Cambridge Memorial Hospital
Clinical Services Strategy

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Executive Summary: CMH's Clinical Services Strategy

Background

In the discussions that preceded the CMH Strategic Plan 2014-2017, a foundational question was raised: "*What is future role of Cambridge Memorial*?" As other hospitals had already specialized in regional programs, it was important to clarify our role to the community and to internal stakeholders. The promise of a new build and the only hospital in Waterloo Wellington with growth capacity, created a compelling opportunity and clarity of purpose to define our role. This emerged as a strategic imperative ***(****See* ***Appendix 1*** *Mission, Vision & Values 2017-19 Strategic Plan Summary*)**.** In 2017, the Board approved the Clinical Services Strategy (CSS) as part of CMH's 2017-19 Strategic Plan. It provided the framework to consider any regional unmet clinical service gaps that could be offered in a large community hospital.

The plan also reaffirmed the importance of improving quality, driving value and affordability and strengthening our people as a progressive acute community hospital. It cemented our belief that a locally governed community hospital is a strong model for affordable and exceptional clinical care.

With the leadership of the Chief of Staff, Dr. K. Rhee, existing clinical teams were engaged through one-on-one and in team meetings to discuss current strengths, future opportunities and the challenges they thought could be barriers to success.

This complemented the strategic planning sessions that heard from external partners, regional leaders and stakeholders. Market research focused on utilization conducted by the Hay Group was shared at the sessions. A joint Medical Advisory Committee, Directors and Board of Directors session was hosted for further deliberation and feedback. While patient feedback was incorporated based on third party stakeholders, direct patient feedback was limited. That said, public consultation was sought with an on-line survey distributed through the hospital's website and social media channels, which provided insight into our community's wishes for their hospital.

The underlying philosophy was to build on our clinical strengths, meet community needs and be flexible so to proactively respond to the changing landscape of healthcare. The goal was to focus on priority clinical areas to ensure success in building an efficient and effective quality model. Four clinical areas emerged as growth opportunities.

Marketed as 'Petals of Care,' these clinical areas were organized into a poppy to help create internal meaning. The centre of the flower denoted the core services that are essential to building new or enhancing current clinical programs. The areas identified for further focus and investment include:

Figure 1: CMH Petals of Care

Specialized Medical – with emphasis on cardio respiratory care; renal health, geriatric services, medical oncology, liver health, hematology, endocrine and neurology and ICU expansion
Focused Mental Health – with emphasis on addictions, psycho-geriatrics, concurrent care, child-adolescent mental outpatient, community partnerships and advanced modalities
Specialized Surgery – with emphasis on minimally invasive surgery, oncology, joints, peri-operative pain.
Woman & Child – with emphasis on Level II nursery, paediatrics hospitalists, obstetrics repatriation, early loss clinic, midwifery scope reassessment, 'Baby Friendly' initiative, paediatric urgent care and CMH breast centre.

The initial requirement for specialized growth as outlined is a strong foundation of core services. These core services must be collaborative and responsive to the 'petals". Core services are fundamental to every community hospital and include top notch Emergency care, a responsive Laboratory and robust Diagnostic Imaging Department. Critical Care Services are a component of the essential core services that are aligned to ensure care close to home which may be earlier repatriation with highly specialized clinical services.

Growth Philosophy in Petals of Care

Core and petals of care services identified for growth must be efficient and effective. Services will be evaluated through three lenses: volume (serving the most people), cost (service is sustainable) and quality (aligns with protects patients and incorporates patient experience as a pillar of quality). How well a service meets these criteria will determine the level of funding it will receive to grow.

Finally, growth will only happen if a service embraces the TDT Model - *Teams, Data and Technology*. This model is shown to keep services competitive in a resource-diminishing environment. When fully optimized, high-functioning, collaborative teams will use data to reduce variation through standardization; they will rapidly deploy technology enablers; and, they will ensure community trust by becoming an organization recognized for delivery of quality services.

The word "team" has traditionally indicated hospital inter-professional teams of providers. The new and evolving definition of teams is that same inter-professional team, guided by the patient that operates within a larger system or community of integrated practice. Strong medical leadership in partnership with administrative leadership is another expectation to ensure alignment of purpose and goals. As CMH moves closer to the Accreditation Canada standard of patients as partners in developing or co-designing and providing clinical services, the concept of team again broadens and deepens.

Data drives accountability and transparency of data to drive improvement is fundamental to the quality improvement process. The availability and timeliness of clinical and operational data to make decisions is paramount to the success of any growth plans. Clinical outcomes are measured against provincial or international standards, compared to financial forecasts and interpreted through the lens of patient experience. While not explicit in the strategic plan, the evolving CMH Information Technology strategy that assists providers in achieving

quality outcomes, links patient data to community partners as outlined in the WWLHIN e-health strategy and allows patients access to their health record enables the level of excellence that is sought.

The detailed Clinical Planning for the four petals began in 2017 and as a baseline integrated redesign of programs to align with the capital redevelopment project (CRP). As the CRP represents a significantly enlarged footprint with new workflows and opportunities, construction delay has impeded milestones and implementations of new processes in certain programs. The delay however did facilitate additional planning that allowed more robust planning incorporating patient feedback and using QI tools. This time facilitated a review of the existing program quality structure, performance dashboards or scorecards and determined the requirements to assist the planning and monitoring functions across the organization. A new business intelligence tool was created to fill this void while at the same time the Transformation Office was charged to assist in refreshing the unit level quality program with the re-introduction of daily huddles with relevant data pushed out to inform quality improvement goals.

The following document will describe in more detail the Clinical Services Plan, the associated priority program plans with year over year goals and align with the post construction operating plans (PCOP).

Background and Context

Cambridge Memorial Hospital (CMH) has a distinguished and valued history that dates back to 1886. As a cornerstone for acute care services in the Waterloo Region, CMH is driven by its desire to serve its community with exceptional services and care. CMH has proven that hard work by caring providers with a clear commitment to the patient care and a willingness to be innovative, can lead to great achievements.

CMH is regarded for its quality care and is designated a Registered Nursing Association of Ontario (RNAO) Best Practice Spotlight Organization. The hospital is currently undergoing a capital redevelopment project, which is the largest single investment in health care in Cambridge's history. Slated for completion in 2021, the project will see the addition of a state-of-the-art patient care wing (opening spring 2019) and the complete refurbishment of an existing patient care wing. Once finished, core services will expand and specialty services added to better meet the growing health care needs of the community.

CMH is a community hospital with dedicated and skilled health care professionals, technicians and staff providing primarily primary and secondary services to residents of Cambridge, the township of North Dumfries and the Region of Waterloo.

(*See **Appendix 2** Demographic Profile of Cambridge North Dumfries in the context of the Waterloo Region*).

CMH has an annual operating budget of approximately $125 million. With 144 beds and significant ambulatory care departments, CMH provides critical care, surgical, medical, rehabilitation medicine, obstetrics and pediatric inpatient and outpatient programs and is a designated Schedule 1 hospital providing mental health services. CMH offers systemic therapy in partnership with Grand River Regional Cancer Centre.

CMH is ranked as a medium community hospital by the Ministry of Health and Long Term Care. The following table provides an overview of the hospital profile in terms of the associated human resources and clinical activity volumes.

Table 1: Summary Statistics, 2017/18

Employees	1,142
Medical & Professional Staff	280
Volunteers	453
Total Patient Days	54,349
Inpatient Admissions	10,796
Emergency Department Visits	51,912
Day Surgeries (inc. minor procedures)	10,945
Inpatient Surgeries	2,446
Ambulatory Clinic Visits	85,591
Newborns	1,402

As background for the strategic plan, the Hay Group had completed some demographic research and identified key information that assisted in clinical planning, such as the higher chronic condition rates, higher use of ED and acute hospitalization rates compared to regional peers. Patient patterns of health care revealed that residents were seeking care elsewhere in the region that could be provided at CMH formed the basis for further exploration in clinical service planning exercises.

In November 2016, the hospital, together with St. Mary's General Hospital and Grand River Hospital, undertook a review of our market share/utilization information. The focus of this work was to update the work undertaken in 2014. This work was completed by Health Stats Inc. and helped to shape the 2017-19 CMH Strategic Plan.
(*See **Appendix 3** Distribution of Cases for Cambridge Catchment, by Program*)

Some of the key findings from the 2015-16 information that were used at the strategic planning session are:

- In 2015/16, 70% of all inpatient acute care hospitalizations for Cambridge catchment area residents were provided by CMH.
- Highest % capture for Pulmonary, Gastro/ Hepatobiliary, and General Internal Medicine
- There appears to be opportunities to repatriate more care to CMH.

While there is the need for interpretation to distinguish localization of specialized services such as NICU, Cardiac the data reveals that CMH has opportunity forrepatriation and growth. The distribution of cases by level of care provides another perspective on the opportunity. (See ***Appendix 4*** *Distribution of Cases for Cambridge Catchment Level of Care 2015/16)*

From the 2017-19 strategic planning work, the following observations of our community and service needs were extracted:

- Cambridge and North Dumfries have 12.8% of residents over the age of 65 and a total catchment area population of 133,000.
- Cambridge has a slightly higher chronic condition rate when compared to other regions.
- Cambridge has a slightly higher rate of emergency department utilization when compared to others regions.
- Cambridge, as a community, has a higher percentage unemployed and a lower rate of secondary education completion than the provincial mean.
- Cambridge has a lower average household income than the Ontario average.

Community and stakeholder engagement in 2017 was a core principle in planning. Input was gathered from stakeholders and community partners such as emergency medical services, Waterloo Wellington LHIN, community providers, sub-acute and long term care providers as well as partner hospitals. A community survey was posted on the CMH Facebook page that gathered 400 responses. Information from the WWLHIN Patient Experience (269 responses) and internal work life surveys (600 staff & 100 physicians). Patient involvement occurred via input from the Patient and Family Advisory Committee.

Feedback from community partners at strategic planning sessions identified opportunities for greater collaboration with timely communication and notification of Emergency Department visits and hospitalizations. The access to CMH mental health services was noted as untimely and creating challenges for this group of patients who were waiting to access specialists. This feedback led to a goal in the 2014-2017 strategic plan to establish a framework for partnerships within local community; in the 2017-2019 strategic plan the goal was expanded to develop new models of care internally and within our sub region of Cambridge North Dumfries.

The Hay Group data outlined population growth and demand projections for 178 acute care inpatients. This was framed with the post construction reality of the additional 54 beds that provided a total of 166 acute care beds. This concept of ensuring new models of care, enhanced community partnerships to continue the path of quality and enhanced patient experience is threaded through the clinical services plan in the goal of growth with redesign.

An emphasis of the clinical services plan is not only which clinical programs will grow but rather how they will grow, how programs will be evaluated through the lens of additional volumes, cost and risk. The following Table 2 outlines some of the criteria used to guide decision making.

Table 2: Decision Making Criterion

Criterion	Description
Strategic Fit	The extent to which a health service contributes to advancing the strategic directions of the organization (i.e., “fit” with the organization’s mission, vision, values, and goals/objectives).

