequences. Management and the North East LHIN need to closely monitor implementation in order to address these issues. *See Section VII Risks*

IV. Observations and Recommendations

A. Engagement of Other Health Service Providers in Greater Sudbury

Background

Because of its sheer size in terms of programs and services, size of budget, number of staff and physicians, and connections to the Northern School of Medicine (NOSM), HSN dominates the health system landscape in Greater Sudbury and the North East LHIN.

During our review, we found that the domination of the landscape is exacerbated by the fact that HSN also operates some programs that would normally be found in a community setting outside the hospital. The rationale from HSN for taking on these types of programs is that “no one else was providing the service”.

Primary Care

In our interviews, we also heard that the number of primary care physicians serving the Greater Sudbury area is relatively high. Most agreed that since the opening of the Northern Ontario School of Medicine (NOSM) Family Medicine program, the number of primary care physicians working in Greater Sudbury has increased significantly. Based on information provided by the City of Lakes Family Health Team (FHT), there are currently 129 Family Physicians working in Greater Sudbury, with 18 of those physicians working at the FHT.

With a greater complement of primary care physicians, it provides an opportunity for HSN to review their programs and services to determine what programs should and can be divested from the hospital. And as the LHIN takes on more responsibility for primary care, this report has identified opportunities to leverage this primary care capacity.

Clinical Services Planning

From our review, it is clear that a system-wide clinical service planning review would be beneficial. In simple terms, clinical service planning determines where a service should be provided, and which organization should provide the service.

We have observed that there are programs and services at HSN that may be more appropriately delivered in the community or by another hospital. For example, HSN is providing a significant amount of community mental health services that may be more appropriately delivered by an organization like CMHA Sudbury/Manitoulin. In addition, there may be opportunities for better alignment of acute and specialized mental health services with those mental health services provided by North Bay Regional Health Centre (NBRHC).

We also heard frequently from community partners that because HSN is so big, and is responsible for so many programs and services, that they dominate system planning conversations. Some providers welcomed this leadership, while others indicated that their input is not heard.

The City of Lakes Family Health Team (FHT) welcomed the engagement of HSN, especially from an information technology perspective as they partnered to transfer information into the FHT’s electronic medical record (EMR). However, we also heard from the Canadian Mental Health and Association (CMHA) that they are often told what HSN is doing, as opposed to be actively engaged in system planning work. As the largest provider of care in the LHIN, it is imperative that HSN work closely with its system partners to explore opportunities for partnership and collaboration. In March of 2014, the 25 hospitals and the CCAC, in collaboration with the LHIN, conducted a clinical service plan focused on quality based procedures. The plan enabled the system to explore together best practice models for the delivery of QBP services in the North East.

We believe that a similar clinical services planning exercise would assist not only HSN, but all health sector partners in determining what services they should provide. Depending on the scope and size of this review, an exercise of this nature could take several months or years to complete, but it would ultimately provide the blueprint for future service delivery and resource allocation by the LHIN. Working closely with its health system provider partners, the LHIN should take the lead in this work.

Recommendation 1 - Clinical Services Planning				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN continue to take a lead in coordinating multi-sector clinical discussions	HSN CEO	Within 30 days of receiving this report	Health System Providers understand the changes to programs and services which HSN is considering
b)	That a Clinical Services Planning exercise be undertaken for the health services providers across the North East LHIN	North East LHIN CEO	Within 120 days of receiving this report, a scope document be developed which outlines a proposed plan for this work	After consultation with partners, health service providers know where a service should be provided, and which organization should be providing the service

Community Engagement in HSN Budget Development

As part of our review, the North East LHIN asked us to assess whether HSN had adequately engaged community providers in its budgeting process. Our assessment is that HSN should have done more to engage other health service providers during the development of its budget.

As noted earlier, due to the size of the programs and services offered by HSN, even small adjustments in an HSN program can have a significant impact on a community provider or smaller hospital in the LHIN. The HSN CEO was quite active in communicating the process which was being undertaken to balance the budget with local media, HSN staff, physicians and volunteers. Although HSN leadership is active on many community committees, there was minimal engagement with other health organizations about the impacts of budget changes at HSN.

We heard from HSN leadership that it is difficult to engage community providers with significant details on its budget because it was a continual work in progress as different alternatives were explored and debated before a final decision had been made on any program changes. In addition, it is clear that the commitment of staff resources to the budget process inside HSN was significant, and it was “all hands on deck”, leaving little staff capacity for external consultation.

However, there are options available to bring health service providers together to discuss changes to programs and services that may come as a result of an organization’s budgeting process. For example, all health service providers within a sub-region could meet several months in advance of the upcoming fiscal year to discuss possible changes to their programs and services.

In addition, in the risk section, the Team has identified that for areas of clinical service reduction a risk mitigation strategy requires the inclusion of an analysis of system impacts, capacity and consultative planning to support any clinical service reductions.

in our governance review section, the Review Team has provided a recommendation for the LHIN to bring health service provider Boards together to ensure closer alignment in both their strategic planning and budget development.

The engagement of the North East LHIN in the HSN’s budget development is also discussed in the section on Program Changes Requiring LHIN Approval.

Recommendation 2 - Community Engagement in HSN Budget Development			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN and the LHIN develop an engagement strategy to allow health service providers to engage each other in their respective budgeting processes	<p>HSN Senior VP & COO</p> <p>Supported by North East LHIN, VP, Performance and Accountability</p>	Within 120 days of receiving this report	All health service providers are informed of significant changes to programs and services coming as a result of organizational budgeting processes in their region

B. Program Changes Requiring LHIN Approval

Reallocation of Resource

HSN is taking steps to eliminate or reduce several programs and services. In many cases, HSN has already reduced the program/service, and using the savings to assist in balancing the budget. Some strategies clearly identify that community-based services could be substitutes for the hospital-based service. HSN must work with the LHIN to assess the community need and determine if alternative services should be (and can be) provided by another provider (see previous section on clinical services planning). The LHIN would have to work with HSN to balance reallocating the funding to the provider who will be assuming this program, versus HSN achieving budget savings. The LHIN and HSN must be careful to just not transfer services and risk causing PSLRTA (Public Service Labour Relations Transition Act) to be triggered.

In other words, the LHIN needs to confirm if HSN would keep the funding for programs that it is cancelling, or does the LHIN need to fund some other provider?

Service and Program Changes require LHIN Approval

It should be noted that under Section 27 of the Local Health System Integration Act (LHSIA), any health service provider, including a hospital, shall give notice to the LHIN of a proposed integration. It is important to note that the definition of an “integration” is quite broad, and includes starting or ceasing services, or transferring, merging or amalgamating services.

In an organization with the size and complexity of HSN, some threshold must be established so that small service and program changes do not have to be put forward to the LHIN for approval. Without this threshold, it would be difficult for HSN to operate efficiently as it would be continuously looking for LHIN approvals. However, there is no question that significant program and service changes must be reviewed by the LHIN.

Throughout this review, there has been some debate between HSN and the North East LHIN about the amount of information shared by HSN on the proposed changes in its balanced budget plan. We do know that LHIN leadership team members have begun monthly meetings with HSN leadership team members more recently. Regardless, it is clear that the LHIN had expected more detail earlier in the process. So, the Review Team would recommend that HSN should regularly and formally review their pressures and developing strategies with the LHIN, whether at these monthly meetings or at special meetings. The LHIN could go further and establish some type of Memorandum of Understanding between the LHIN and its health service providers that sets out its expectations for the sharing of information involving significant program and service changes.

Recommendation 3 - LHIN Approvals for Program Changes			
Recommendation	Responsibility	Implementation Date	Intended Outcome
a) That HSN take regular steps to share information on proposed program and service changes with the North East LHIN and partners before making final budget decisions	HSN CEO	Immediately and ongoing	The LHIN and other system partners are fully informed of any proposed changes to programs and services at HSN
b) That the North East LHIN develop a memorandum of understanding with providers to set out expectations for sharing of information on proposed changes to programs and services	North East LHIN CEO	Within 90 days of receiving this report	The LHIN and its health service providers understand the expectations for sharing of information on service and program changes

C. Recommendations on the Balanced Budget Plan proposed Clinical Reductions

Overview

With the large amount of work undertaken in the HSN balanced budget process, we wanted to ensure that our recommendations tied back to work which was undertaken by the HSN team. The Review Team made its own assessments as to any opportunities that were not identified. Those are reported on later in this report.

This section reflects our review of programs and the proposed restructuring identified in HSN's proposed budget. It should be noted that based on the time-limitations of this review, it was not possible to fully explore each program and service change, however, the Team evaluated whether HSN has completed the appropriate assessment of each change to justify them in the budget.

The team assessed which strategies appeared to have greater patient impact and performed more significant review there. As part of the budget process, HSN provided the LHIN with a "Pressures Relief Package" document. This package was prepared by HSN in response to a request from the LHIN to provide them with a listing of programs that could be retained by HSN and not cut as part of its budget, should additional funding become available. This document became another source for our review.

The next three sections of this report provide our assessment of;

- This section IV.3. The Team's review of the clinical initiatives and our assessment of which initiatives should be put on hold at this time.
- Section V is our identification of recommendations relating to broader clinical programs and medical services
- Section VI relate to non-clinical observations and recommendations.

Review of the proposed clinical changes - "the Initiatives"

Management completed a thorough review of all possible clinical strategies, whether they be revenue, efficiencies, staff reduction or clinical service reductions in order to help them determine opportunities versus risks of implementation. We reviewed all of this analysis and focused our energy on key proposed savings initiatives which would have the most impact on patient care if they were indeed eliminated from the HSN budget.

Management was very thorough identifying ideas ranging from \$10,000 to \$840,000. Many strategies are about efficiencies in staffing levels and/or supplies, incremental revenue, reducing service levels (which could increase wait-times) and some wholesale clinical service reductions. Reducing some capacity which would extend wait times for Nuclear Medicine for example, while reducing 40 Operating Room blocks would affect patient wait-times. One other initiative that many hospitals have already advanced is closing the Outpatient Lab, sending patients to the community labs.