Alignment with External Directives	The extent to which a health service is limited by government mandates (e.g., protected programs) and legislated obligations, and/or contributes to achieving regional or provincial health services objectives. E.g. CCO targets or WTIS targets
Ideal Patient Experience	The degree to which plans move the health service closer to or further from the ideal patient experience, as defined through the community engagement process.
Clinical Impact	The extent to which health services volumes are sufficient to ensure clinical competency, patient safety and effective care, as well as considerations related to uniqueness of the service in the local/regional areas and to quality of service provided.
Community Needs	The extent to which health services and volumes are consistent with health needs of a defined community (or catchment area), including present and future demands for service.
Partnerships (external)	The extent to which a health service works in partnership with other organizations to coordinate delivery of care to defined populations (e.g., to enhance service quality, improve access, optimize resource utilization in the region or local catchment area).
Interdependencies (internal)	The extent to which a health service coordinates and collaborates with other health services within the organization to enhance quality or optimize resource use.
Resource Implications	The extent to which the resource context for health services delivery has implications for degrees of freedom in relation to prioritization, including funding source (e.g., base hospital budget, ministry of health volume-based funding, donation, revenue-generating activity), availability of staff (e.g., nurses, physician expertise) and capital resources (e.g., equipment, space), contractual arrangements (e.g., union contracts) and model of service delivery

Background

CMH provides community level care in medicine, surgery, woman and child care and is a Schedule 1 mental health facility, with community outpatient mental health programs. CMH provides 24/7 emergency care and ambulatory clinics that support the core inpatient programs. CMH has a rehabilitation program[1] of 14 beds. The table below provides an overview of the current state using beds as a proxy for clinical growth.

[1] The final bed capacity within the CMH functional program and associated footprint will provide 31 beds. The rehabilitation growth plan required for phase 3 of the CRP is outside the scope of this report as it will be created in partnership with regional partners. There is a rehabilitation consultation report commissioned by the WWLHIN in 2016 which will be the foundation for this planning.

Table 3: Inpatient Bed Profile

Unit	Budget Beds (17/18)	End-State PCOP	Planned Growth
Medicine A	25	68	18
Medicine B	25		
Surgery	28	35	7
Paediatrics	7	11	4
Mental Health	20	25	5
Critical Care	8	11	3
Special Care Nursery	6	6	0
Obstetrics (post-partum)	10	15	5
Rehabilitation	14	31	17

The following section outlines the current state for the clinical programs in 2017/18 when formal planning started in response to the Board approval of the Clinical Service Plan. It is worth noting that some gaps in service provision (lack of subspecialists to meet community needs) and models of physician care (closed access ICU) were identified for improvement prior to this time such that much of this work is an evolution and not clearly delineated in a fiscal year. Building a clinical program and associated physician recruitment in a competitive environment is often a multi-year process. Physician Recruitment is limited to those who can appreciate a future vision and want to contribute to the multi-year plans with incremental achievements annually. An example of this is the liver health concept within specialized medicine that requires active physician engagement to develop a detailed program plan with measured year over year growth.

The CMH medical leadership model is evolving; however it remains as an organizational goal to support the provincial emphasis on inter-professional teams, clinical quality outcomes that include patient experience and the concurrent goals of a system approach to transitions of care across the continuum. Health care has a history of silos and lack of connectivity across sectors so the challenge is to remove barriers for patients accessing specialist care while concurrently providing innovative technology that integrates into workflows. Medical leadership that is able to partner with administrative leadership is foundational to achieve the goals of the clinical services plan. These principles of collaboration, inter-professional team work, quality and improved patient experience are embedded in selection of physician and clinical leaders.

In any acute care setting, there is reliance on clinical support services (diagnostics, laboratory services and pharmacy) to support patient care and in this case, CMH is fortunate to have strength in skill and leadership in these areas to support the planned growth.

CMH is fortunate to have a strong relationship and connections with primary care as evidenced by a Chief of Family Medicine at Medical Advisory Committee, the welcome participation of the Chief of Staff at primary care business meetings, community practitioners supporting surgical assistant role in the operating room and family medicine coverage of inpatient rehabilitation program.

Clinical Support Services

Similar to the core clinical services required to support the Petals of Care in the growth strategy, there is a requirement for the clinical support services to augment any growth. To reiterate, CMH is fortunate to have strength in both leadership and service delivery in these essential services. The following is an overview of these services.

Cardiac Respiratory Diagnostics Unit at CMH provides services to inpatients and outpatients. The current test complement includes ECG, Exercise Stress Testing, and Echocardiography including contrast studies, pulmonary function testing and holter monitoring. Plans for expansion of services over the next year are in development and this expansion will broaden our test offerings to include Stress Echocardiography. The Cardiac Respiratory program is supported by a group of dedicated professionals including cardiologists, respirologists, echo technologists, cardiac technologists, respiratory technologists and clerical staff. The Echocardiography lab just recently achieved CorHealth accreditation.

Diagnostic and testing services at CMH include CT, MRI, Nuclear Medicine, X-Ray, Ultrasound, Mammography, Ontario Breast Screening and Bone Density.
These DI services include diagnostic tests related to Emergency Medicine, Oncology, Orthopedics, General Surgery, Obstetrics & Gynecology, Gastroenterology, Cardiology, Internal Medicine & Pediatrics. Image guided biopsies of breast and thyroid and various musculoskeletal procedures are performed in Ultrasound. Image guided biopsies are performed in Mammography for detection of breast cancer or pre-operative surgical planning. Image guided pain control procedures such as steroid injections are performed in Fluoroscopy/MRI, CT and Ultrasound. The Diagnostic Imaging Department is the only facility in Cambridge & North Dumfries that offer these services.

Radiologists at CMH are all fellowship trained with sub-specialization in the following specialties: Body Imaging, G.I. & Liver Imaging, Musculoskeletal imaging, neuroimaging, and Women's Health.

It is anticipated that diagnostic services growth will occur in response to both community and changing hospital programs; (**Appendix 5** *Diagnostic Imaging Volumes)* reflects trends in diagnostic volumes. It is important to note that growth in some areas such as MRI is capped based on MOHLTC volume funding and may not meet actual demand. Diagnostic tests of this nature are prioritized and there is a focused effort to ensure that the priority cases are completed in compliance with the Ministry of Health and Long Term Care (MOHTLC) guidelines.

Infection Prevention and Control (IPAC) department at CMH supports the infection prevention and control needs across the organization. The Infection Control Practitioners, hand hygiene auditor, and clerical staff work closely with staff in clinical areas to provide education and guidance to staff, physicians, volunteers, patients and their families. Physician leadership and support for IPAC is provided by a dedicated Infectious Disease Specialist who also provides consultations for inpatient and ED patients. A follow up clinic offers transition support for recently discharged patients and community consultation.

Laboratory Department at CMH is a licensed department, as well as ISO 15189 Plus accredited, participating in mandatory assessments every two years. Laboratory services are provided 24/7 for ED and hospital inpatients and additional daytime services are provided for a variety of outpatient clinics. The Laboratory performs testing in disciplines of biochemistry, hematology, transfusion medicine, and histo/pathology, with microbiology and specialized testing referred to other testing sites.
The Pathologists provide expertise in areas of surgical pathology and support in all other clinical disciplines. Since reporting wait times to Cancer Care Ontario (CCO), CMH Pathology has been recognized for meeting or exceeding the wait time benchmarks, reporting results within 14 days for all disease sites. This ranks our Pathology department as one of the top performing laboratories in the province.

Pharmacy Department services inpatients and selected outpatient programs with timely procurement, safe distribution and expert support for administration. The pharmacy participates in the Ontario College of Pharmacy annual accreditation process and creates annual improvement plans to meet new and emerging standards. The pharmacy team works closely with Grand River Regional Cancer Centre to prepare systemic therapy according to standardized protocols, minimize wastage and ensure safety in medication preparation. Other functions of the pharmacy department focused on patients are:

- Patient medication education/counseling
- Drug information to respond to patient or family medication questions
- Personalized patient medication assessments for safety and effectiveness, and interaction with the health care team to optimize medication therapy
- Medication reconciliation starting with the best possible medication on admission to reconciliation on internal transfer and discharge.
- Liaise with community pharmacies as required and requested.

The pharmacy staff, made up of pharmacists and pharmacy technicians provides both clinical and distribution services to the inpatients and select outpatient of the hospital. The medication management system adheres to the Ontario College of Pharmacists and Accreditation Canada Standards.

The role that pharmacy plays in patient care is ever evolving and expanding to meet the needs of the patients and the clinical teams. d

Medical Day Care – CMH offers systemic therapy in partnership with Grand River Regional Cancer Centre. The Medical Day Clinic (MDC) and the oncology program supports physical, emotional, psycho-social and spiritual well-being of patients and families while providing seamless transitions of care between home, hospital, and community, to enhance the quality of life for people living with cancer. At CMH, MDC is a multi-disciplinary program for out-patients that provide diagnosis, treatment, and complex symptom management for those experiencing oncological or hematological disorders. MDC manages oncological and hematological referrals, treatment, and provides systemic therapy (chemotherapy, immunotherapy) and supportive therapies (blood transfusions, IV Medications). The team consists of two Medical Oncologists, a GRH Radiation Oncologist on site one day per week Oncology Associates (OA), Clinical Trials RN, Registered Nurses, Social Work, Dietician, Pharmacists and other support staff.

The CMH model has medical oncologists hired by Grand River Regional Cancer Centre and situated at CMH while the specialized nursing is provided by CMH employees. This clinic works closely with the regional cancer centre to ensure common practices, standards and expected volumes and targets are achieved.

Diabetic Education Clinic is complementary to the community based education program, supported with regional intake and CMH also provides the specialty of pediatrics and insulin pump management. These nurses support inpatient consultation as required. (*See **Appendix 6** Ambulatory Care Clinic Visit Activity)***.**

Chronic Obstructive Lung Disease (COPD) Clinic which is an NP led model to support these patients, transition to primary care or co-manage as appropriate with the community respirologists. (See **Appendix 6** *Ambulatory Care Clinic Visit Activity)*

The Emergency Department: The current footprint was built for 30,000 patients and current volumes are greater than 51000,(2017/18) which creates frequent challenges to efficient processes and delays in care. The current department is operating with triage separated from the main department in a temporary nature to support the capital redevelopment project construction. This temporary configuration has created additional distance for ambulatory patients and waiting space is also fragmented. The new CRP space is double the current footprint and will be a welcome relief for patients, staff and physicians. Despite this space reality, the ED team is providing best practice clinical care and making significant improvements in patient flow to decrease wait times. The goals for this department are minimal growth with focus on clinical excellence, patient flow and patient experience. Learning from other organizations, it is appreciated that opening new Emergency Departments can exceed volume expectations and this remains a calculated risk to monitor. As a quality standard, the goals of the clinical programs are to prevent readmissions or ED revisits (mental health, chronic diseases such as congestive heart failure) and these metrics are monitored by the specific programs.

The ED visits have been declining year over year (3% annually), however this is noted as positive as the lower triage (conditions that can be managed in the community) volumes are decreasing and the higher triage or acuity ED visits are increasing. (*See **Appendix 7** Emergency Department Visits by Acuity*)

Critical Care: CMH currently has 8 critical care beds that flex to include a stepdown model of care. In preparation for the increased complexity planned in the clinical growth plan, the critical care intensivist model was introduced in 2016. Initially day time intensivist coverage occurred with the longer term goal of recruitment to 24/7 coverage. The timetable to achieve this end state model is influenced by many parameters, such as number of critical care beds, acuity of patients, compensation and competition in this field. This intensivitist model is a standard for critical care and often difficult to achieve and maintain in small community hospitals so there is pride in the ability to recruit skilled physicians and maintain this model during the delay with CRP. Growth plans are predicated on ability to care for increasing complex patients in this community, repatriate from tertiary centres and support the planned growth in surgery and medicine. Specific quality improvements for critical care implemented are inter disciplinary bedside rounds that include the patient and family.

In response to the physician recruitment of intensivists and the progression towards a closed access ICU, the critical care volumes have increased 25% since 2016/17. The indicators of acuity such as invasive mechanical ventilation and central line days have increased at a greater rate. *(See **Appendix 8** Clinical Care Activity and Acuity)*

Year One 2017- 2018

Medicine Program:

The medical program at CMH reflects a community hospital, the majority of patients are admitted from the Emergency Department and there is minimal specialization of the medical beds (e.g. dedicated beds for oncology, cardiology, respirology). The medical patients are primarily cared for within a hospitalist model. One of the medical units (Med A) cohorts cardio pulmonary admissions with telemetry units supported by ICU infrastructure and ICU RNs. These telemetry patients are uniquely managed by the general internal medicine group of physicians. Oncology palliative patients are admitted to Med B and this group of patients is cared for by the GPO (General Practitioner Oncology Associates) with support from the medical oncologists as required or requested.