We reviewed the initiatives in order to determine where best to spend our time- assessing the impact, determining if management could go further, or considering alternatives.

In this Section 3, we discuss strategies that we feel have the most significant impact and should be funded.

1) Service: Diabetes Education (DEC), Pressure: \$280,245

Recommendation: HSN continue to operate this centre and should work with the LHIN to assess needs and identify alternatives. This should be funded by the LHIN, or through other savings identified in this report (see Section G). See our recommendation for LHIN funding for 2018/19 in Section G.

See “Diabetes Education Centre” section and Recommendation 4.

2) Service: Complex Diabetes (CCDC), Initiative: \$275,000

Recommendation: Due to the significance in the region, the Team concludes that HSN should continue to operate this centre and should work with the LHIN to assess needs and identify alternatives. This should be funded by the LHIN, or through other savings identified in this report (see Section G). See our recommendation for LHIN funding for 2018/19 in Section G.

Rationale: The population of the Greater Sudbury area and the North East as a region has disproportionally high diabetes levels in comparison to the rest of the Province.

3) Service: Adult Cystic Fibrosis, Initiative: \$68,000

Recommendation: HSN continue to operate this centre and should work with the LHIN to assess needs and identify alternatives. This should be funded by the LHIN, or through other savings identified in this report (see Section G). See our recommendation for LHIN funding for 2018/19 in Section G.

Rationale: This is a sensitive service within the region, no other programs exist which would be able to support adults with Cystic Fibrosis.

4) Short Term Assessment and Treatment (STAT) - Outpatient Geriatric Rehab, Initiative: \$772,736

Recommendation: HSN continue to operate this centre and should work with the LHIN to assess needs and identify alternatives. This should be funded by the LHIN, or through other savings identified in this report (see Section G). See our recommendation for LHIN funding for 2018/19 in Section G.

See “Short Term Assessment and Treatment (STAT) program” section and Recommendation 5.

- 5) Service: Daffodil Additional Funding Amount (7 Months), Initiative: \$840,000

Recommendation: HSN continue to operate this centre and should work with the LHIN to assess needs and identify alternatives. This should be funded by the LHIN, or through other savings identified in this report (see Section G). See our recommendation for LHIN funding for 2018/19 in Section G.

**This funding should come from the North East LHIN Home and Community funds, as opposed to the hospitals Initiatives fund.

See “Community-Based Surge Beds at Daffodil” section and Recommendation 7

- 6) Service: Forensic Pathology, Initiative: \$100,000

Recommendation: That HSN continue to operate this service and negotiate with the coroner’s office for additional support.

Rationale: This is the only service in a large region. Volume pressures could be supported one-time by the LHIN while negotiations with the Coroner’s office proceed

- 7) Birthing Centre: Initiative: \$58,000

Recommendation: HSN implement these savings more slowly and the LHIN bridge for this year.

Rationale: identified clinical risks due to vagaries of patient volumes

- 8) Service: Heart Failure Clinic, Initiative: \$154,000

Recommendation: HSN continue to operate this centre and work with the LHIN to assess needs and identify alternatives. This should be funded by the LHIN, or through other savings identified in this report (see Section G). See our recommendation for LHIN funding for 2018/19 in Section G.

See “Medicine Patient Flow” section and Recommendation 9

- 9) Service: Critical Care Response Team (CCRT) and Virtual Critical Care (VCC), Initiative \$270,000

Recommendation: The Team accepts HSN’s proposed change of the CCRT. We are estimating 50% of the strategy value

Rationale: Many hospitals determine they have the need for this service but cannot afford it. Critical Care Services Ontario (CCSO) has the process to formally evaluate

the need and recommend priority investments. HSN should approach CCSO to submit its case for need for funding to fully support both the CCRT and VCC programs. Alternatively, HSN could prepare and submit an H-SIP to the North East LHIN for evaluation.

10) Service: Medicine Cardiac Rehab, Initiative: \$440,000

Recommendation: HSN continue to operate this centre and work with the LHIN to assess needs and identify alternatives. This should be funded by the LHIN, or through other savings identified in this report (see Section G). See our recommendation for LHIN funding for 2018/19 in Section G.

See “Medicine Patient Flow” section and Recommendation 9

11) Service: Medical Day, Initiative \$580,000

Recommendation: The Team supports HSN’s change. Perhaps as a bridge the LHIN could fund one-time until an alternative provider is re-established.

Rationale: Medical Day supports cancer patient PICC line care, infusions for congestive heart failure patients, blood transfusions, simple antibiotic infusions and hydration’s. Home and Community Care formerly provided the PICC line care, as is the case in other LHIN’s.

See “Medical Cancer Services” section and Recommendation 8

12) Service: Intensive Rehab Unit, Initiative: \$248,375

Recommendation: HSN continue to operate this centre and work with the LHIN to assess needs and identify alternatives. This should be funded by the LHIN, or through other savings identified in this report (see Section G). See our recommendation for LHIN funding for 2018/19 in Section G.

Rationale: The unit has a demonstrative positive impact on patient flow which is a suitable benefit for the cost of this program.

- 13) Mental Health Initiatives: The Hospital has identified a number of initiatives, totaling \$1.6M. Many are efficiencies that we support. Following are initiatives that should be funded while alternatives are investigated.
- a) Community Mental Health - ACTT Team, Initiative: \$100,000
 - b) Acute Mental Health - Inpatient Unit, Initiative: \$170,000
 - c) Acute Mental Health - Inpatient Psychiatry Discharge Planner, Initiative: \$100,000
 - d) Community Mental Health - Mood and Anxiety and Eating Disorders, Initiative: \$140,000
 - e) Acute Mental Health Inpatient, Initiative: \$60,000
 - f) MHAP Community: Positive Steps, Initiative: \$200,000

The recommendation for all of these mental health initiatives is HSN should continue to operate these services. The LHIN and HSN should work with community mental health providers both within HSN and in the community to explore alternative models of care and funding arrangements.

HSN has submitted new mental health proposals. The LHIN should evaluate these in concert with the above or move funding to the proposed Day Program (partial hospitalization program).

See “Mental Health Service” section.

D. Additional Details on Recommendations on proposed Clinical Reductions in Balanced Budget Plan

Diabetes Education Centres (DECs)

DECs provide individuals with the tools, skills and confidence needed to properly self-manage their diabetes, and enable them to live healthy lives. The Diabetes Education teams consist primarily of a registered nurse and a dietician who work with family physicians and diabetes care experts.

With HSN’s proposed reductions in its DEC, the Review Team investigated different options for the provision of this service. The Review Team believes that this is another opportunity for HSN to focus on its acute service role, and divest itself of programs that may be more appropriately provided in a community or primary care setting.

Although it is important that the DEC’s are aligned with the complex diabetes care programs in hospital, the Review Team would recommend that HSN work with its primary care partners in the community, like the City of Lakes Family Health Team and the Centre de santé communautaire du Grand Sudbury, to determine if the DEC’s can be located in a community setting, close to the medical home of the patient. We would also recommend that the LHIN’s primary care physician lead be involved in this

task. Should this program be divested, it would be expected that the resources associated with this program also be divested from HSN.

In addition, the Review Team was informed by HSN leadership that there is a very high number of patients not showing up for their appointments with the DEC. We were told that the “no-show” rate can be as high as 30%. This is a significant amount of capacity which is being wasted when patients do not show up for their appointment. We did not investigate this issue in detail, but HSN needs to determine why the no-show rate is so high and take steps to address it. Whether it is because patients have to pay for parking, or reminders are not being sent by the DEC in advance of an appointment, the hospital is not making effective use of its capacity, and patients are not receiving the diabetes education they require when they miss an appointment.

Recommendation 4 - Diabetes Education Centres				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN undertake a review of its DEC program to determine if it can be more appropriately provided in a community or primary care setting	HSN, Senior VP, Patient Experience, and North East LHIN Primary Care Physician Lead	Within 150 days of receiving this report	Patients receive their diabetes education in a community setting
b)	That HSN investigate why the patient “no-show” rate is so high, and implement a plan to address it	HSN, Senior VP, Patient Experience	Within 90 days of receiving this report	HSN makes effective use of its diabetes education capacity, and patients receive the diabetes education they require

Short Term Assessment and Treatment (STAT) program

The STAT program was started by HSN in 2012, and provides rehabilitation and restorative care to frail elderly patients on an outpatient basis. The goal of the program is to improve the transition for frail patients from hospital to home, and we are told that it has been effective in reducing admissions of enrolled patients. HSN has indicated that the STAT program will be eliminated as part of its budget revisions.

STAT provides a mechanism for frail, elderly patients to transition from the HSN emergency department to a destination other than a hospital bed. The program works closely with the North East Specialized Geriatric Centre (NESGC) and is actually managed by the Executive Director of the NESGC.

Although several sources indicated that the program has been successful in keeping frail seniors from being admitted unnecessarily to hospital, little data has been collected on the program, making it difficult to support the belief that the program has had a significant positive impact. However, based on our review, we believe that the closure of the STAT program would have a negative impact on both patient flow and Alternate Level of Care (ALC) numbers in HSN.

As HSN moves to balance its budget, the Review Team did consider alternatives to the current model to determine if the program could be delivered in a different manner, possibly outside of the hospital in a community setting, possibly by a primary care provider. The feedback we received varied between different sources - HSN physician leadership supported the move of STAT to a community program, while the RGP believes that the program is best suited for a hospital setting.

Based on the time limits of this review, the Team did not have the opportunity to fully investigate options for alternative delivery models. Therefore, the Review Team would recommend that the STAT program be maintained for another year with one-time funding from the LHIN through its recent injection of home and community care funding from the ministry. During this next year, a proper evaluation should be undertaken to determine the effectiveness of the STAT program over the longer term. In addition, it is recommended that the NESGC provide recommendations to the LHIN to ensure better integration of the program with other hospital and community programs serving the frail elderly population.

Recommendation 5 - STAT Program				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That the North East LHIN provide one-time funding to maintain the operation of the STAT program until March 31, 2019	North East LHIN CEO	Within 30 days of receiving this report	STAT program is maintained to allow a proper evaluation of its effectiveness and identify a model of care in both the hospital and community setting which will best meet the needs of frail seniors
b)	That an evaluation of the STAT program be undertaken to create the best model for frail seniors in the acute, community and primary care settings	North East LHIN VP, Home and Community Care, HSN Senior VP, Patient Experience, and NESGC Medical Director	Within 150 days of receiving this report	STAT program model is designed to best meet the needs of frail seniors

Acute Stroke

HSN piloted an Acute Stroke model for seven months between September 2017 and March 2018, and according to HSN, it has demonstrated success in reducing the length of stay (LOS), and achieved the quality and financial benchmarks within the Stroke Quality Based Procedure Handbook. We did not evaluate those results. This pilot was paid by HSN through an “Innovation” fund which was made available within the hospital.

The Review Team was informed that when the Stroke Centre was established at HSN in 2007, it did not receive funding for Allied Health professionals, which other hospitals had received during the developmental phase of the provincial stroke planning network. We were told that because HSN was first designated as an “Enhanced” Stroke Centre, as opposed to a “Designated” Stroke Centre, funding was not provided for those Allied Health resources. Now that HSN is a “Designated” Stroke Centre, the Allied Health funding has still not been provided.

The Review Team recommends that a discussion with the Ministry of Health and Long-Term Care be initiated to determine if this inequity in funding of the Allied Health professionals across Designated Stroke Centres can be rectified. Based on the outcomes achieved during the short pilot, we would recommend that a business case be prepared for presentation to the ministry in an effort to secure the required funds.

Recommendation 6 - Acute Stroke Program				
Recommendation	Responsibility	Implementation Date	Intended Outcome	
a)	That HSN submit a formal Program Proposal to the North East LHIN for consideration of the Acute Stroke Pilot against the principles and priorities outlined in the Regional Stroke Strategy	HSN CEO	Within 90 days of receiving this report	More permanent realization of the pilot benefits, and explore opportunities to secure funding for Allied Health professionals not previously funded
b)	That the North East LHIN should evaluate whether the acute stroke proposal prepared by HSN would be a priority investment to drive that strategy	North East LHIN CEO	Within 120 days of the issuance of this report	The proposed investment can be evaluated against other priorities across the North East LHIN
c)	That a business case be prepared and presented to the Ministry of Health and Long-Term Care to secure funding of Allied Health professionals in the Acute Stroke program	HSN Senior VP, Patient Experience and North East LHIN VP, Performance and Accountability,	Within 150 days of receiving this report	Allied Health professionals are funded as part of Acute Stroke team at HSN

Community-Based Transition Beds at Daffodil

HSN has been operating an 8 bed community-based transitional care unit, which act as transitional beds, as patients move from hospital to an alternate destination in the community (e.g. home, long-term care, supportive housing). The hospital has utilized surge bed funding to offset the program cost. As part of HSNs balanced budget plan, the beds will be closed.

Based on our review, we believe that these beds provide a good alternative for those patients requiring a small amount of additional care before living independently, or independently with support, and their closure will negatively impact patient flow in the hospital and increase alternate level of care (ALC) days.

During the course of our review, the North East LHIN agreed to continue to fund these beds from home and community care funding recently provided to the North East LHIN by the ministry.

Although these beds will be funded until at least the end of the fiscal year, we would recommend that a review of the model of care be undertaken to ensure this capacity is most effectively used. We were informed that these beds have not been operating at a high capacity, and that there may be more effective ways to leverage providers of home and community care.

Recommendation 7 - Community-Based Surge Beds at Daffodil			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That with funding being received from the North East LHIN to allow the continuation of the 8 surge beds at Daffodil, a review of the model of care be undertaken to ensure the most effective use of this resource for high quality patient care	North East LHIN, VP, Home and Community Care, and HSN Senior VP, Patient Experience	Within 150 days of receiving this report	Surge beds at Daffodil are operating in the most effective model to provide high quality patient care

Medical Cancer Services

HSN has identified pressures in a number of medical services that are partially providing cancer services. These include:

- Medical Day Care
- Clinical Pharmacist
- Chemotherapy Suite

The Chemotherapy suite is an efficiency change and should proceed.

We are unable to determine what percent of the Medical Day Care unit and Pharmacist are cancer services pressures. The Medical Day unit provides many services which help avoid emergency visits and admissions. One pressure is PICC lines, which are sometimes provided in the community elsewhere.

Cancer Care Ontario (CCO) has confirmed that this service was formerly provided by community care, and that is the most common model in Ontario

HSN and the LHIN should evaluate alternatives, including transferring this service back to community care.

Recommendation 8 - Cancer Services			
Recommendation	Responsibility	Implementation Date	Intended Outcome
<p>That HSN and the North East LHIN evaluate if it is possible to restart a PICC line service back in Community Care.</p> <p>HSN should implement improvements in chemotherapy.</p>	<p>HSN Senior VP Patient Experience with North East LHIN, VP, Home and Community Care</p>	<p>Within 90 days of receiving this report</p>	<p>Effective, funded services</p>

Mental Health Services

The Review Team heard frequently throughout our work that there are insufficient mental health services in Greater Sudbury to meet the needs of the population. Through our discussions, HSN has communicated that they have experienced the following increases in their mental health emergency department (ED) visits and admission rate since 2010:

- 64% increase in adult mental health patients presenting to the ED;
- 157% increase in the number of child and youth mental health patients presenting to the ED;
- 32% increase in the Admission Rate for adult mental health patients (compared to 18% provincially); and

- 32% increase in the Admission Rate for children and youth Mental Health patients (compared to 17% provincially).

In total, \$1.625M and 18.1 FTEs from the mental health programs at HSN are included in the proposed budget reductions.

The Team obtained an understanding of the nature of the savings through discussions with senior HSN and LHIN personnel, and through review of supporting documentation to further explain aspects of the savings.

During the period of the review, we were informed that HSN is moving forward with a Partial Hospitalization Program (PHP), also known as a “Day Hospital”. Based on our discussions with HSN, LHIN and community leaders, there was a consensus that this program would help to address mental health pressures on the system, and provide better care than the existing model. The PHP was the result of a review of the system by key community partners from the Canadian Mental Health Association, Child & Family Centre, and the City of Lakes Family Health Team with the objective of establishing a clear vision for the next 5 years, which would best meet the needs of the patients, clients, and families that they serve.

The PHP offers services in an outpatient setting that patients can attend for six or more hours a day, for five days of the week (currently). The PHP offers clinical diagnosis, therapeutic milieu, psychiatric evaluation, pharmacology/medication management, group and individual based services, psychological testing, and brief counselling. The duration of this program is 4 weeks.

As noted previously, the demand for both inpatient and community mental health services continue to increase. To address this demand, HSN submitted a request for new funding in early June 2018 to support 2 additional paediatric mental health beds, 3 additional adult mental health inpatient beds, and funding to support an expansion of the PHP which is now only operating five days per week. HSN has informed the Review Team that the Day Hospital was to be funded at \$2.4M through HSN’s Post Construction Operating Plan (PCOP) funding, but this funding was never received from the ministry.

The Review Team understands the pressures HSN is facing to support patients coming to the hospital requiring mental health care. To ensure the appropriate capacity is in place to support these patients, the LHIN should consider these requests over the course of the year as it prioritizes other investments into the system.

The summary of the results of the review and the Team’s evaluation of the proposed Mental Health Program savings identified in the “Consolidated Summary of Clinical Savings” document received from HSN is outlined below:

Table 5			
Program	FTE	Annualized Savings	Team Evaluation of Savings
Adult Inpatient Psychiatry (AIP)		\$390,000	We heard a consistent message that many of the reductions are appropriate, as they are not effective from a clinical perspective due to the lack of time patients are in the AIP and the CAMHP program. However, \$330,000 (3.7FTE) of the funding for the AIP are recommended to be funded for 1 year while alternatives are found for care either in the community or through the PHP as these cuts would have a direct impact on patient care.
Child and Adolescent Mental Health Program (CAMHP)		\$460,000	
Mood and Anxiety Program		\$100,000	This is the only program of its nature in the region. It was created due to a ministry initiative since it is a priority area. The cut of a social worker will increase wait times and could result in an increase in emergency room visits. Therefore, it is recommended that the \$100,000 funding remain for this FTE.
MHAP Program		\$85,000	No clinical impact resulting from the change. Savings is reasonable.
Positive Steps		\$200,000	The message we heard was that HSN should not be running the Positive Steps program and that CMHA should be. It is recommended that the \$200,000 funding continue for one year for these 2 FTE while the transition occurs.
ACTT		\$160,000	Cost of ACTT teams are generally less in the community - \$1.3M vs. \$1.6M. The reductions need to be evaluated for compliance with ACTT standards by HSN. In the future, moving ACTT teams to a willing community partner such as CMHA could result in overall system-wide cost savings. Due to the need for mental health services in the community presently, the one clinical FTE (\$100,000) should be funded while alternative are explored.

Eating Disorders		\$40,000	This was created for adults. They opened it to children due to need in the community, which has resulted in a big waitlist. Ministry of Children and Youth Services (MCYS) should fund this role. This cut would leave a gap in eating disorder services for children not being met otherwise. Funding of \$40,000 is recommended to be maintained until funding can be obtained from MCYS.
Crisis		\$90,000	
Counselling & Treatment		\$40,000	
Community Admin		\$60,000	
Total	18.1	\$1,625,000	

Recommendation 9 - Mental Health Services				
	Recommendation	Responsibility	Implementation Date	Intended Outcome
a)	That the North East LHIN provide \$770K in one-time funding to support the community mental health program and services that have the potential to strain mental health care in the community if eliminated	North East LHIN CEO	Within 120 days of receiving this report	Needed mental health programs and services are maintained to allow evaluation of more permanent solutions
b)	That HSN, the North East LHIN, and community partners continue to evaluate the mental health programs currently offered by HSN in the medium and long term	HSN, VP Patient Experience, North East LHIN VP Strategy and Planning, CMHA and NBRHC	Within 120 days of receiving this report	Community mental health programs are located with the appropriate resources and the appropriate providers

c)	That HSN and the North East LHIN, as part of the review of community mental health services, identify opportunities to reallocate funds to the HSN Partial Hospitalization (PHP) program	HSN, Senior VP and Chief Operating Officer and North East LHIN VP, Performance and Accountability	Within 120 days of receiving this report	Funding is secured to permit the full-time operation of the PHP
d)	That HSN and the North East LHIN investigate the availability of funding from MCYS for children’s mobile crisis	HSN, Senior VP and Chief Operating Officer and North East LHIN VP, Performance and Accountability	Within 120 days of receiving this report	Funding is secured to support children’s mobile crisis program operated by HSN

V. Other Observations resulting in Recommendations for Clinical Services Medical Programs and Services

Medical Services

As part of our review, our Team heard from different sources about the challenges facing patients in accessing care for some medical services. These challenges then become budgetary challenges as more patients may be unnecessarily admitted to hospital, and have more difficulty transitioning out of hospital once admitted.