With the goals of improved inter professional communication, improved patient experience with greater family engagement and achieving quality outcomes and length of stay targets, a new model of care delivery was introduced in 2018. The Accountable Care Unit (ACU) concept was introduced, building on current use of bedside whiteboards and nursing transfer of accountability at the bedside for shift change. The additional feature introduced early in 2018 was bedside rounding that brought the inter-professional team to the patient (and family) on a clearly communicated daily schedule. A pharmacist was added to this team to augment the team recognizing their contribution to the plan of care with monitoring and advice on the medication treatment plan. This new model has been readily accepted by the nursing staff and the home and community discharge team as it affords direct communication of the plan of care. Informal feedback from patients and family members has been positive. A significant challenge has been the ongoing pressure of additional ten or more patients which are often bed spaced on other units, interrupting the planned physician workflow.

This clinical model represented a major shift in physician practice and with changes of this significance; stabilization has taken time and effort. Growth in medicine while focused on increased subspecialty presence to support both the community and hospital needs also requires the transition to a closed access model of intensivist coverage for the ICU for day and night time coverage. The medical admissions enter via the Emergency Department such that Medicine is responding to community growth, number and accessibility of community practitioners, and community health resources. Medicine program reflects home and community services (formerly CCAC) capacity and sub-acute resources (rehabilitation, long term care, and palliative programs) as the available beds can be disproportionally filled with alternate level of care (ALC[2]) patients. Managing growth in Medicine is challenging to

[2] ALC- When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care [CCC], Mental Health or Rehabilitation), the patient must be designated ALC1 at that time by

ensure the patient acuity that requires acute care versus growth in ALC in the absence of active daily management. CMH has an integrated discharge planning team who focus in the ED on admission avoidance or timely supported transition plans at discharge.

Medical outpatient or ambulatory clinics at CMH are complementary to our inpatient programs. CMH appreciates the provincial health care system goal to provide care in the community setting where possible. The following ambulatory clinics are in operation. (*See **Appendix 7** Emergency Department Visits by Acuity*)

Renal and Liver Health were identified subspecialties in the clinical plan. Renal was predicated on a partnership with Grand River Hospital and the establishment of a satellite dialysis clinic located at CMH. Currently residents of Cambridge North Dumfries travel to Grand River Hospital for this life sustaining treatment and an analysis has demonstrated the critical mass for local care. This proposal has support from Grand River Hospital, Ontario Renal Network and the Waterloo Wellington LHIN and awaits Ministry of Health and Long Term Care capital approvals. This hemodialysis outpatient program provides local nephrologist consultation and builds capacity for this service. The hemodialysis program on site, coupled with the presence of the nephrologist will facilitate repatriation to CMH when the principle limitation is access to dialysis.

Similar to renal, there is a gap in a comprehensive liver clinical service offering and this has been identified as a community priority. The risk in alcoholic cirrhosis (from a steady rise is substance use) and viral liver disease (from a changing demographic) have given rise to this gap. Currently there is 1 gastro intestinal physician with this clinical focus who alone will not manage this demand. Planning is in the preliminary stages for this growth and will be tied to the Endoscopy growth plan with CRP. This plan will include a robust and enhanced team to manage acute gastrointestinal bleeds. This links to the evolution from generalized medical care to a more specialized approach to medical care The recently graduated general surgeons have trained in a curriculum of sub specialty in which included gastroenterology which would manage this clinical presentation, whereas the historical training would include this competency for general surgeons. This is another contributing factor to the CMH investment and commitment to a liver gastrointestinal health plan.

The medical human resource plan has been a significant focus to address gaps in medical sub specialties both in hospital and community. The growth with specialization of medical practice requires multi-year strategies to move from a generalist to a specialist model and recruit sufficient specialists to align with the planned clinical growth and to support the on call requirements. Recruitment is aligned with clinical goals and often includes investments in new capital equipment, new resources and development of new processes with inter-professional team members.

Mental Health Program 2017-18

CMH was granted Schedule 1 hospital status in 2011 and operates 20 inpatient beds, a structured day hospital program, outpatient clinics, specific child and youth outpatient clinics and provides 24/7 psychiatric support to the Emergency Department. Despite best

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the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination2 (or when the patient's needs or condition changes and the designation of ALC no longer applies).

efforts, the community mental health reputation was less than ideal based on significant wait lists in the outpatient clinics which amplified as CMH migrated to central intake system with Here 24/7 a Canadian Mental Health Association (CMHA) intake portal developed in 2017.

In 2016/17 CMH partnered with local hospitals to launch the regional bed tracking system (component of the existing provincial system) specific to mental health Schedule 1 inpatient beds. The goal is to ensure that patients are not waiting for care in a local Emergency Department when there is capacity at a neighbouring hospital. This initiative started a cultural shift of collaboration across mental health facilities and supported goals of system thinking.

Significant effort has been focused on redesigning service delivery to better reflect changing philosophy of mental health care and address the access issues. A consultant provided a review of the day hospital program and work started in 2017 to redesign this program with goals of community physician direct referral, direct admission process that was responsive to patient needs and efficiency with staff resources to facilitate the increased volumes. This work has started in the current space and while the new CRP space will offer significant additional space and opportunities, the core program is now in place to build on. A pending benefit in the new space is the adjacency to the inpatient unit that allows inpatients to easily attend appropriate programming in this space.

The reduction of the growing wait list was also a priority and the approach was multi-pronged. In the past year, CMHA had introduced central intake for adult referrals via a portal, Here 24/7. This portal process was poorly understood by CMH as well as community practitioners and required significant work to perform a value stream analysis, workflow review, implement changes and evaluate. One of the goals was to work with community partners and stream line the referral form which assisted CMH with clarity regarding consultation goals and reduced delays in booking appointments. At the same time, the psychiatrists and all mental health outpatient staff were asked to review caseloads and identify scheduling changes that would assist with increased and timely input. Additional weekend clinics and evening clinic appointments were established for short periods to support increased assessment and treatment. For long term clinic patients, new partnerships with community practitioners occurred to discharge these often stable patients and create capacity for new patients. During this time, recruitment continued for psychiatrists to support the demand. The other pathway that was created by the Chief of Psychiatry was a new responsiveness to telephone consultation by community practitioners such that referrals may be avoided with this level of continuous and immediate specialist support.

This significant and complex work culminated with the clinical and administrative leadership support and wait lists dropped significantly as new processes continue to be monitored and managed. It was so important to set this stage for growth as the community providers now trust and compliment the CMH mental health services, which is foundational to our growth goals and patient experience goals. This wait list is closely monitored by the program to ensure that the patients are seen in accordance with their assigned priority and established appropriate wait times.

Outreach through community partnerships was another goal that CMH was able to advance with the support of the Chief of Psychiatry, recruitment of a new psychiatrist and partnership with community providers. Langs, a local community health centre was identified as a partner with available space and willingness to provide in kind clerical resources to pilot a new model. The CMH social worker and psychiatrist work at Langs weekly on a set date and time seeing Langs patients. This physical co-location creates a new venue for physician consultation, case review, teaching and relationship building. This pilot started in 2017 and evaluation highlighted the merits of this model embedded in primary care for patients and practitioners. Based on this positive evaluation an outreach site was established at Grandview with a decreased frequency that matches the practice demand as well as another outreach operating in downtown Galt in partnership with the Nurse Led Practitioner Clinic. It is understood by CMH leadership that these outreach initiatives offer multiple benefits and align with provincial and local plans to provide care in the community.

Child and Youth Mental Health Services remain a small component of the CMH outpatient program. There is dedicated funding and reporting to the Ministry of Community and Social Services. Lutherwood is the lead agency for planning and service delivery for child and youth (CMHA supports adult community mental health). There is a larger initiative reviewing the model of mental health services for this vulnerable group and CMH will await direction and align efforts as we participate in planning forward. It is of note that this provincial funding for child and youth mental health has recently moved to the Ministry of Health and Long Term Care.

Electro Convulsive Therapy (ECT) was started in 2017, recognizing this therapeutic modality was a foundational component of a mental health program as well as an opportunity to enhance local care for residents. Prior to this, the majority of patients were traveling to Grand River Hospital three times per week for the duration of the therapy. Community providers noted that this travel was often a challenge for this group of patients and willingness to consent was limited. The ECT service is delivered in the post anesthetic care unit and requires skilled nurses competent in Phase I recovery of patients, as well as support from an anesthesiologist, respiratory therapist, and nursing staff from the mental health unit. Establishing ECT therapy at CMH prior to the CRP completion, demonstrated the cross clinical program collaboration to achieve strategic goals.

Addictions and Opioid treatment: This is a hospital wide (community/provincial) challenge. It remains a significant gap for Cambridge North Dumfries sub region which has been highlighted as a hotspot for opioid overdoses *(See **Appendix 9** ED Visits for Opioid Overdose)*. Addiction requires a multi-pronged approach that includes prevention, safety and risk mitigation, acute treatment and longer term support in a community setting.

CMH treats acute overdoses, concurrent medical issues that require hospitalization and counseling or treatment in an outpatient setting. Addiction requires a system (health & social services) response and this is in the development stages in Waterloo region. CMH has implemented protocols and continues to evolve practices to emerging best practices. The best opportunity may be for CMH to effectively partner across the system to create solutions. Current actions include:

- Introduction of standardized assessment tools specific to alcohol use that contributes to a provincial data base.
- Standardized order sets for opioid withdrawal treatment have been introduced.
- Partnership with local community agency Stonehenge to establish peer support for overdose patients
- Partnership with community providers to establish a rapid addiction assessment clinic

CMH benefits from the established Mental Health Family Advisory Council which provides regular counsel on initiatives, planning and provides feedback on current programming from a user/family member perspective. Recruitment of new family council members has successfully occurred by existing members in their attendance and support of CMH family education sessions regarding living with mental illness.

A program planning exercise was hosted in June 2017 with community partners to gain feedback on opportunities, strengths and weaknesses to consider with future growth. Broad representation of about 50 stakeholders identified system issue gaps in subsidized housing, lack of addiction treatment services, difficulty navigating the system, long wait lists for service and gap of services for child and youth. Communication among and across providers was also identified as a challenge, not unique to mental health however problematic in this population. This feedback guided planning efforts and cemented the CMH commitment to participate with system partners in a new provincial pilot of a C-QIP (collaborative quality improvement plan) with the focus of improved access to mental health services. This C-QIP concept was introduced with the assistance of Health Quality Ontario. The WWLHIN staff, hospital and community organizations board members with their senior leaders were brought together for several sessions to learn about this quality improvement concept. Local gaps in service delivery that benefit from a system lens were discussed and priorities debated. The subsequent board commitment brought system partners together with renewed clarity of purpose and timelines to improve access to mental health services.

Surgical Program 2017 2018

The surgical services program at Cambridge Memorial Hospital (CMH) primarily delivers care to the residents of Cambridge and North Dumfries in keeping with a community level of care. The exception is the breast reconstruction program which when introduced with Board approval in 2014 was unique for community hospitals.

During the 2016/17 fiscal year, the staffing complement for the perioperative program included 37 surgeons, 13 anesthesiologists, and 122 nursing staff working across the areas of the Pre-surgical Clinic, Surgical Daycare, Operating Room, Post Anesthetic Care Unit, and Minor Procedures.