In particular, the Review Team heard about the challenges in accessing psychiatry services in the hospital. We heard that patients requiring mental health care in the emergency department are often admitted to hospital after 5:00pm as psychiatrists are not available to care for them after hours. We also heard that there is limited interaction between the psychiatrists working at the North Bay Regional Health Centre at the Kirkwood Centre in Sudbury and the psychiatrists working out of HSN, many of whom have offices at the Kirkwood Centre. We also heard that psychiatrists are not fulfilling their teaching responsibilities to train new psychiatrists.

Based on our assessment of the challenges facing patients attempting to access psychiatry services, the Review Team believes that a review of the department would be helpful for both HSN and the department itself. An external review by a peer group would provide insight and analysis to improve the functioning of the department, and its interaction with other medical services and clinical programs and ultimately provide better care for the patients coming to HSN.

In our conversations with both the HSN CEO and Chief of Staff, they indicated that they are aware of the issues facing the psychiatry department and are working with the Chief of Psychiatry to address the issues to improve access and care for patients. In our discussions, the CEO and Chief of Staff did express some hesitation at an external review because it can be very unsettling for the physicians and members of the clinical team, citing two recent external reviews in cardiology and diagnostic imaging, and that HSN already has a plan in place to address these issues.

We also spoke with the Chief of Psychiatry who indicated that the department is taking steps to address some of these shortcomings by moving to in-hospital coverage to 10:00pm. However, with this increased coverage in the hospital, she indicated that there are concerns about continued coverage of the many community clinics in the region, as it is the same group of psychiatrists. She also indicated that the department is developing an urgent mental health and addictions team to assist with increased volumes of patients coming to HSN for mental health care.

However, based on our review, we believe that all medical services in HSN should be subject to external reviews on a regular cycle, starting with the psychiatry department. We believe that there is considerable benefit for external reviews as they provide an opportunity for an informed peer reviewer to review existing practices, and identify opportunities for improvements to patient care. The review would not only identify possible shortcomings, but also provide recommendations

around implementation of best practices from other jurisdictions, and most importantly, break the inertia of the status quo in the pursuit of better patient care.

Recommendation 10 - Medical Services				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That all medical services at HSN be subject to an ongoing, regular cycle of external reviews	HSN CEO and HSN Chief of Staff	Within 90 days of receiving this report, an outline of the scope and timing of these external reviews be completed for endorsement of the HSN Board	Clinical programs are enhanced by addressing possible shortcomings, implementation of best practices, and breaking the inertia of the status quo in the pursuit of better patient care
b)	That an external review of the HSN psychiatry department be completed	HSN CEO and HSN Chief of Staff	Within 180 days of receiving this report	Improved access and enhance care for patients requiring psychiatry services

Medicine Patient Flow

Medicine is almost constantly in surge. That ongoing status not only impacts patients, but the constant pressure on staff to deal with too many patients contributes to the ongoing sick and overtime problems that HSN is experiencing. We observed several factors that contribute to the pressure on Medicine beds, and undoubtedly length of stay and costs. Certain budget strategies might just exacerbate this.

1. HSN has high admission rates: Per North East LHIN analysis compared to other large emergencies, HSN has higher admissions of 18-74 (3.9%), children (1.2%) and elderly (1.9%). Geography and lack of alternatives certainly contribute to these data.
2. Rehabilitation: HSN has a rehabilitation service (e.g. physiotherapy, occupational therapy, etc.) and inpatient rehab beds that many centres do not have. These services do not seem to be fully integrated with the acute services, as it appears that there is a model of care that Rehabilitation starts when the patient is transferred to the Rehab unit. This is not a current practice in many centres, wherein the rehab team reaches out INTO the acute units. Patient recovery is much faster, and flow improves.

3. Clinics: HSN has identified various possible reductions in outpatient clinics which could have a significant impact on flow of patients from Emergency and Medicine. These include reductions in the Adult Cystic Fibrosis, Acute Stroke Unit, Heart Failure. If anything, HSN should be investing in a more comprehensive Medical Day Unit in order to divert Emergency visits and reduce readmission.

Combined, these initiatives will reduce admissions and length of stay. Management should prioritize the work for the best benefit.

Recommendation 11 - Medicine				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN complete a review of admitting practices and protocols in order to reduce admissions - this review should include an assessment of clinics below	HSN Senior VP, Patient Experience, and HSN Chief of Staff	Within 120 days of receiving this report	Reduced admissions and reduced surge beds in medicine
b)	That HSN assess the effectiveness of separate Heart Failure Clinic, Medicine Cardiac Rehab, Medical Day in order to best support Emergency and avoid readmission	HSN Senior VP, Patient Experience, and HSN Chief of Staff	Align timing with master planning exercise currently underway	Reduced admissions and reduced surge beds in medicine
c)	That HSN work with the Rehabilitation service in order to develop a new model of care focused on activation as soon as possible. Work should be undertaken in line with the Rehabilitation Care Alliance and Senior Friendly Care best practices	HSN Senior VP, Patient Experience	Within 120 days of receiving this report	Reduced cost and clinical variance. It is expected that this could reduce medicine length of stay Improved activation while on medical floors

Hospitalists

Hospitalists are physicians who provide care for patients who are admitted to HSN and do not have a most responsible physician (MRP), including those patients without a family physician, specialist or sub-specialist. In other words, hospitalists provide care for “orphan” patients. Hospitalists provide a very important function in the care and flow of patients throughout the hospital and help to reduce length of stay and alternate level of care (ALC) days.

At HSN, there is a group of 12 hospitalists (5 full-time & 7 part-time), who act as a group to share the responsibilities for this service. Funding for these positions is considered to be a “blended” model as HSN “tops-up” the amount that OHIP pays these physicians. Although the Government of Ontario does not support hospitals funding doctors in addition to OHIP, many hospitals “top-up” the income as a recruitment and retention strategy. As part of the balanced budget plan, HSN is reducing the amount of top-up by approximately 33%, dropping the contribution from \$1.5M to \$1M.

The perceived impact of this reduction varies depending on who the Review Team asked. HSN recognizes that the reduction is significant, but it is in keeping with reductions which were already proposed by HSN, although the impact of the reduction is now more significant as it has been condensed into one fiscal year. HSN believes that some of this shortfall can be addressed through additional billings by the physicians to OHIP, but we cannot verify this. HSN has indicated that the billing amounts would be increased if they happened in off-hours.

On the other hand, in our discussion with the physician lead for the hospitalists, the physicians believe that this reduction will ultimately impact patient care. With the reduction in top-up, we were told that the hospitalists will not only see a reduction in income, but also a reduction in the number of physicians who will form part of their group. We heard that the reduction in top-up will mean that there would be 2 less physicians rounding during the day, reducing the average number of patients seen per day from 105 to 75. The physician lead also indicated that the top-up amount was already reduced by 17% two years ago.

The hospitalists can significantly impact length of stay with their quality of care, but also their timelines in seeing new patients and completing timely discharge. HSN is negotiating a new arrangement with the Hospitalists and should include the above financial terms and incentives, with productivity measures such as volume of patients and length of stay.

The hospitalists hand over patients on Friday. Whatever day the rotation happens, that day experiences a delay in clinical care and discharge, as the new hospitalist learns about their patients. A Friday presents a risk of not starting treatment and then the patient waits the weekend. There could be a length of stay benefit by changing this to Tuesday.

The Review Team has only been able to secure limited benchmarking data from other hospitals on the amount of funding provided by hospitals to their hospitalists. So, without solid benchmarking, it is very challenging to determine the “right” amount of

top-up. Therefore, we would support HSN in the top-up reduction based on the assurance that the hospital has undertaken the appropriate analysis to ensure that this change will not negatively impact patient care. It will also provide an opportunity for HSN to strengthen its accountability agreement with the hospitalists to provide when the current agreement expires on September 6th, 2018.

In addition, there is a need to determine if additional care can be provided by the internal medicine department to assist with the possible reduction in the number of hospitalists rounding during the day.

Recommendation 12 - Hospitalists				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN continue with its funding reduction in top-up for its hospitalists, and that the accountability agreement with the hospitalists be strengthened to require additional off-hours care for patients	HSN, VP Medical and Academic Affairs	Within 60 days of receiving this report	Orphan patients receive care in the evenings and weekends
b)	That HSN establish performance terms with hospitalists, such as length of stay, volume of patients, response to emergency scheduling and perhaps incentives and monitor workload for variation.	HSN, VP Medical and Academic Affairs	Within 60 days of receiving this report	Reduced cost and clinical variance, as well as reduced length of stay

Cancer Surgery

The management team has completed a very thorough review of pressures, and benchmarking in order to identify the appropriate areas for reduction. Non-clinical reductions have been implemented. Management has utilized their decision support and case costing tools to guide this work. Management has made significant improvements in the cost to deliver a number of QBP's bringing them down below the funded rate. However, there remain challenges, which require a review of the service model. These include Colorectal which is close, AA and breast cancer without reconstruction.

HSN delivers breast cancer surgery with reconstruction below expected, but not breast surgery without reconstruction. This might mean that the delivery is very similar. Also, HSN has been unable to reduce colorectal costs to below the funding rate. Furthermore, management believes other centres are having a similar experience. Management should complete a full review of the care delivery and ensure that standard protocols are implemented.

Recommendation 13 - Cancer Surgery				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN review its protocols to standardize and reduce costs for Breast Cancer Surgery without reconstruction	HSN Senior VP, Patient Experience	Within 120 days of receiving this report	Reduced cost and clinical variance
b)	That HSN benchmark with the other major centres in order to confirm if all are having difficulties meeting the QBP cancer cost or learn and improve	HSN Senior VP, Patient Experience	Within 120 days of receiving this report	Best Practice and reduce costs

Formalization of Arrangements

It was identified that, not unlike many other hospitals in the province, there is a lack of formal arrangements for the use of office space and professional staff for private practice purposes.

It is noted that many of these professional staff make a great contribution to HSN patients and the community. Many of these office-use arrangements evolved over time.

Specifically, there are psychiatrists, pathologists, oncologists and radiologists that are receiving the benefit of office space, administrative staff and potentially other professional staff.

Given the current financial position of HSN, and the efforts being made to balance their budget going forward, the formalization of market value remuneration arrangements is recommended.

Recommendation 14 - Formalization of Arrangements			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN undertake a formalization of market value remuneration agreements for office use and resource use (administrative and clinical)	HSN, Senior Vice President and Chief Operating Officer	Within one year of receiving this report	HSN is receiving the appropriate remuneration for the use of offices and staff by medical practitioners for private practice purposes.

VI. Observations and Recommendations on Non-Clinical Functions Resulting from our Review

System Leadership

The behaviour of health service provider and LHIN leaders at both the administrative and governance level, plays a significant role in the overall performance of the health system. When leaders are not communicating effectively and/or not working collaboratively, system performance can suffer. When system performance suffers, it can have a negative impact on the quality of care being provided, as well as on the budgets of individual organizations and the entire LHIN. Examples of this negative impact could include duplication of services, limited exploration of ways to “do things better”, and barriers to patients, residents and clients as they move between organizations providing care.

There are several observations our team has made in our review of system leaders. We heard frequently throughout our review that the previous CEOs of the LHIN and HSN “did not get along”, and had difficulties working together in a collaborative fashion. It is fortunate that there is new leadership in both organizations, and we saw that the HSN Board has actually prioritized community partnerships for their new CEO.

To ensure that all system leaders understand the impact of their words, actions and approach on colleague leaders across the LHIN, we would recommend that all system leaders be subject to 360 reviews, and that their respective Boards take steps to address any areas identified for improvement in their leader. There are many off-the-shelf, easy-to-use tools to complete this assessment.

The Review Team was also told that members of the LHIN leadership team are not always aware of what is happening in each other’s portfolios. With both a large geography and a large number of providers, we understand that it must be challenging to keep abreast of issues across the health system. However, we would encourage the LHIN leadership team to create a process for sharing of information across portfolios.

Recommendation 15 - System Leadership				
Recommendation	Responsibility	Implementation Date	Intended Outcome	
a)	That all service accountability agreements require health service provider Boards to complete a 360 assessment of their organizational leader on an annual basis, and that the LHIN undertake a 360 review of its CEO on an annual basis	North East LHIN Board	Within 180 days of receiving this report	All system leaders understand their impact on other partners in the health care system
b)	That the North East LHIN create a structure to better share information across the portfolios within the LHIN organization	North East LHIN CEO	Within 60 days of receiving this report	Members of the LHIN leadership team are kept abreast of key information across all portfolios in the LHIN

Working Capital

The Government of Ontario established a program in March 2014 to fund hospitals under the understanding that the funding would not be spent but held in short-term assets in order to improve the hospital's cash position and working capital. Hospitals were required to sign an agreement to commit a portion of the program, and to live up to certain obligations going forward. The government has since determined an amended working capital calculation. The adjustments are not relevant to this report.

Health Sciences North had a significant working capital shortfall, putting the organization at risk. This hospital was a beneficiary of this program, receiving significant funding (\$57,936,000) over three years, starting in 2013/14. The Hospital signed an agreement committing to:

- not use the funds for operating purposes;
- not use the funds for capital purchases - equipment, building or local share of building projects; and
- not increase services.

HSN ran a deficit in 2016/17 and with capital purchases has had its working capital deficit rise again. Therefore, the hospital is in default of this agreement.

Key HSN Financial Results during the program are:

Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Revenue	\$432.0 M	\$438.0 M	\$440.8 M	\$451.2 M	\$462.4 M	\$479.4 M
Expense	430.3 M	436.1 M	439.3 M	449.0 M	467.3 M	\$487.2 M
Net Income	1.7 M	1.9 M	1.5 M	2.2 M	(4.9 M)	(7.8 M)
Adjusted Current Assets	33.7 M	39.1M	32.0 M	56.0 M	53.9 M	49.4 M
Adjusted Current Liabilities	109.8 M	112.9 M	59.5 M	64.7 M	58.1 M	72.1 M
Adjusted Working Capital	(76.1 M)	(73.8 M)	(27.5 M)	(8.7 M)	(4.2 M)	(22.7 M)
Current Ratio	0.25	0.31	0.43	0.71	0.74	0.57
Long-Term Debt	(\$ 20.6 M)	(\$22.4 M)	(\$ 37.3 M)	(\$47.7 M)	(\$ 90.0 M)	(\$76.5 M)

HSN, the North East LHIN and the ministry were successful in reducing the working capital shortfall progressively until March 2017. HSN has experienced a significant reversal in 2017/18 by running an increasing deficit and not curtailing capital purchases, and therefore, as noted earlier, the hospital is in default of this agreement.

HSN currently has long-term debt at April 1, 2018 of \$76.5M. \$19.97 M of this is being reclassified to the HSN Research Institute, so the long-term debt will decrease this year.

Recommendation 16 - Working Capital				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN evaluate options in to become compliant with the working capital agreement. Operating deficits will prevent this so balancing the budget is obviously the first priority	HSN CEO	Within 90 days of receiving this report	HSN to have the financial resources for future flexibility The current working capital and debt position gives the hospital little flexibility to deal with issues and capital needs
b)	That HSN and the North East LHIN develop a new working capital recovery plan and debt repayment plan in order to not only introduce stability, but bring HSN back into conformance with this agreement	HSN CEO and North East LHIN CEO	Within 120 days of receiving this report	
c)	That HSN take steps to ensure capital purchases are not reduced to such a low level that it might introduce clinical risk, as defined in the agreement	HSN CEO	Within 120 days of receiving this report	

Governance

As part of our review, the Team met with the HSN Board of Directors. We found the Board to be informed, engaged, and most importantly, supportive of the direction of the HSN CEO and leadership in the 2018/19 budgeting process. The Board plays a significant role in the direction of the organization, and it is clear that it takes this responsibility seriously.

As the largest provider of patient care in the region, any changes to programs and services, even small or subtle changes, can have a significant impact on other providers. To assist the HSN Board to understand the impact of its changes on other providers, it is recommended that the HSN Board meet with Board members from other health service provider Boards on at least an annual basis.

Recommendation 17 - Governance			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That a forum be created to allow the Boards of Directors of all health service providers in Sudbury and across the North East LHIN to meet on an annual basis to discuss program and service changes in the coming fiscal year	North East LHIN, VP Planning	Within 120 days of receiving this report, a date be set for this forum	Health system governors will better understand the impact of budget changes across the entire system

Sick and Overtime

HSN is experiencing significant sick and overtime costs. In 2017/18, HSN recorded \$7.968M in sick costs and \$5.020M in overtime costs. These tend to correlate, as sick drives overtime where replacements are required to cover staff who are off sick. In addition, there are cases where staff have switched shifts in order to receive the “third weekend” premium, which also has a significant effect on costs. Managers do not have sufficient scheduling information to manage this when they create schedules and approve switches.

Within ONA, there is a 70% fulltime / 30% part time required split for these union employees, this makes it more difficult for the hospital to cover absences with part time staff, rather than overtime, as fewer are available.

HSN has a formal attendance, management process which is administered by a third party, however this only applies for absences of 3 days or greater. HSN finds that it is the one and two day absences that are having the greatest effect on costs.

HSN does not have a Human Resources Information System (HRIS). The payroll function is managed under the Finance department, and very little information is directly maintained by Human Resources. For example, physical employee files have to be delivered to and from the HR department.

Recommendation 18 - Sick and Overtime			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN complete an assessment of their Human Resources department to identify their data requirements	HSN, VP People Relations & Corporate Affairs	Within 120 days of receiving this report	HSN will identify a system to implement which will improve Human Resource's data, improve scheduling capabilities and ultimately help reduce sick and overtime

Non-Urgent Transportation

In respect to traditional non-urgent transportation, it was identified that availability of transportation was inconsistent, and the costs can be unsustainable. The LHIN is currently completing a project which focuses on non-patient transportation across the region.

Recommendation 19 - Non-Urgent Transportation			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN work alongside the LHIN and the other three hub hospitals to develop a non-urgent transportation strategy	HSN, Senior VP, Patient Experience, and North East LHIN VP, Performance and Accountability	Within 180 days of receiving this report	Improve availability and reduce average cost

Admitting

Admitting is spread throughout the hospital in over ten areas, which creates many financial and physical inefficiencies. We also heard about negative feedback from patients that they have been moved between multiple locations within the hospital which, required repeat admissions, which caused them some unnecessary distress and discomfort.

Recommendation 20 - Admitting				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That in the short to medium term, HSN should identify any underutilized areas that could be used to consolidate admitting, specifically space near the entrance to the hospital	HSN Senior VP and Chief Operating Officer, and HSN Senior VP, Patient Experience	Within 120 days of receiving this report	Consolidate admission areas to fewer locations within the hospital.
b)	That HSN undertake a long term consolidation of admitting to a convenient location within the hospital as part of HSN's capital plan	HSN Senior VP and Chief Operating Officer, and HSN Senior VP, Patient Experience	Within 9 months of receiving this report	Consolidate admission areas to one location within the hospital.