The Surgical program planning involved small group meetings with each surgical subspecialty to outline strengths weaknesses and opportunities for growth. *(See **Appendix 10** Surgical Sub specialties volumes)* Data analysis and business plans for growth identified new expenses, capital and projected impact on other departments (Diagnostic Imaging, Lab etc.) as well as volume targets. Recruitment needs were also identified and incorporated into physician human resource power planning goals. A surgical program

planning session was held in February 2017 to identify gaps in planning and opportunities that may not have been previously considered. The principles for growth and identified areas for growth were reviewed as well as background data. Data presented included volumes, type of surgery, wait time data, Cancer Care Ontario targets and previous achievements re wait time and volumes. Health Quality Ontario clinical best practice guidelines provided a resource to evaluate current practice and strategy for growth. Unfortunately invited former patients were not able to attend and subsequent phone interviews occurred which confirmed support of proposed plan. Community practitioners were positive with the planned expansion of surgery offered locally. In planning to grow specialized surgery CMH had the additional benefit of a recent WWLHIN surgical plan that was completed in 2016/17. The goal was to augment the surgical program with new surgeries that would be safely completed in a community hospital and meet demand of Cambridge North Dumfries community. This WWLHIN surgical plan combined with CMH data outlined opportunities for growth and highlighted in the data were:

1) Breast reconstruction – CMH is the only hospital that performs immediate breast reconstruction surgery. In 2017 CCO guidelines highlighted the expectation that all breast cancer patients have a referral for this surgical intervention. As referrals can occur years after any active treatment this is a significant growth opportunity.
2) Gynecology Surgery – wait lists were above target and repatriation opportunities were identified. Move to minimally invasive surgery Minimally Invasive Surgery (MIS) to meet best practice standards.
3) Urology Surgery – repatriation opportunities, growth to meet CCO wait time targets. Expansion to include MIS approaches.
4) Orthopedics – growth to meet demand, address wait times and expansion of surgery offered to meet unmet community needs (increase shoulder surgery and add ankle surgery, ortho spine surgery).
5) ENT – expansion to include new surgeries to meet community demand
6) General Surgery – expansion to include “upper gut” MIS procedures, continued growth in MIS approach.

To augment the surgical program and setting the stage for growth in providing a greater complexity of surgery a need for a pain service was identified. CMH invested in adopting a comprehensive team approach to pain management. A dedicated Acute Pain Service (APS) that includes a full time Nurse Practitioner (NP) collaborating with the Department of Anesthesia began in 2016. This model of care supports safe and timely care for admitted patients across multiple programs. Within the Women’s and Children program, the daily anesthesiologist assigned to the acute pain service provides access for either a request for pain management (epidural) or c-section. The NP continues to monitor these patients for pain relief and symptom management. The enhanced access to pain management is integral to the program and our goal to improve the patient experience. The majority of patients seen by this service align with orthopedics, followed by obstetrics, general surgery and urology.

Like many surgical programs in the province, there had been a shift from inpatient care to ambulatory procedures as a result of technology, anesthesia practices & pain management

modalities and advance patient preparation. This concept of teams, data and technology was emphasized in the clinical services plan as a foundation for CMH growth and redesign.

Capital equipment needs are significant in any surgical program and the planned expansion of services identified additional in new equipment beyond the requirements set out in the CRP. Equipment purchases were identified and prioritized to support the introduction of new surgeries or increase volumes. One piece of equipment to provide new sinus surgery by ENT is an image intensifier which allows projection of CT scan images during the surgery to perform this microsurgery. The procurement and implementation benefited from a collaborative approach between diagnostic imaging physicians and staff, ENT surgeons and clinical surgical leadership to ensure alignment of processes. This surgery was introduced in 2017 and aligned with the goal of new surgeries closer to home as patients are were previously referred to London for care.

Quality Program for Surgery

Similar to the pain service as fundamental, the need to consider the specific quality monitoring required augmenting the increased complexity of surgical cases was identified. In 2015, Health Quality Ontario in 2015 launched the Surgical Quality Improvement program, utilizing the model of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). This program consists of a community of practice, sharing best practices, submission of specific clinical data with comparison to best clinical outcomes and feedback. In 2018, CMH joined over 32 sites in Ontario participating in this data sharing initiative with targets and goals that are measurable and meaningful to the patient experience and quality outcomes. Participating hospitals report improvement with this focused attention, relevant data, the collaborative practice environment that supports shared learning and improved surgical clinical outcomes within 3 three years of membership. A dedicated staff to review charts is an element of this success in partnership with the physician/surgeon champions who were identified in 2017 to drive this quality agenda.

Similar to previous discussions regarding health human resources, the clinical services plan guided recruitment of surgeon subspecialties, anesthesiologists and perioperative staff to ensure ability to repatriate surgical volumes and growth to ensure wait time targets or provide new surgical services that are appropriate for a community hospital.

Woman & Children Program 2017 2018

The Woman and Children's program at Cambridge Memorial Hospital is a small community program that services the community to ensure access to care close to home. The program consists of the following areas: obstetrics triage assessment, labour and delivery and postpartum. There is a special care nursery and a small inpatient paediatric unit. The patient volumes across the program have remained fairly constant year over year at about 1400 annual deliveries. CMH has obstetrician/gynecologists and midwives who support the birthing aspect and Pediatricians who support the special care nursery and paediatrics. The program has four distinct specialized care areas which in its current space create inefficiency and staffing challenges as these areas require unique and advanced clinical knowledge and expertise. In particular the stand alone, small and essential inpatient paediatrics unit with seasonal variation contributes to this scenario. This is not a unique

situation to CMH but is an issue in most community hospitals where sustaining a small program is part of the overall strategic plan for the hospital to ensure access and care close to home.

There is a surgical paediatric population (both day surgery and inpatient) who are managed by the specific surgical specialist. The majority of paediatric surgical care is for tonsillectomy procedures. In 2017/2018 in response to a long wait list at Hamilton, a local oral maxiofacial surgeon began alveolar palate repairs. This offered local complex surgical procedures, in partnership with Hamilton, closer to home.

An associated and essential ambulatory clinic supports 24 hour check of infants for bilirubinemia and cardiac follow up. The paediatricians support this daily clinic for all hospital or home midwifery births.

The volume of births drives the program growth and CMH has not kept local market share for labor and delivery patients. This is due in part to some reputational issues regarding pain management as well as due to the current aging infrastructure in a somewhat elective program where environment and experience prevail. Care processes in the current infrastructure are fragmented with C-sections occurring in the main operating room. *(See **Appendix 11** Birth Volumes)*

In 2016, members of the CMH Patient and Family Advisory Council (PFAC) questioned the hospital about the community reputation of care provided on the Obstetrics program; specifically, if we had noticed a decline in our birth numbers in recent years from community members choosing to deliver at other hospitals.

Data analysis indicated that only three out of four women with a Cambridge or North Dumfries postal code were delivering low risk vaginal births at Cambridge Memorial Hospital (CMH); the remaining 25% were delivering elsewhere. (See **Appendix 12** *Cambridge and North Dumfries Mothers Delivered, Market Share)*

Following an article printed in the Cambridge Times in January 2017, over 40 email and telephone responses from community members regarding care received on the obstetrics program and/or from parents who chose to birth elsewhere and their rationale for doing so. From all of this feedback five (5) themes were distilled and in April 2017 we invited community members to CMH to validate these themes. The five (5) themes were: bonding, respect/dignity, choice, relationship with staff and information sharing.

These findings and themes were challenging for the program staff and physicians to appreciate; however there was a collective will to improve the service delivery and the communication. Additional feedback was gathered and included a request to augment the lactation support available which was achieved with a volunteer led breast feeding program. Also noted was the emotional upheaval for new parents with any infant transfers post birth to support greater neonatal clinical needs. The improvement plan focused on service enhancement to increase modalities and interventions that could be provided at CMH to decrease transfers post-delivery and support earlier repatriation primarily from Hamilton when the tertiary level of neonatal ICU was required.

Breast feeding is recognized as a best practice and CMH continues on the journey towards achieving standards of baby friendly accreditation. This is multi-year journey and annual goals are established towards this goal. CMH has realized incremental improvement in breast feeding rates with associated and expected decrease in formula supplementation rates which reflects this work.

Care and attention to the patient and family experience, with a dedicated focus on communications strategies that will promote CMH as a preferred birthing program moved to a top priority. It is appreciated that while the physical environment is important and constrained pre-CRP, the caring moments, respect and communication is a stronger driver of patient experience scores.

Current state, pre CRP planning, c-sections were performed in the OR surgical suite with recovery in the main post anesthetic recovery room. In preparation for the new footprint where there is a dedicated operating room and recovery room for c-sections within the labour and delivery area, transition planning for the labour and delivery nurses included training to develop this new competency. With the full support of the obstetricians, anesthesiologists, the OR nurses have partnered with their colleagues to ensure a successful transition of these skills and competencies.

The plan for the Woman and Children's program is focused on growth to align with community needs. The focus of the work will be efforts to ensure quality programs aligned with provincial maternal child standards and ensuring a positive patient experience.

The surgical program at CMH will provide capacity and support for two important aspects for the health of women and children within our region.

1) Maintain a small pediatric surgery program. This program provides access to services such as otolaryngology, dentistry (that require hospital services), and oral maxillofacial procedures. There are no plans to increase volumes or change case types of this service which currently accounts for approximately 6% of the entire surgical volume.
2) Repatriation of volumes with increased surgical capacity in gynecological surgery to improve access and reduce current significant wait times for this surgery

Enablers for Success

How each program grows to meet the community needs was a deliberate focus with the intent of inter-professional models, a focus on patient experience and effective and efficient service delivery. The infrastructure and corporate or community systems that are required to achieve these goals are enablers of success.

- IT infrastructure that supports timely communication
- Notification to primary care providers of ED visits and admissions (in place)
- E-notification that includes home and community services of ED visits and admissions. (December 2018)
- A strategic plan that ensures technology to enable key clinical processes that support patient safety goals (medication reconciliation, physician order entry, bedside verification of medications)

- E-tools that support and promote patient engagement (CoHealth/My Chart)
- Decision Support data that is timely, assists in process improvements, quality monitoring and efficiency capture.
- Program level clinical dashboards to drive quality in reporting performance to benchmarks established by CCO, HQO and the provincial wait time strategy
- Department of Family Medicine link with Medical Advisory Committee and CMH Integration with Local Health Integration Network Home & Community Services in the structure of CMH discharge planning model
- PFAC/ Mental Health Family Advisory Councils direct and ongoing link with community members for advice and feedback
- Accreditation Standards to meet and surpass (e.g. medication reconciliation at discharge)
- Community Partnerships/Structure to build trusting relationships that enable system change. Examples of system initiatives are:
    - Improve Discharge Planning processes– c QIP –reduce rates of admissions for chronic conditions (CHF & COPD)
    - Increase access to mental health services – c-QIP to establish system improvement goals

Stakeholder Consultation

As identified the basis for the clinical service plan was the strategic planning session that provided baseline demographics, utilization patterns and included consultation from leadership, Board and community partners. The Clinical Service Strategy was shaped with the following inputs:

- Extensive market research conducted by the Hay Group for the Waterloo Hospitals Collaborative Committee and CMH, which culminated in a joint MAC-Board of Directors Retreat in 2015
- Broad based internal stakeholder feedback sessions that spanned every clinical department, each medical leader and each Director and Manager at CMH in 2016
- Solidification of the CMH Post Operating Construction Plan (PCOP) through 2016 and 2017
- The initial feedback from the strategic planning sessions informed the clinical services plan in concepts of timely access to community level services, partnerships with community providers, an emphasis of the community reliance on the mental health services offered at CMH. There was feedback to provide services for chronic conditions such as dialysis where regular travel to Kitchener was challenging.
- The Chief of Staff hosted specific clinical sessions to listen to ideas, learn about barriers and create the clinical services plan. Barriers were themed as feasibility, foundation or fear. Fear being loss of a program for the community. The themes of partnership, doing things differently in terms of new inter-professional models, reliance on data for decision making and improved use and integration of technology emerged as themes.

As highlighted, each clinical program in creating the plan forward gathered utilization data, learned from stakeholders (meetings with stakeholders to learn more about gaps,

opportunities, priorities and strengths). The following is a high level of themes heard and considered in planning documents.