Research

HSN funds a significant portion of the Health Sciences North Research Institute’s (HSNRI) administrative costs. Prior to 2017/18 this funding was treated as a loan. Starting in 2017/18 this was converted into an operating expense in the HSN records, i.e. not to be repaid. This impact was \$3.4M In the 2018/19 budget, this support has been reduced to \$2.0M.

HSN has directed that Commercial activities are funding these costs. While this is allowable, it means that commercial activities are not funding patient care, which could further help with the operating budget. HSN should approach the Foundation so that they work to support these research administration costs. This philosophy is a current discussion amongst the CAHO Hospitals.

Recommendation 21 - Research Administration			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN should work with its three Foundations to transition to the Foundation supporting Research Administration costs. This would free up commercial revenues to fund clinical activities	HSN CEO	Within 180 days of receiving this report	Research Administration becomes funded from the Foundation resulting in commercial activities further helping to balance the clinical budget.

VII. Risks

Any major budget change introduces risks. Those include unintended reductions in patient care and quality, impact on the community and not achieving the savings. Given the speed with which this budget has been implemented, the possibility of any or all of these consequences is real. Obvious risks in this plan include:

- Forensic Pathology reduction and whether it impacts other partnerships;
- Whether the Hospitalists can successfully be engaged to change practice;
- Whether the hospital can manage without the Critical Care Response Team if already established;
- And ongoing low investments in Housekeeping and Security. Perhaps the offsite locations simply affect the “math” calculation of this benchmarking, but we would be remiss if we did not draw attention to this. HSN management should continue to monitor the implementation and its impacts and must continue to keep the North East LHIN informed. The Team has a recommendation in particular to Security and Housekeeping.

Risk Management

Recommendation 22 - Risk			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN closely monitor the benefits and clinical impacts of these budget changes.	HSN CEO	Continuous	To help ensure that budget cuts do not have a detrimental impact on patient and staff safety.

Security / Housekeeping

Plant Security and Housekeeping benchmarked very well against similar hospitals (6th and 11th percentile respectively based on 2016/17 data). Non-clinical support areas are being cut across the board. Therefore, there are impactful, potential risks that may occur with these functions running so lean.

Recommendation 23 - Security / Housekeeping			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN closely monitor potential impacts of the lean running of these functions (e.g. increased outbreaks and increased patient or staff security related incidents)	HSN, Senior VP, Patient Experience	Continuous	To help ensure that budget cuts do not have a detrimental impact on patient and staff safety.

VIII Funding

In summary, we saw that HSN exercised a tremendous amount of highly valuable analysis, which led to a comprehensive budget plan and internal engagement starting in October 2017. At the time this report was written, the LHIN had asked HSN management to identify key significant “pressures” and that even if they are addressed, the remaining deficit would be \$4.9M. We reviewed all budget strategies, including the Pressure Relief document. The table below outlines a summary of the Initiatives for which we propose that the North East LHIN fund to get to the deficit of \$4.9M with less disruption.

We are accepting that a large variety of small initiatives be implemented. However, we are recommending significant one-time funding from the North East LHIN to maintain many of these services, allowing for more thorough review of alternatives and submission of funding proposals.

The original HSN deficit strategy identified that 113 in-year FTE’s would be eliminated. 37 Fte’s or 50 people have been laid off to date, leaving 106 people filling 76 FTE positions to be eliminated. This magnitude of change does not come without cost, so the budget included an estimate of severances for staff. As at this time, those remaining 106 staff have not yet been given notice. If some restructuring is not advanced because LHIN funding is provided, then approximately 35 people, 39.7 FTEs will not be affected in 2018/19. Therefore, restructuring will cost less. We estimated a reduction in restructuring of \$1,500,000.

It is noted that due to the 3-month delay in implementing the clinical savings, there will be a financial impact of the delay. We estimated \$1,075,000.

There are a variety of risks in implementing the remainder of this plan and achieving the previously approved strategies. So, we set a provision for about \$500,000 in risks.

There are other recommendations in this report that could result in medium to longer-term savings such as improving length of stay, being more aggressive regarding sick, then purchasing a formal HRIS system to improve management of sick and overtime and implementing the formalization of rental agreements with medical staff. These amounts have not been estimated as the timeline to implement those changes could extend beyond the current year. However, this revenue stream is a key area for HSN to approach and address in order to reduce clinical impact of reductions in 2019/20 and going forward.

Initiatives we support continuing to operate	Savings	FTE's
Diabetes Education (DEC)	\$ 280,245	
Complex Diabetes (CCDC)	\$ 275,000	
Adult Cystic Fibrosis	\$ 68,000	
Short Term Assessment and Treatment (STAT)	\$ 772,736	
Daffodil Additional Funding Amount	\$ 840,000	
Forensic Pathology	\$ 100,000	
Birthing Suite	\$ 58,000	
Heart Failure Clinic	\$ 154,000	
Virtual Critical Care (partial)	\$ 135,000	
Cardiac Rehab	\$ 440,000	
Medical Day	\$ 550,000	
Intensive Rehab Unit	\$ 248,375	
Mental Health Programs	\$ 770,000	
TOTAL	\$4,691,356	39.7

Recommended changes to HSN Financial plan

	2018/19 Impact
Do NOT implement strategies above	(\$4,691,356)
Other Savings to be implemented (Overtime, admitting, LOS, Rent) Given that implementation timing is uncertain - annual achievable savings range from \$500,000 to \$1,000,000, but there will be a delay	\$300,000
Provision for risk and implementation challenges	(\$500,000)
Savings/deferral of budgeted severance costs	\$1,500,000
Delay in savings	(\$1,075,000)
North East LHIN funding to support above service pressures	<u>\$4,470,000</u>
<i>Net Impact</i>	<u>\$3,644</u>
Source of LHIN Funding	
<i>Funding from Home and Community funds</i>	<i>\$1,610,000</i>
<i>Funding from Hospital funds</i>	<i>\$2,860,000</i>

In conclusion

The Team recommends that the North East LHIN provide \$1,610,000 in funding from its home and Community funds, and \$2,860,000 from its Hospital funds in order to stabilize HSN. We have introduced a bit of flex in the forecast for risk and contingencies. HSN would implement all other identified strategies, except for the strategies identified above. HSN should exercise a concerted effort to reduce sick and overtime. This should achieve the \$4.9M deficit target in 2018/19 on the way to a balanced position in 2019/20. This will also allow time for the LHIN and HSN to determine whether these services are needed, and if so whether they could be better provided in the community.

Appendix A - Recommendations

Recommendation 1 - Clinical Services Planning				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN continue to take a lead in coordinating multi-sector clinical discussions	HSN CEO	Within 30 days of receiving this report	Health System Providers understand the changes to programs and services which HSN is considering
b)	That a Clinical Services Planning exercise be undertaken for the health services providers across the North East LHIN	North East LHIN CEO	Within 120 days of receiving this report, a scope document be developed which outlines a proposed plan for this work	After consultation with partners, health service providers know where a service should be provided, and which organization should be providing the service

Recommendation 2 - Community Engagement in HSN Budget Development			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN and the LHIN develop an engagement strategy to allow health service providers to engage each other in their respective budgeting processes	HSN Senior VP & COO supported by Health East LHIN, VP, Performance and Accountability	Within 120 days of receiving this report	All health service providers are informed of significant changes to programs and services coming as a result of organizational budgeting processes in their region

Recommendation 3 - LHIN Approvals for Program Changes			
Recommendation	Responsibility	Implementation Date	Intended Outcome
a) That HSN take regular steps to share information on proposed program and service changes with the North East LHIN and partners before making final budget decisions	HSN CEO	Immediately and ongoing	The LHIN and other system partners are fully informed of any proposed changes to programs and services at HSN
b) That the North East LHIN develop a memorandum of understanding with providers to set out expectations for sharing of information on proposed changes to programs and services	North East LHIN CEO	Within 90 days of receiving this report	The LHIN and its health service providers understand the expectations for sharing of information on service and program changes

Recommendation 4 - Diabetes Education Centres			
Recommendation	Responsibility	Implementation Date	Intended Outcome
a) That HSN undertake a review of its DEC program to determine if it can be more appropriately provided in a community or primary care setting	HSN, Senior VP, Patient Experience, and the North East LHIN Primary Care Physician Lead	Within 150 days of receiving this report	Patients receive their diabetes education in a community setting
b) That HSN investigate why the patient “no-show” rate is so high, and implement a plan to address it	HSN, Senior VP, Patient Experience	Within 90 days of receiving this report	HSN makes effective use of its diabetes education capacity, and patients receive the diabetes education they require

Recommendation 5 - STAT program				
Recommendation	Responsibility	Implementation Date	Intended Outcome	
a)	That the North East LHIN provide one-time funding to maintain the operation of the STAT program until March 31, 2019	North East LHIN CEO	Within 30 days of receiving this report	STAT program is maintained to allow a proper evaluation of its effectiveness and identify a model of care in both the hospital and community setting which will best meet the needs of frail seniors
b)	That an evaluation of the STAT program be undertaken to create the best model for frail seniors in the acute, community and primary care settings	North East LHIN VP, Home and Community Care, HSN Senior VP, Patient Experience, and NESGC Medical Director	Within 150 days of receiving this report	STAT program model is designed to best meet the needs of frail seniors

Recommendation 6 - Acute Stroke Program				
Recommendation	Responsibility	Implementation Date	Intended Outcome	
a)	That HSN submit a formal Program Proposal to the North East LHIN for consideration of the Acute Stroke Pilot against the principles and priorities outlined in the Regional Stroke Strategy.	HSN CEO	Within 90 days of receiving this report	More permanent realization of the pilot benefits and explore opportunities to secure funding for Allied Health professionals not previously funded.
b)	That the North East LHIN should evaluate whether the acute stroke proposal prepared by HSN would be a priority investment to drive that strategy	North East LHIN CEO	Within 120 days of the issuance of this report	The proposed investment can be evaluated against other priorities across the North East LHIN
c)	That a business case be prepared and presented to the Ministry of Health and Long-Term Care to secure funding of Allied Health professionals in the Acute Stroke program	HSN Senior VP, Patient Experience and North East LHIN VP, Performance and Accountability,	Within 150 days of receiving this report	Allied Health professionals are funded as part of Acute Stroke team at HSN

Recommendation 7 - Community-Based Surge Beds at Daffodil			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That with funding being received from the North East LHIN to allow the continuation of the 8 surge beds at Daffodil, a review of the model of care be undertaken to ensure the most effective use of this resource for high quality patient care	North East LHIN, VP, Home and Community Care, and HSN Senior VP, Patient Experience	Within 150 days of receiving this report	Surge beds at Daffodil are operating in the most effective model to provide high quality patient care

Recommendation 8 - Cancer Services			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN and the North East LHIN evaluate if it is possible to restart a PICC line service back in Community Care. HSN should implement improvements in chemotherapy.	HSN Senior VP Patient Experience with North East LHIN, VP, Home and Community Care	Within 90 days of receiving this report	Effective, funded services

Recommendation 9 - Mental Health Services				
	Recommendation	Responsibility	Implementation Date	Intended Outcome
a)	That the North East LHIN provide \$770K in one-time funding to support the community mental health program and services that have the potential to strain mental health care in the community if eliminated	North East LHIN CEO	Within 120 days of receiving this report	Needed mental health programs and services are maintained to allow evaluation of more permanent solutions
b)	That HSN, the North East LHIN, and community partners continue to evaluate the mental health programs currently offered by HSN in the medium and long term	HSN, VP Patient Experience, North East LHIN VP Strategy and Planning, CMHA and NBRHC	Within 120 days of receiving this report	Community mental health programs are located with the appropriate resources and the appropriate providers
c)	That HSN and the North East LHIN, as part of the review of community mental health services, identify opportunities to reallocate funds to the HSN Partial Hospitalization (PHP) program	HSN, Senior VP and Chief Operating Officer and North East LHIN VP, Performance and Accountability	Within 120 days of receiving this report	Funding is secured to permit the full-time operation of the PHP
d)	That HSN and the North East LHIN investigate the availability of funding from MCYS for children's mobile crisis	HSN, Senior VP and Chief Operating Officer and North East LHIN VP, Performance and Accountability	Within 120 days of receiving this report	Funding is secured to support children's mobile crisis program operated by HSN

Recommendation 10 - Medical Services				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That all medical services in HSN be subject to a ongoing, regular cycle of external reviews	HSN CEO and HSN Chief of Staff	Within 90 days of receiving this report, an outline of the scope and timing of these external reviews be completed for endorsement of the HSN Board	Clinical programs are enhanced by addressing possible shortcomings, implementation of best practices, and breaking the inertia of the status quo in the pursuit of better patient care
b)	That an external review of the HSN psychiatry department be completed	HSN CEO and HSN Chief of Staff	Within 180 days of receiving this report	Improved access and enhance care for patients requiring psychiatry services

Recommendation 11 - Medicine				
Recommendation	Responsibility	Implementation Date	Intended Outcome	
a)	That HSN complete a review of admitting practices and protocols in order to reduce admissions - this review should include an assessment of clinics below.	HSN Senior VP, Patient Experience, and HSN Chief of Staff	Within 120 days of receiving this report	Reduced admissions and reduced surge beds in medicine
b)	That HSN assess the effectiveness of separate Heart Failure Clinic, Medicine Cardiac Rehab, Medical Day in order to best support Emergency and avoid re-admission	HSN Senior VP, Patient Experience, and HSN Chief of Staff	Align timing with master planning exercise currently underway	Reduced admissions and reduced surge beds in medicine
c)	That HSN work with the Rehabilitation service in order to develop a new model of care focused on activation as soon as possible. Work should be undertaken in line with the Rehabilitation Care Alliance and Senior Friendly Care best practices	HSN Senior VP, Patient Experience	Within 120 days of receiving this report	Reduced cost and clinical variance. It is expected that this could reduce medicine length of stay. Improved activation while on medical floors.

Recommendation 12 - Hospitalists				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN continue with its funding reduction in top-up for its hospitalists, and that the accountability agreement with the hospitalists be strengthened to require additional off-hours care for patients	HSN, VP Medical and Academic Affairs	Within 60 days of receiving this report	Orphan patients receive care in the evenings and weekends
b)	That HSN establish performance terms with Hospitalists, such as length of stay, volume of patients, response to emergency scheduling and perhaps incentives and monitor workload for variation.	HSN, VP Medical and Academic Affairs	Within 60 days of receiving this report	Reduced cost and clinical variance, as well as reduced length of stay

Recommendation 13 - Cancer Surgery				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That HSN review its protocols to standardize and reduce costs for Breast Cancer Surgery without reconstruction.	HSN Senior VP, Patient Experience	Within 120 days of receiving this report	Reduced cost and clinical variance
b)	That HSN benchmark with the other major centres in order to confirm if all are having difficulties meeting cancer QBP cost or learn and improve.	HSN Senior VP, Patient Experience	Within 120 days of receiving this report	Best Practice and reduce costs

Recommendation 14 - Formalization of Arrangements			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN undertake a formalization of market value remuneration agreements for office use and resource use (administrative and clinical)	HSN, Senior Vice President and Chief Operating Officer	Within one year of receiving this report	HSN is receiving the appropriate remuneration for the use of offices and staff by medical practitioners for private practice purposes.

Recommendation 15 - System Leadership			
Recommendation	Responsibility	Implementation Date	Intended Outcome
a) That all service accountability agreements require health service provider Boards to complete a 360 assessment of their organizational leader on an annual basis, and that the LHIN undertake a 360 review of its CEO on an annual basis	North East LHIN Board	Within 180 days of receiving this report	All system leaders understand their impact on other partners in the health care system
b) That the North East LHIN create a structure to better share information across the portfolios within the LHIN organization	North East LHIN CEO	Within 60 days of receiving this report	Members of the LHIN leadership team are kept abreast of key information across all portfolios in the LHIN

Recommendation 16- Working Capital				
Recommendation	Responsibility	Implementation Date	Intended Outcome	
a)	That HSN evaluate options in to become compliant with the working capital agreement. Operating deficits will prevent this so balancing the budget is obviously the first priority.	HSN CEO	Within 90 days of receiving this report	<p>HSN to have the financial resources for future flexibility</p> <p>The current working capital and debt position gives the hospital little flexibility to deal with issues and capital needs.</p>
b)	That HSN and the North East LHIN develop a new working capital recovery plan and debt repayment plan in order to not only introduce stability, but bring HSN back into conformance with this agreement.	HSN CEO and North East LHIN CEO	Within 120 days of receiving this report	
c)	That HSN take steps to ensure capital purchases are not reduced to such a low level that it might introduce clinical risk, as defined in the agreement.	HSN CEO	Within 120 days of receiving this report	

Recommendation 17 - Governance			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That a forum be created to allow the Boards of Directors of all health service providers in Sudbury and across the North East LHIN to meet on an annual basis to discuss program and service changes in the coming fiscal year	North East LHIN, VP Planning	Within 120 days of receiving this report, a date be set for this forum	Health system governors will better understand the impact of budget changes across the entire system

Recommendation 18 - Sick and Overtime			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN complete an assessment of their Human Resources department to identify their data requirements.	HSN, VP People Relations & Corporate Affairs	Within 120 days of receiving this report	HSN will identify a system to implement which will improve Human Resource's data, improve scheduling capabilities and ultimately help reduce sick and overtime.

Recommendation 19 - Non-Urgent Transportation			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN work alongside the LHIN and the other three hub hospitals to develop a non-urgent transportation strategy.	HSN, Senior VP, Patient Experience, and North East LHIN VP, Performance and Accountability	Within 180 days of receiving this report	Improve availability and reduce average cost.

Recommendation 20 - Admitting				
Recommendation		Responsibility	Implementation Date	Intended Outcome
a)	That in the short to medium term, HSN should identify any underutilized areas that could be used to consolidate admitting, specifically space near the entrance to the hospital.	HSN Senior VP and Chief Operating Officer, and HSN Senior VP, Patient Experience	Within 120 days of receiving this report	Consolidate admission areas to fewer locations within the hospital.
b)	That HSN undertake a long term consolidation of admitting to a convenient location within the hospital as part of HSN's capital plan.	HSN Senior VP and Chief Operating Officer, and HSN Senior VP, Patient Experience	Within 9 months of receiving this report	Consolidate admission areas to one location within the hospital.

Recommendation 21 - Research Administration				
Recommendation		Responsibility	Implementation Date	Intended Outcome
That HSN should work with its Foundation to transition to the Foundation supporting Research Administration costs. This would free up commercial revenues to fund clinical activities		HSN CEO	Within 120 days of receiving this report	Research Administration becomes funded from the Foundation resulting in commercial activities further helping to balance the clinical budget.

Recommendation 22 - Risk			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN closely monitor the benefits and clinical impacts of these budget changes.	HSN CEO	Continuous	To help ensure that budget cuts do not have a detrimental impact on patient and staff safety.

Recommendation 23 - Security / Housekeeping			
Recommendation	Responsibility	Implementation Date	Intended Outcome
That HSN closely monitor potential impacts of the lean running of these functions (e.g. increased outbreaks and increased patient or staff security related incidents)	HSN, Senior VP, Patient Experience	Continuous	To help ensure that budget cuts do not have a detrimental impact on patient and staff safety.

Appendix B - Third Party Validation Team

The Third Party Validation team consists of Kevin Empey, Michael Barrett, Joe Filippelli and Peter Hearn.

Kevin Empey has just completed acting as Supervisor of Brockville General Hospital. Prior to this he was President and Chief Executive Officer of Lakeridge Health for 8 years. Kevin is a Chartered Accountant (now CPA) and a graduate of Harvard's Advanced Management Program.