Medicine – early planning occurred with the physician leads to strengthen critical care and move to an intensivist model of ICU care. Discussions occurred at Medical Advisory Committee and updates were provided to the Board. The platform for a new model on medicine evolved from a leadership search for an inter-professional model that enhanced quality of care and improved patient experience. The liver health plan is in the early stages of socialization with Medical Advisory Committee and physicians.

Mental Health – a strong voice to increase access with reduction in wait times, transparency in the outpatient programs to clarify all the programs offered to assist with referrals, partnerships with community providers to augment and strengthen discharge transition planning and new partnerships to contribute to emerging issues such as opioid use addiction. CMH was encouraged to implement the planned ECT program as soon as possible and continue with plans for outreach.

Surgery Program offered advice in keeping with a community hospital and growth in breast reconstruction, general surgery, urology, ENT to meet local needs. There was support to increase the orthopedic surgery offered and to advance goals of minimally invasive surgery. There was recognition of the requirement to continue to build the pre-operative clinic for the more complex surgeries as well as the need to continue to evaluate length of stay and conversion from inpatient to outpatient.

Women & Child supported modest growth and focus on processes that enhance patient experience. A goal for an early loss clinic or protocol, advance the clinical practice skills for midwifery, move the elective c-sections out of the main OR were identified. The addition of the acute pain service and accessibility to anesthesia for epidural pain management were positive steps forward to address a long standing program gap. The goal to increase the level of the special care nursery was commended by the paediatricians who have heard concerns from patients re transfer out or their relief when their infant can return to the local community.

Summary: A comprehensive CMH Clinical Services Plan emerged and was finalized incorporating stakeholder feedback and utilizing the criteria presented. . It is understood in healthcare that planning beyond three years at an operational level is subject to change. Program priorities were discussed and determination of what can we do now, what investments are required, what is contingent on new space. Where possible, what is the biggest impact for patient care drove the immediate. An example is the addition of ECT for mental health patients. It was understood as a gap for a Schedule 1 facility programming and creating hardship for patients to travel out of their community. The physician expertise was available as a locum and 2 psychiatrists championed this modality. A brilliant example of cross program planning emerged as surgery accepted this priority and partnered with mental health to bring this treatment into the community. A noted priority is treatment program for opioid addiction, however recruitment of this physician expertise remains a challenge hence the timing to introduce this service offering does not match the community urgency.

Each clinical petal program has created a 4 year high level plan to map out the goals and deliverables. Each initiative has or will undergo extensive planning, using process improvement tools and including the patient voice as possible. The program plans can be found in the appendix.

Appendix 13 CMH Medicine 4 Year Program Plan
Appendix 14 CMH Mental Health 4 Year Program Plan
Appendix 15 CMH Perioperative 4 Year Program Plan
Appendix 16 CMH Women & Child 4 Year Program Plan

The magnitude of organizational change that CMH is undergoing is significant as each clinical program is moving forward to grow volumes, change models of care, on board new practitioners and introduction of new equipment, new processes and new standards of care. As a community hospital, CMH has thrived with the generalization approach to patient care and now CMH will evolve forward with the advance of PCOP funding. Program Specific Risks/ Organizational Risk and Mitigation strategies

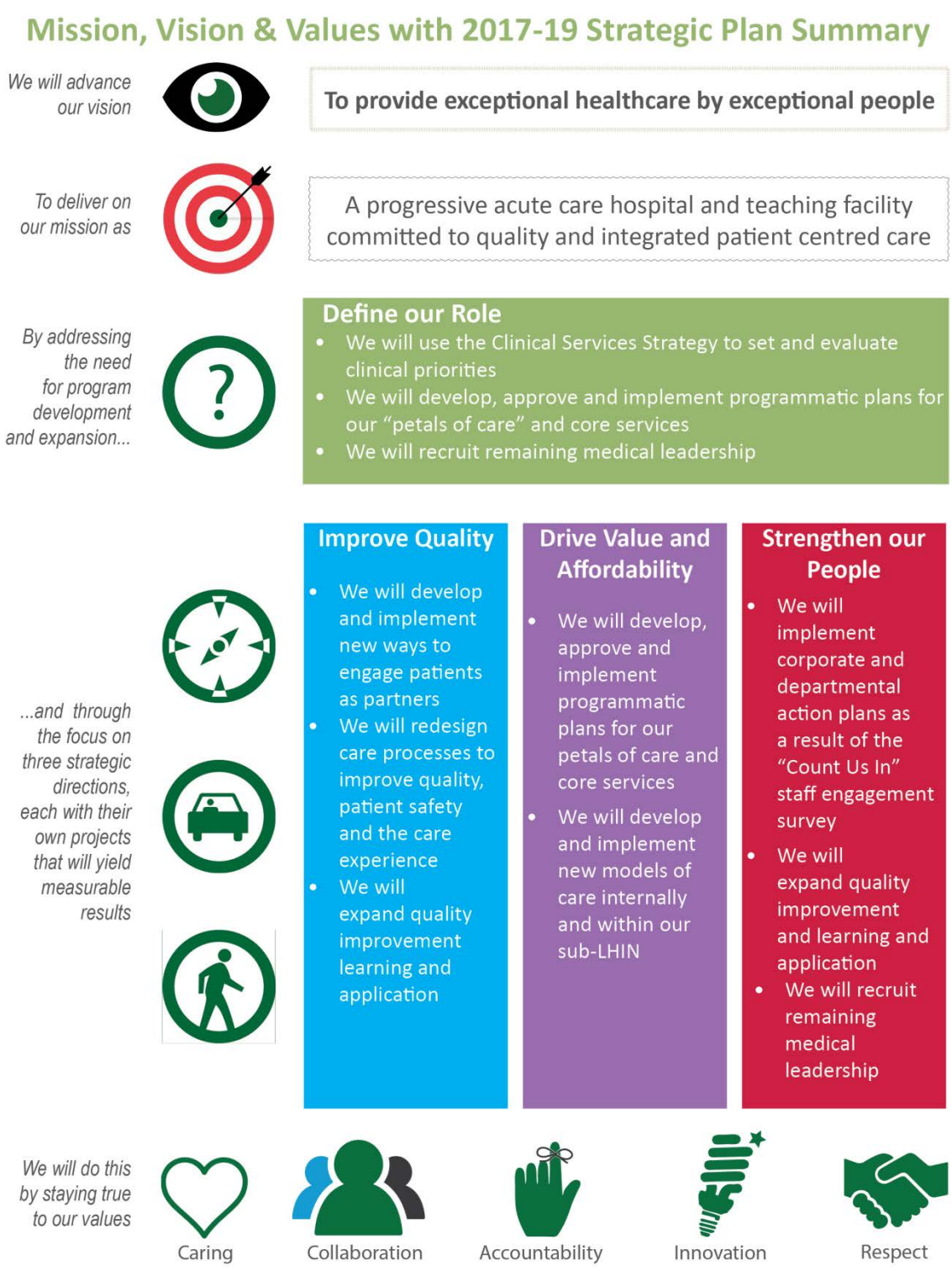
Program /Department	Risks	Mitigation Strategies
All	Delay in CRP	Continued focus on improvement strategies which can be implemented prior to move Regular communication to leaders and organization wide
All	Inability to recruit and retain required staff and physician skills to align with growth plan	Constant communication with Human Resources, Chief of Staff office, staff and physician engagement strategies – proactive planning & recruitment for best candidate, organizational fit & alignment of strategies.
All	Change fatigue	Leadership focus on staff & physician engagement, modeling positive yet realistic approach to improve care processes and clinical outcomes
All	Specialization vs generalization in a community hospital	Communication, benchmark performance and advance time to adapt
Surgery	Emphasis on program growth & simultaneous changing processes is significant PCOP relies on growth of volume & weighted cases that is sustained	Constant communication, review and data to confirm directional intent and outcomes are aligned
Mental Health, Medicine	Overcrowding /boarding in the ED with delay in CRP	Continuous review of bed plan, new models & opportunities with existing space Focus on safety for ED staff and physicians
All	Unknown provincial or	Attention to provincial & WWLHIN

Program /Department	Risks	Mitigation Strategies
	WWLHIN initiatives such as funding models changing	signals for change. Close work with decision support and finance re cost per case, physician leadership and partnership
All	Patient Experience	Clinical focus on access, quality using available standards, corporate priority
Woman & Child	Dated sub optimal space	Focused attention on improvements that can be advanced to augment program
All	Reputation	Partnerships with community and system providers. Advance interest, ability and readiness to funders. Demonstrate capability to lead system change with innovative initiatives

This document is the result of consultation, alignment with CMH strategic plan the CRP growth plan and significant discussion and debate within the clinical programs. The attached “clinical petals” or program plans are directional guides to achieve the planned growth, create a broad organizational understanding of the specific plans, volume targets and clinical goals. These four year program plans will assist with multiyear planning however be reviewed annually and updated as required. It is envisioned that they will assist in capital planning decisions, human resource planning and may influence the IT strategic plan. The clinical services plan will assist partner organizations in alignment and support regional planning exercises. The WWLHIN has implemented a localized approach to planning so this directional document will assist the Cambridge North Dumfries sub region in their system planning.

APPENDIX

Appendix 1 Mission, Vision & Values with 2017-19 Strategic Plan Summary



Appendix 2 – WWLHIN Sub–Region Demographics

APPENDIX 2
Waterloo Wellington LHIN

SUB-REGION DEMOGRAPHICS

WELLINGTON

TOTAL POPULATION	AVERAGE HOUSEHOLD INCOME	LOW-INCOME POPULATION	SENIORS AGE 65+
92,884	89,389	7,885	15,517

RURAL AREA POPULATION	IMMIGRANT POPULATION	ABORIGINAL POPULATION	POPULATION WITH FRENCH AS MOTHER TONGUE
44,062	9,115	1,385	960

KW4 KITCHENER-WATERLOO-WELLESLEY-WILMOT-WOOLWICH

TOTAL POPULATION	AVERAGE HOUSEHOLD INCOME	LOW-INCOME POPULATION	SENIORS AGE 65+
397,271	86,540	43,600	55,609

RURAL AREA POPULATION	IMMIGRANT POPULATION	ABORIGINAL POPULATION	POPULATION WITH FRENCH AS MOTHER TONGUE
22,837	84,935	4,320	5,365

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GUELPH & PUSLINCH

TOTAL POPULATION	AVERAGE HOUSEHOLD INCOME	LOW-INCOME POPULATION	SENIORS AGE 65+
137,980	85,251	14,885	19,839

RURAL AREA POPULATION	IMMIGRANT POPULATION	ABORIGINAL POPULATION	POPULATION WITH FRENCH AS MOTHER TONGUE
7,476	25,950	1,985	2,045

CAMBRIDGE-NORTH DUMFRIES

TOTAL POPULATION	AVERAGE HOUSEHOLD INCOME	LOW-INCOME POPULATION	SENIORS AGE 65+
145,240	82,710	15,625	19,790

RURAL AREA POPULATION	IMMIGRANT POPULATION	ABORIGINAL POPULATION	POPULATION WITH FRENCH AS MOTHER TONGUE
4,954	26,560	2,495	2,145

WATERLOO WELLINGTON LHIN

TOTAL POPULATION	AVERAGE HOUSEHOLD INCOME	LOW-INCOME POPULATION	SENIORS AGE 65+
773,375	85,910	81,995	110,755

RURAL AREA POPULATION	IMMIGRANT POPULATION	ABORIGINAL POPULATION	POPULATION WITH FRENCH AS MOTHER TONGUE
79,329	146,560	19,285	10,515

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Appendix 3 Distribution of Cases for Cambridge Catchment, by Program 2015/16

Distribution of cases for Cambridge Catchment, by program, FY2015/16

Program	Total Cases	Hospital					
		CMH	Grand River	St. Mary's	Hamilton HSC	Guelph General	Other
Neonatology	1,613	75%	9%	0%	6%	4%	6%
Obstetrics	1,608	74%	9%	0%	6%	4%	7%
Pulmonary	1,075	88%	3%	5%	2%	1%	2%
Cardiology	921	68%	4%	19%	3%	1%	5%
Orthopaedics	826	76%	7%	0%	6%	2%	9%
General Surgery	779	59%	9%	2%	5%	8%	16%
Gastro/Hepatobiliary	775	82%	6%	2%	2%	2%	6%
Other Internal Medicine	711	80%	6%	1%	4%	2%	6%
Neurology	387	41%	42%	1%	6%	2%	9%
Urology	360	69%	5%	2%	5%	4%	14%
Non-Acute	288	77%	8%	5%	3%	1%	6%
Otolaryngology	277	69%	3%	1%	5%	3%	19%
Gynaecology	264	64%	8%	0%	8%	9%	12%
Haematology	246	46%	13%	1%	17%	2%	20%
Endocrinology	185	76%	8%	0%	7%	2%	8%
Neurosurgery	172	18%	6%	1%	45%	1%	29%
Psychiatry	147	43%	45%	0%	5%	1%	7%
Other Reasons	144	65%	12%	1%	6%	3%	13%
Nephrology	138	64%	14%	2%	4%	0%	17%
Cardiac Surgery	112	0%	0%	81%	10%	1%	8%
Vascular Surgery	80	5%	1%	0%	5%	83%	6%
Plastic Surgery	52	38%	0%	0%	23%	2%	37%
Thoracic Surgery	49	0%	0%	67%	8%	0%	24%
Ophthalmology	15	40%	7%	7%	13%	0%	33%
Dental/Oral Surgery	14	7%	0%	0%	0%	0%	93%
Ungroupable	1	0%	0%	0%	100%	0%	0%
Grand Total	**11,239**	**70%**	**9%**	**4%**	**6%**	**3%**	**9%**

Appendix 4 Distribution of Cases for Cambridge Catchment by Level of Care 2015/16

Distribution of Cases for Cambridge Catchment by Level of Care, FY2015/16

Level of Care	Total Cases	% Distribution of Cases by Hospital					
		CMH	Grand River	St. Mary's	Hamilton HSC	Guelph General	Other
Primary	5,555	78%	10%	2%	3%	2%	5%
Secondary	4,597	70%	8%	2%	6%	4%	9%
Tertiary	900	30%	5%	21%	17%	4%	23%
Quaternary	187	8%	3%	8%	27%	18%	36%
Grand Total	**11,239**	**70%**	**9%**	**4%**	**6%**	**3%**	**9%**

Appendix 5 Diagnostic Imaging Volumes

Diagnostic Imaging Volumes

Service	16/17	17/18	18/19*	Trend	18/19 P7
Radiography	46,616	47,394	48,231		28,278
Electrocardiography	26,808	26,739	27,314		16,014
Ultrasound	22,967	25,625	28,591		16,763
CT	20,939	22,525	24,716		14,491
MRI	8,916	9,242	8,861		5,195
Nuclear Med	5,223	5,100	5,185		3,040
Mammography	2,466	2,162	1,987		1,165
Ontario Breast Screening Program	2,905	2,817	3,201		1,877
Echocardiography	3,012	2,901	2,917		1,710
Bone Mineral Density	1,516	1,360	1,358		796
**18/19 projected year-end volumes based on P7 YTD activity*					

Appendix 6 Ambulatory Care Clinic Visit Activity

Ambulatory Care Clinic Visit Activity

Other Ambulatory Clinics	16/17 (Baseline)	17/18	18/19*	Trend
COPD Clinic	448	392	387	
Diabetic Education	1,705	1,725	1,873	
Fracture Clinic	11,767	11,722	10,938	
General Medicine Clinic	-	-	911	
Geriatric Clinic	949	921	915	
Neuro Clinic	-	-	371	
Pain Clinic	5,686	6,262	7,059	
MDC Clinic Visit	10,853	10,689	10,790	
MTTM - Medical Day Care	1,003	1,004	1,221	
**18/19 projected Weighted Cases based on P6 YTD activity; all else based on P8 YTD activity*				

Appendix 7 Emergency Department Visits by Acuity

Emergency Department Visits by Acuity

ED Visits by CTAS	16/17 (Baseline)	17/18	18/19*	Trend
CTAS 1	369	554	551	
CTAS 2	9,280	11,559	11,822	
CTAS 3	29,037	26,598	28,932	
CTAS 4	13,468	8,637	8,426	
CTAS 5	1,448	4,538	2,335	
Unknown	22	26	38	
Total	**53,624**	**51,912**	**52,104**	
% Visits CTAS 1-3	*72%*	*75%*	*79%*	
% Visits CTAS 4-5	*28%*	*25%*	*21%*	
**18/19 projected year-end volumes based on P7 YTD activity*				

Appendix 8 Critical Care Activity & Acuity

Critical Care Activity & Acuity

Critical Care	16/17 (Baseline)	17/18	18/19*	Trend
Critical Care Patient Days	2,078	2,619	2,643	
Mechanical Invasive Ventilation Days	679	1,129	1,218	
Mechanical Non-Invasive Ventilation Days	500	568	358	
Central Venous Line Days	730	1,058	1,269	
**18/19 projected year-end volumes based on P8 YTD activity*				

Appendix 9 ED Visits for Opioid Overdose

ED Visits for Opioid Overdose, Cambridge Catchment Residents, Sep 2017 – Aug 2018

CMH Catchment is defined as Cambridge, North Dumfries and South Kitchener

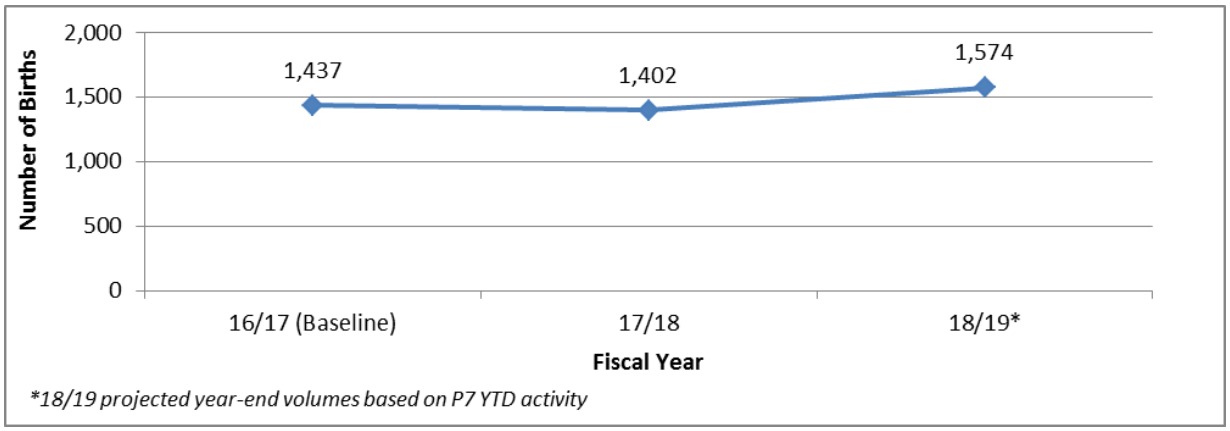
Hospital of ED Visit	Cases	% Capture
CMH	127	79%
Grand River	9	6%
St. Mary's	8	5%
Guelph General	4	3%
Other	12	8%
Total	**160**	**100%**

Appendix 10 Surgical Sub Specialties volumes

Service	Adult											Paediatric		
	Outpatient				Inpatient				Total					
	16/17 (Baseline)	17/18	18/19*	Trend	16/17 (Baseline)	17/18	18/19*	Trend	17/18	18/19*	Variance	17/18	18/19*	Trend
DENTAL / ORAL	54	76	95		74	68	71		144	166	22	58	61.5	
ENDOSCOPY	1,433	1,497	1,427		76	87	104		1,584	1,531	-54			
ENT	1,006	886	1,050		316	363	440		1,249	1,490	241	371	441	
GEN	5,422	5,136	5,478		609	650	653		5,786	6,131	345			
OBGYN	629	692	732		627	550	626		1,242	1,358	116			
OPHT	1,605	1,675	1,736			1			1,676	1,736	60			
ORTHO	1,244	1,281	1,275		974	983	1,017		2,264	2,292	28			
PLASTIC	663	782	591		55	66	45		848	636	-212			
URO	2,174	2,586	2,819		157	184	183		2,770	3,002	232			
Total	**14,230**	**14,611**	**15,201**		**2,888**	**2,952**	**3,139**		**17,563**	**18,340**	**777**			
Elective	*96%*	*96%*	*97%*		*61%*	*63%*	*63%*		*91%*	*91%*	*0%*	*97%*	*96%*	
Non-Elective	*4%*	*4%*	*3%*		*39%*	*37%*	*37%*		*9%*	*9%*	*0%*	*3%*	*4%*	
**18/19 projected year-end volumes based on P7 YTD activity*														

Appendix 11 Birth Volumes

Birth volumes



Appendix 12 Cambridge & North Dumfries Mothers Delivered, Market Share

Cambridge & N. Dumfries Mothers Delivered, Market Share

Hospital of Delivery	Caesarean Section		Vaginal Delivery		Total	
	17/18	18/19 Q1	17/18	18/19 Q1	17/18	18/19 Q1
CMH	74%	77%	80%	81%	78%	79%
Other	26%	23%	20%	19%	22%	21%

CMH Program Plans

Appendix 13 CMH Medicine 4 Year Program Plan

Appendix 13

Medicine 4-Year Program Plan
2017/18 to 2020/21

CMH is positioned for growth with PCOP funding, new physical space (Medicine A and ICU) and a revised clinical services plan. Inherent in this growth strategy is a desire to do things differently, embed patient and family experience into all interactions with providers and partners, achieve quality metrics (CCO, CCSO and HQO). Medicine, intensive care services are considered core services that are imperative to building a strong clinical plan. Specialized medical services introduced will only be successful with this base strength. The Medical Day Care program growth which provides consultation and systemic therapy as a satellite of GRRCC as well as outpatient medical procedures will be guided by the specialized medical growth plan.