Kevin has worked in the Hospital sector since 1990, with senior roles at University Health Network, Peel Memorial Hospital and St. Michael's Hospital. He currently is a guest lecturer at The Ontario Hospital Association, University of Toronto and York University. Kevin has been very involved with the creation of shared services and with the government regarding funding models for hospitals. In 2016 and early 2017, he Chaired the Healthcare Sector Supply Chain Strategy Panel for the Government of Ontario.

Michael Barrett has more than 28 years of experience in municipal planning and health care administration, in increasingly more responsible positions with the County of Oxford, the Ministry of Health and Long-Term Care, the Children's Hospital at London Health Sciences Centre, and St. Joseph's Health Care London. Most recently, Michael was the Chief Executive Officer (CEO) of the South West LHIN for almost 10 years until October 2017. Michael has also acted as a Lead Investigator under the Patients First Act. He currently sits on the Ronald McDonald House Charities Canada National Board of Directors, and has been a member of the National Board since 2016.

Joe Filippelli is a Managing Director in the Advisory Services, Consulting practice. Joe is a Chartered Professional Accountant and has over twelve years of experience in financial advisory roles. Joe has a portfolio of public sector clients. He specializes in leading reviews, audits and investigations of organizations within the healthcare sector. Joe was the head of Internal Audit at Porter Airlines where he implemented and managed an internal audit department for three years. Joe articulated in the audit assurance practice at PricewaterhouseCoopers.

Peter Hearn is a Senior Consultant for BDO, he started off his career in the UK for Deloitte as an outsourced internal auditor for various public sector clients including National Health Service ("NHS") organizations. Since joining BDO, Peter has worked on several engagements for the South East LHIN including reviews and investigations of specified health care providers. Peter holds his Certified Internal Auditor (CIA) designation.

Appendix C - Interview List

- Dr. Lakyntiew Aulakh, Chief of Psychiatry, HSN
- Michelle Beaudry - ONA Health Professionals President for HSN
- Elaine Burr - North East LHIN, Patient Flow System Planning Lead
- Shelley Carpenter - Director, Human Resources, HSN
- Dr. Jo-Anne Clarke MD - Assistant Professor, Geriatric and Internal Medicine, HSN, and Director of the Regional Geriatric Program
- Dave Courtemanche, Executive Director, City of Lakes Family Health Team (FHT)
- Dr. Killian De Blacam MD - Chair, HSN Medical Advisory Committee
- Marc Demers - North East LHIN, Director Hospital Sector
- Sandra Duhamel - Director, Decision Support, HSN
- Kate Fyfe - North East LHIN, Vice President, Performance and Accountability
- Dominic Giroux - President and Chief Executive Officer, HSN
- HSN Board of Directors
- Dr. Jordan Herst MD - Vice-Chair, HSN Medical Advisory Committee
- Darren Jermyn - Interim Associate Vice President, Health Promotion, HSN
- Carolyn Jodouin - Director, Finance, HSN
- Richard Joly - North East LHIN, VP Home and Community Care, North East LHIN
- Dr. David McNeil - Senior Vice President Patient Experience and Digital Transformation, HSN
- Stephanie Paquette - North East LHIN, Mental Health and Addictions Lead
- Joe Pilon - Senior Vice President and Chief Operating Officer, HSN
- Marion Quigley - CEO, CMHA Sudbury/Manitoulin
- Dave Shelefontiuk - CUPE President for HSN
- Steve St. Denis - Budget Manager, HSN
- Lise St. Marseille, Mental Health Director, North Bay Regional Health Centre
- Rhonda Watson - Vice President, People Relations and Corporate Affairs, HSN

Appendix D - Key Document Review List

- Assessment of Organizational Culture, Strengths, Weaknesses, Opportunities, Threats - Presentation to the HSN Board of Directors by the CEO, January 9, 2018
- Approved Scope of the 2019-2024 Strategic Plan
- Communication to HSN and HSNi Staff, Board Members and External Partners from the CEO regarding changes to Senior Leadership of Health Sciences North from the CEO, January 12, 2018.
- CEO's Blog, first 100 days, February 8, 2018
- HSN Strategic Planning Environmental Scan, March 5, 2018
- Communication to HSN Board of Directors regarding a Financial Action Plan from the CEO, March 8, 2018
- Pressure Relief Package for HSN
- 2018-19 Recommended Budget Presentation
- 2018-19 Budget Presentation
- Approved 2018-19 performance Goals - HSN's Senior Leadership Committee, May 7, 2018
- HSN 2017-18 Financial Statements and Audit findings from KPMG, May 7, 2018
- 2018-19 Approved Budget by Program including Sick and Overtime provisions
- 2018-19 Program Budget Template
- Consolidated Summary of Budget Savings 2018-19
- Financial Improvement Initiatives 2017-18
- List of Physicians by Nominal Role as at June 2018
- HBAM Funding Actual and Forecast Analysis
- MIS Trial Balance Benchmarking
- Adult Partial Hospitalization Business Case, May 31, 2018
- Child and Adolescent Partial Hospitalization Business Case, May 31, 2018
- Summary of Current and Proposed HSN Mental Health Inpatient Beds, June 8, 2018
- HSN Internal Financial Statements - April 2018

Appendix E - Project Scope

TERMS OF REFERENCE

LHIN Led Third Party Validation of the 2018-2019 Approved Budget at Health Sciences North (HSN)

Background

HSN is Northern Ontario's largest hospital, Northeastern Ontario's academic health science center belonging to the Council of Academic Hospitals of Ontario (CAHO), the second largest hospital designated under Ontario's French Language Services Act, and one of Canada's Top 40 Research Hospitals and a hospital ranking in the Top 10% of 680 North American hospitals participating in the American College of Surgeons' National Surgical Quality Improvement Program (ACS NSQIP).

HSN plays a key leadership role in Northeastern Ontario as one of its largest employers and as its only tertiary care center. Its 4,250 employees, 500 physicians, 2,100 learners and 700 volunteers are not only located in 15 sites in Greater Sudbury, but also in more than 17 other locations in Chapleau, Elliot Lake, Espanola, Gore Bay, the James Bay Coast, Little Current, Massey, Mindemoya, North Bay, New Liskeard, Kapuskasing, Kirkland Lake, Parry Sound, Sault Ste Marie, St. Charles, West Parry Sound and Timmins.

HSN's Mission is to "Improve the health of northerners by working with our partners to advance quality care, education, research and health promotion". Its Vision is to be "globally recognized for patient-centered innovation". It is a complex hospital classified by the Ontario Ministry of Health and Long-Term Care pursuant to Regulation 964 - Classification of Hospitals under the *Public Hospitals Act* in seven (7) categories:

- Category A - General / Teaching Hospital (the only one in Northeastern Ontario);
- Category D - Cancer Care Hospital (the only one in Northeastern Ontario);
- Category J - Special Rehabilitation Hospital (the only one in Northeastern Ontario);
- Category K - to provide local diagnostic and treatment services to handicapped or disabled individuals (the only one in Northern Ontario);
- Category M - Computerized Axial Tomography (CTs) Hospital (one of six in Northeastern Ontario);
- Category N - Magnetic Resonance Imaging - MRI scan Hospital (one of four in Northeastern Ontario);
- Category T - Cystic Fibrosis Hospital (the only one in Northern Ontario).

Over the years, HSN has introduced a number of impactful programs for patients meeting regional and provincial priorities. As HSN works towards eliminating an estimated \$13.5 million deficit in 2017-2018, the North East Local Health Integration Network (NELHIN) wants to sustain a number of clinical supports at HSN while the NELHIN develops its 2019-2022 Integrated Health Service Plan (IHSP) and HSN develops its 2019-2024 Strategic Plan. The CEO

of the NELHIN has been appointed to HSN's 32-member 2019-2024 Strategic Planning Steering Committee while HSN's CEO has been appointed to the NELHIN's 20-member IHSP Steering Committee.

Purpose of the Validation

The Board of Directors of HSN unanimously approved on April 12, 2018 a budget for the 2018-2019 fiscal year that includes a reduction of 113 full-time equivalent (FTE) staff and a return to a surplus position in 2019-2020, consistent with its accountability to maintain a balanced budget.

In order to best meet the needs of North East residents, there is a need to better understand the service demands and their impact on the costs of care. There is also a need to determine if the way the HSN provides care is optimal given its mandate, the need for services and the health care context in which it operates.

To ensure that an appropriate level of service continues to be available today and into the future, the NE LHIN, in collaboration with the HSN, commissioned a third party validation of the Balanced Budget plan prepared by HSN. This analysis provides insight into the health needs of the people in the NE in the coming years recommends strategies to ensure that HSN services will be available to meet the needs of the population while ensuring financial sustainability of the hospital and our health system.

The Budget Plan validation will examine: (a) the overall fiscal and utilization performance of the organization, (b) the key processes, barriers and opportunities related to the transition and flow of patients within and external to the organization and (c) corporate fiscal decision making and oversight processes.

The Reviewer will report to the Chief Executive Officer of the NE LHIN during the review. The Reviewer will present an embargoed written report of findings and recommendations to the NE LHIN by June 30, 2018.

Oversight of the approved budget will be the responsibility of HSN, with accountability to the NELHIN.

Scope of the Validation

The Reviewer will:

1. Review and assess the feasibility of HSN's approved 2018-2019 budget that would result in the hospital returning to a balanced budget in 2019-2020, and determine if there are any additional efficiencies to be gained;
2. Assess the long-term financial plan that will enable HSN to maintain an operating surplus in future years and address the working funds deficit;
3. Do a comparative analysis of demand and performance with other Ontario hospitals to understand variability in key areas;
4. Review environmental scan to gain an understanding of the future state, based on needs of the population, the mandate of the Hospital and expectations of stakeholders.
5. Consider the impact of the approved budget on revenues from Health System Funding Reform (Health Based Allocation Model) and future funding opportunities;
6. Review and identification of the impact of the implementation of quality-based procedures on future demand.

7. Recommend as required additional partnerships to support patient care provision and care transitions;
8. Assess the readiness and capacity of hospital governance to support and hold management accountable for the implementation of the approved budget;
9. Assess the readiness and capacity of hospital management to implement the approved budget and account for its results.