The following is an overview of the multi-year pathway forward with an urgency and focus on redesigned care, service expansion that began in 2017-2018 to create a platform for growth and new models of inter-professional care required to achieve organizational goals. Endoscopy reports via Medicine Program in 2018/19 in preparation for the GI Liver Health Plan

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
2017/18				
Patient Experience/Primary Care Partnerships				
Cambridge Memorial Hospital provides the best option for affordable locally governed care close to home. Specialized Medicine is defined as a petal of care. • Hire and stabilize the physician leadership with the CMH vision and ability to execute the plans • New sub-specialty on-call for Medicine Programs • Internal Medicine team that supports admissions, the ICU, medical issues on other units and outpatient work for admission avoidance and pre-op assessments • Develop GI and Liver Health program to support service gaps, regional centre of excellence	Drafted model and recruitment plan including key milestones and deliverables –2017/18	Improve access to care for patients. Create system efficiencies through access /timely consults. Wait times are in keeping with standards (CCO) Qualitative standards are met (CCSO) Improve outcomes Meet changing practice standards for cancer screening	Recruit practitioners with skills to match community demand. Resources are in place, as planned, to support practitioners in practice and to achieve planned volumes and/or practice standards -	Risk of time delay if recruitment challenges for certain sub-specialists. Risk that model is not sustained/sudden, unexpected manpower gaps after implementation. i.e." no turning back" and there are service gaps. Mitigate by maintaining positive relationships with community providers and LHIN partners. Mitigate by supporting physician leaders with regular status update meetings and regular division planning meetings, creating a collaborative environment.
Reduce variation through engaged standardization. Create clarity with standard operating procedures, patient order sets and use of program data. • Leadership in the implementation of HQO Quality	Initiated internal and external stakeholder engagement	Increase bed capacity through reduction in LOS, reduced readmissions and reduced ALC.	Build collaborative relationships with community providers	Risk -Practitioner reluctance to apply standards. Mitigate through engagement during the drafting process and use of data to demonstrate efficiencies and reinforce quality standards met

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Medicine 4-Year Program Plan
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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Standards in the Medicine program o Focus on high volume populations (CHF, COPD), readmissions, ALC, Palliative care	2017/2018			
• Quality and Operations committee that invites regular input from clinical, decision support	Quality framework drafted 2017/18 Communication and education completed 2017/18		Scorecard/dashboard to measure and repot performance. Clinical Unit huddles to show staff how unit improvement goals and action plans contribute to corporate quality indicators	
• Medication reconciliation at discharge for 100% Medicine patients	Environmental scan for options completed 2017/18	Patient safety, Accreditation standard, improved transition of care/reduce risk of readmission	Reporting for compliance/ feedback to teams to support quality improvement and sustainability	
• Build Medicine service to support care needs and quality outcomes	Target detailed planning 2018/19		Physician leadership and model (as above)	
Rapidly and effectively deploy technology enablers • Improve communication with home and Community Services and Primary Care upon discharge	Ideas drafted 2017/18	Reduce gaps in care transition across the continuum and reduce readmission rates Improve patient engagement in their plan of care during and post discharge, improve communication and coordination/reduce gaps in follow up between hospital and community	Privacy and confidentiality across LHIN, signed documents Standard and up to date patient education material	Risk that the creation/agreement of evidence or content takes longer than planned. Mitigate by starting with LHIN or regional materials and seek consensus for adoption rather than create new.
Create community trust by becoming a high reliability organization that values input from patients & consistently provides quality care. • Recruit family and patient advisor members to planning meetings and quality meetings	Organizational plan 2017/18 CMH PFAC established 2014	Improve input from patient/family perspective to create new opportunity to improve patient satisfaction	Organizational PFAC is in place Support for patient and family advisors in this role at the unit level Support for team to consider best opportunities to engage patients and families in a new way	Risk that roles are not clearly understood and member experience is not positive. Mitigate by learning from others and educating the member and team in advance.

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
LHIN Partnership				
Strengthen community partnerships • One Team approach with Home and Community Care to keep ALC rates low	Changes to leadership and joint reporting structure with introduction of LHIN and CMH Integrated Manager role, May 2017	Improve acute bed capacity by limiting ALC days	Community partner active participation Collaboration with LHIN partners to apply standards	Risk that ALC volumes continue to rise and community resources continue to lag behind needs. Mitigate by ensuring accurate collection of data and reports to show trends and barriers to discharge. Use data to advocate for community resources to meet needs.
Create new models of service delivery				
Medicine Program Accountable Care model Medicine A • Standards • Audit for success • Structure • Sustainability	Planning 2017/18 Implemented January 2018	Improve discharge planning Process to reduce LOS (meet benchmark LOS 5.5 days), increase medicine bed capacity, and improve patient and family engagement. Improve patient satisfaction. Improve staff satisfaction and retention.	Physician staffing and model to allow for geographic assignment to ACU. LHIN Home and Community resources to support model 7 days per week	Risk that team members do not buy in to the model and/or critical milestones required to achieve success. Mitigated through investment in consultant resource, content expert and experienced clinicians. Investment in up front staff and physician education, leadership presence during implementation and the application of process improvement tools to support continuous improvement and sustainability
2018/19				
Patient Experience/Primary Care Partnerships				
Cambridge Memorial Hospital provides the best option for affordable locally governed care close to home. Specialized Medicine is defined as a petal of care. • Hire and stabilize the physician leadership with the CMH vision and ability to execute the plans	Commenced April 2018 Neurology hired June 2018 Cardiology hired December 2018 GI liver specialist –recruitment commenced 2018/19 Medical Oncologist (3rd)- recruitment 2018/19, hired to	Improve access to care for patients. Create system efficiencies through access /timely consults. Wait times are in keeping with standards (CCO) Qualitative standards are met (CCSO) Improve outcomes	Recruit practitioners with skills to match community demand. Resources are in place, as planned, to support practitioners in practice and to achieve planned volumes and/or practice standards -Admissionist model (implemented April 2018) -Internal Medicine Clinic (implemented April 2018) -Neurology Clinic (implemented July 2018)	Risk of time delay if recruitment challenges for certain sub-specialists. Risk that model is not sustained/sudden, unexpected manpower gaps after implementation. i.e." no turning back" and there are service gaps. Mitigate by maintaining positive relationships with community providers and LHIN partners. Mitigate by supporting physician leaders with regular status update

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
• New sub-specialty on-call for Medicine Programs • Internal Medicine team that supports admissions, the ICU, medical issues on other units and outpatient work for admission avoidance and pre-op assessments • Develop GI and Liver Health program to support service gaps, regional centre of excellence	start July 2019 Cardiology commenced January 2019 Respirology, Gastroenterology target 2019/20 Commenced April 2018 Target for full staff April 2019 Pre-op expansion 2019/20 Planning 2018/19. Target for implementation 2019/20 FIT timeline dependant on province/LHIN	Meet changing practice standards for cancer screening. Meet CCO quality standards such as wait times	-Cardiodiagnostic procedure volume growth (2019/20) A cornerstone for this program =CMH progresses plan to become one of the WWLHIN FIT centres, includes central intake for FIT -Funded colonoscopy volumes from CCO, increase from base to reduce wait time for symptomatic cases -Medicine growth -Opening of 3 state-of the art Endoscopy Suites -Surgical growth	meetings and regular division planning meetings, creating a collaborative environment. Risk of delays: -physician recruitment -FIT implementation timeline in the province -delayed move in to new endoscopy/expanded rooms, would limit growth
Reduce variation through engaged standardization. Create clarity with standard operating procedures, patient order sets and use of program data. • Leadership in the implementation of HQO Quality Standards in the Medicine program o CHF, COPD order sets, pathways per partnerships/cQIP below o ALC best practices and standards	Initiated 2017/2018 CHF orders live 2018, COPD orders in draft, go-live target January 2018/19. QIP drafted 2018/19 Work plan commenced June 2018.	increased case weights and reduced LOS (within benchmark), reduced readmissions, reduced ALC. Conservable bed days equivalent to 3.4 beds	Build collaborative relationships with community providers (see below). In partnership with WWLHIN Home & Community Services, continue to explore new models (bundled care for CHF/COPD) that align with goals of admission avoidance, ALC avoidance/best practices or transition planning. *see partnerships cQIP below	Risk -Practitioner reluctance to apply standards. Mitigate through engagement during the drafting process and use of data to demonstrate efficiencies and reinforce quality standards met

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
o Palliative care	Standards implemented for inpatient December 2018 Plan drafted June 2018 Target to Implement Med B 2018/19			
• Quality and Operations committee that invites regular input from clinical, decision support	Commenced April 2018 Target and build scorecards and process to become efficient by December 2019		Scorecard/dashboard to measure and repot performance. Clinical Unit huddles to show staff how unit improvement goals and action plans contribute to corporate quality indicators	Risk-sustaining gains. Mitigate by building in leader standard work and measure this, to support performance improvement and coaching
• Medication reconciliation at discharge for 100% Medicine patients o PDSA o sustainability	Commenced spring 2018 Target Fall 2018/19	Patient safety, Accreditation standard, improved transition of care/reduce risk of readmission	Reporting for compliance/ feedback to teams to support quality improvement and sustainability	
• Build Medicine service to support care needs and quality outcomes o Medicine Program bed needs o Add Level 2 Critical Care	Plan completed December 2018	Improved efficiency with planned services vs ad hoc. Improved staff and physician satisfaction with planned team vs. transient Improved clinical outcomes through access to right bed/right resources (most cost efficient). Increase capacity for level 3 beds without expanding. Increase case weights will have positive funding implications. Improve staff satisfaction and attract new recruits though opportunity to advance skills within the Medicine Program.	Physical Plant/space plan during next phase construction and final phase. Included in WWLHIN Critical Care capacity plan, submitted to CCSO December 2018 CCSO approval for bed expansion Staff training and support to build skills	Risk with limited space during next phase of construction. Mitigate by reviewing plans and decant non-essential resources from planned Medicine unit space to alternate space ie. offices Risk new service with limited capacity. Mitigate with clear admission and discharge criteria and monitor utilization and case mix data.
Rapidly and effectively deploy technology enablers • Implement e-notification that	Implemented December 2018	Reduce gaps in care transition	Privacy and confidentiality across	

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
notifies Home & Community Services and primary Care of discharges		across the continuum and reduce readmission rates	LHIN, signed documents	
• Implement My Chart patient portal for personal health information	Implement pilot early 2019. Expand across program/hospital 2019/20	Improve patient access to their personal health information. Improve transparency and patient satisfaction	Health Care Professional reminder about quality documentation and standards	
• Implement Co-Health application	Implemented Medicine Program fall 2018 Target for implementation MDC/Oncology Program Q4 2018/19	Improve patient engagement in their plan of care during and post discharge, improve communication and coordination/reduce gaps in follow up between hospital and community	Standard and up to date patient education material	Risk that the creation/agreement of evidence or content takes longer than planned. Mitigate by starting with LHIN or regional materials and seek consensus for adoption rather than create new.
Create community trust by becoming a high reliability organization that values input from patients & consistently provides quality care. • Recruit family and patient advisor members to planning meetings and quality meetings	First patient /family advisor participant September 2018	Improve input from patient/family perspective to create new opportunity to improve patient satisfaction	Support for patient and family advisors in this role Support for team to consider best opportunities to engage patients and families in a new way	Risk that roles are not clearly understood and experience is not positive. Mitigate by learning from others and educating the member and team in advance.
LHIN Partnership				
Strengthen community partnerships • One Team approach with Home and Community Care to keep ALC rates low o Standard ALC definitions and data capture o Discharge planning and escalation standards • Meet diversity needs or	QIP drafted 2018/19 Implemented December 2018 Implemented December 2018 Target for 2020	Improve acute bed capacity by limiting ALC days Improve patient experience and satisfaction	Community partner active participation Collaboration with LHIN partners to apply standards Data to confirm populations served. Organizational commitment	Risk that ALC volumes continue to rise and community resources continue to lag behind needs. Mitigate by ensuring accurate collection of data and reports to show trends and barriers to discharge. Use data to advocate for community resources to meet needs. Risk of conflict between cultural needs and patient/staff safety.

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cultural specific needs of the patient populations served			to change and ensure standards align across programs.	Mitigate by learning from how other hospitals have met needs with similar populations.
Create new models of service delivery				
Medicine Program Accountable Care model • Medicine A o Audit for success o PDSA o Sustainability	Implemented January 2018 Sustainability audits implemented spring 2018 Completed April 2018, June 2018, September 2018 Initial target YE 2018/19, revised to 2019/20	Improve discharge planning Process to reduce LOS (meet benchmark LOS 5.5 days), increase medicine bed capacity, and improve patient and family engagement. Improve patient satisfaction. Improve staff satisfaction and retention.	Physician staffing and model to allow for geographic assignment to ACU. LHIN Home and Community resources to support model 7 days per week	Risk that team members do not buy in to the model and/or critical milestones required to achieve success. Mitigated through investment in consultant resource, content expert and experienced clinicians. Investment in up front staff and physician education, leadership presence during implementation and the application of process improvement tools to support continuous improvement and sustainability.
Strengthen sub-region partnerships. Leverage existing partnerships, internal and external to CMH to foster cQIP • Decrease readmissions for CHF and COPD o Innovative models of care o Medication reconciliation o Transitions of care	CHF commenced 2017/18 COPD added and target for completion of plan to address 3 key areas, 2018/19 Implement 2019/20	Reduce variation in care for CHF and COPD. Reduce gaps in care. Reduce readmissions. Admission avoidance	CMH medication reconciliation process including community pharmacists and primary care Standard patient education materials. Implementation of pre-printed order sets at CMH Establish patient pathway that crosses all points of patient transition in the healthcare system Consider in plans-- new partner, Community Paramedic Program Changes to LHIN home and community care resources to avoid admissions	Risk that efforts and models are not sustained. Mitigate by capturing and sharing relevant data among the teams, to support change efforts.
2019/20				
Patient Experience/Primary Care Partnerships				
Cambridge Memorial Hospital provides the best option for affordable locally governed care close to home. Specialized Medicine is defined as a petal of		Improve access to care for patients. Create system efficiencies through access /timely consults. Wait times are in keeping with	Recruit practitioners with skills to match community demand. Resources are in place, as planned, to support practitioners in	Risk of time delay if recruitment challenges for certain sub-specialists. Risk that model is not sustained/sudden, unexpected

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
care. • Hire and stabilize the physician leadership with the CMH vision and ability to execute the plans • New sub-specialty on-call for Medicine Programs • Internal Medicine team that supports admissions, the ICU, medical issues on other units and outpatient work for admission avoidance and pre-op assessments • Develop GI and Liver Health program to support service gaps, regional centre of excellence	Commenced April 2018 GI liver specialist –target for recruitment/start 2019/20 Medical Oncologist (3rd) hired to start July 2019 Respirology, Gastroenterology target spring 2019/20, target full implementation subspecialist call Q1-Q2 2019/20 Commenced April 2018 Target for full staff April 2019, translates to achievement of fully closed access to Critical Care (CCSO standard) Target expansion of Med consult for pre-op 2019/20 Target for implementation 2019/20 FIT timeline dependant on province/LHIN	standards (CCO) Qualitative standards are met (CCSO) Improve outcomes Meet changing practice standards for cancer screening. Meet CCO quality standards such as wait times	practice and to achieve planned volumes and/or practice standards -Admissionist model (implemented April 2018) -Internal Medicine Clinic (implemented April 2018) -Neurology Clinic (implemented July 2018) -Cardiodiagnostic procedure volume growth (2019/20) A cornerstone for this program =CMH progresses plan to become one of the WWLHIN FIT centres, includes central intake for FIT -Funded colonoscopy volumes from CCO, increase from base to reduce wait time for symptomatic cases -Medicine growth -Opening of 3 state-of the art Endoscopy Suites -Surgical growth	manpower gaps after implementation. i.e." no turning back" and there are service gaps. Mitigate by maintaining positive relationships with community providers and LHIN partners. Mitigate by supporting physician leaders with regular status update meetings and regular division planning meetings, creating a collaborative environment. Risk of delays: -physician recruitment -FIT implementation timeline in the province -delayed move in to new endoscopy/expanded rooms, would limit growth
Reduce variation through engaged standardization. Create clarity with standard operating procedures, patient order sets and use of program data. • Leadership in the implementation of HQO Quality Standards in the Medicine program o CHF, COPD order	Initiated 2017/2018 Assess for uptake and utilization of	increased case weights and reduced LOS (within benchmark), reduced readmissions reduced ALC. Conservable bed days equivalent to 3.4 beds	Build collaborative relationships with community providers (see below). In partnership with WWLHIN Home & Community Services, continue to explore new models (bundled care for CHF/COPD) that align with goals of admission avoidance, ALC	Risk -Practitioner reluctance to apply standards. Mitigate through engagement during the drafting process and use of data to demonstrate efficiencies and reinforce quality standards met

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
sets, pathways per partnerships/cQIP below	pre-printed order sets/PDSA 2019/20		avoidance/best practices or transition planning. *see partnerships cQIP below	
o ALC best practices and standards	Standards implemented December 2018. PDSA 2019/20			
o Palliative care/Serious Illness Conversation	Plan drafted June 2018 Target to Implement Med B Q4 2018/19 PDSA and expand to Med A 2019/20			
• Quality and Operations committee that invites regular input from clinical, decision support	Commenced April 2018 Build and become efficient by December 2019	Supports staff engagement, reinforces QI as an organizational priority, allows for utilization of process improvement tools, building leadership capacity among teams,	Scorecard/dashboard to measure and repot performance. Clinical Unit huddles to show staff how unit improvement goals and action plans contribute to corporate quality indicators. Requires leader(s) time and structure to focus and to coach.	Risk-sustaining gains. Mitigate by building in leader standard work to support performance improvement and coaching, and measure this.
• Medication reconciliation at discharge for 100% Medicine patients	Commenced spring 2018	Patient safety, Accreditation standard, improved transition of care/reduce risk of readmission	Reporting for compliance/ feedback to teams to support quality improvement and sustainability	
o PDSA o sustainability	Planned throughout 2019/20 Target November 2019			
• Build Medicine service to support care needs and quality outcomes	Draft complete December 2018	Improved efficiency with planned services vs ad hoc. Improved staff and physician satisfaction with planned team vs. transient	Physical Plant/space plan during next phase construction. Full model realized when construction complete.	
o Medicine Program bed needs	Implement first part of plan with move to new building 2019/20			
o Add Level 2 Critical Care	Initiate model 2019/20	Improved clinical outcomes through access to right bed/right resources (most cost efficient). Increase capacity for level 3 beds	Included in WWLHIN Critical Care capacity plan, submitted to CCSO December 2018 CCSO approval for bed expansion Staff training and support to build	Risk new service with limited capacity. Mitigate with clear admission and discharge criteria and monitor utilization and case

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
		without expanding. Increase case weights. Improve staff satisfaction and attract new recruits though opportunity to advance skills.	skills/competency before full effects realized	mix data.
Rapidly and effectively deploy technology enablers • Implement e-notification that notifies Home & Community Services and primary Care of discharges	Implemented December 2018 Monitor for feedback/intended improvements 2019/20	Reduce gaps in care transition across the continuum and reduce readmission rates		
• Implement My Chart patient portal for personal health information	Implement pilot MDC early 2019. Expand across program/hospital 2019/20	Improve patient access to their personal health information. Improve transparency and patient satisfaction	Health Care Professional reminder about quality documentation and standards	
• Implement Co-Health application	Implemented Medicine, MDC/Oncology Programs Target for implementation Endoscopy 2019-20	Improve patient engagement in their plan of care during and post discharge, improve communication and coordination/reduce gaps in follow up between hospital and community	Standard and up to date patient education material	Risk that the creation/agreement of evidence or content takes longer than planned. Mitigate by starting with LHIN or regional materials and seek consensus for adoption rather than create new.
Create community trust by becoming a high reliability organization that values input from patients & consistently provides quality care. • Recruit family and patient advisor members to planning meetings and quality meetings	First patient /family advisor 2018 Target regular participation by December 2019	Improve input from patient/family perspective to create new opportunity to improve patient satisfaction	Support for patient and family advisors in this role Support for team to consider best opportunities to engage patients and families in a new way	Risk that roles are not clearly understood and experience is not positive. Mitigate by learning from others and educating the member and team in advance.
LHIN Partnership				
Strengthen community partnerships • One Team approach with Home and Community Care to keep ALC rates low	QIP 2018/19 Implemented December 2018	Improve acute bed capacity by limiting ALC days	Community partner active participation Collaboration with LHIN partners to apply standards	Risk that ALC volumes continue to rise and community resources continue to lag behind needs

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
o Standard ALC definitions and data capture o Discharge planning and escalation standards • Meet diversity needs or cultural specific needs of the patient populations served	PDSA 2019/20 Implemented December 2018 PDSA 2019/20 Target January 2020	Improve patient experience and satisfaction	Data to confirm populations served. Organizational commitment to change and ensure standards align across programs.	Risk of conflict between cultural needs and patient/staff safety. Mitigate by learning from how other hospitals have met needs with similar populations.
Create new models of service delivery				
Medicine Program Accountable Care model • Medicine A o Audit for success o Re-launch with new structure o Sustainability • Medicine B	Implemented January 2018 Structure completed and re-launch January 2019 Audit process and PDSA 2019/20 Target implementation 2019/20	Improve discharge planning Process to reduce LOS (meet benchmark LOS 5.5 days), increase medicine bed capacity, and improve patient and family engagement. Improve patient satisfaction. Improve staff satisfaction and retention.	Physician staffing and model to allow for geographic assignment to ACU. LHIN Home and Community resources to support model 7 days per week	Risk that team members do not buy in to the model and/or critical milestones required to achieve success. Mitigated through investment in consultant resource, content expert and experienced clinicians. Investment in up front staff and physician education, leadership presence during implementation and the application of process improvement tools to support continuous improvement and sustainability
Strengthen sub-region partnerships. Leverage existing partnerships, internal and external to CMH to foster cQIP • Decrease readmissions for CHF and COPD o Innovative models of care o Medication reconciliation o Transitions of care	CHF commenced 2017/18 COPD added and planning among 3 work streams 2018/19 Target for Implementation 2019/20	Reduce variation in care for CHF and COPD. Reduce gaps in care. Reduce readmissions	CMH medication reconciliation process including community pharmacists and primary care Standard patient education materials. Implementation of pre-printed order sets at CMH Establish patient pathway that crosses all points of patient transition in the healthcare system Consider in plans-- new partner, Community Paramedic Program Changes to LHIN home and community care resources to avoid admissions	Risk that efforts and models are not sustained. Mitigate by capturing and sharing relevant data among the teams, to support change efforts.
2020/21				

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Patient Experience/Primary Care Partnerships				
Cambridge Memorial Hospital provides the best option for affordable locally governed care close to home. Specialized Medicine is defined as a petal of care. • Hire and stabilize the physician leadership with the CMH vision and ability to execute the plans • New sub-specialty on-call for Medicine Programs • Internal Medicine team that supports admissions, the ICU, medical issues on other units and outpatient work for admission avoidance and pre-op assessments • Develop GI and Liver Health program to support service gaps, regional centre of excellence	Target to have fully implemented 2019/20 Reassess by June 2020 for gaps, improvements and future needs 2021-2025 PDSA 2020/21 Evaluate for intended and unintended program impacts 2020/21, incorporate changes in 2021-2025 plan	Improve access to care for patients. Create system efficiencies through access /timely consults. Wait times are in keeping with standards (CCO) Qualitative standards are met (CCSO) Improve outcomes Meet changing practice standards for cancer screening. Meet CCO quality standards such as wait times	Recruit practitioners with skills to match community demand. Resources are in place, as planned, to support practitioners in practice and to achieve planned volumes and/or practice standards -Admissionist model (implemented April 2018) -Internal Medicine Clinic (implemented April 2018) -Neurology Clinic (implemented July 2018) -Cardiodiagnostic procedure volume growth (2019/20) A cornerstone for this program =CMH progresses plan to become one of the WWLHIN FIT centres, includes central intake for FIT -Funded colonoscopy volumes from CCO, increase from base to reduce wait time for symptomatic cases -Medicine growth -Opening of 3 state-of the art Endoscopy Suites -Surgical growth	Risk of time delay if recruitment challenges for certain sub-specialists. Risk that model is not sustained/sudden, unexpected manpower gaps after implementation. i.e." no turning back" and there are service gaps. Mitigate by maintaining positive relationships with community providers and LHIN partners. Mitigate by supporting physician leaders with regular status update meetings and regular division planning meetings, creating a collaborative environment. Risk of delays: -physician recruitment -FIT implementation timeline in the province -delayed move in to new endoscopy/expanded rooms, would limit growth Mitigate with flexibility in timelines
Reduce variation through engaged standardization. Create clarity with standard operating procedures, patient order sets and use of program data. • Leadership in the implementation of HQO Quality Standards in the Medicine program	Initiated 2017/2018 Target completion of evaluation and sustainability 2020/21 and identify opportunities/new tactics to include in 2021-2025 plan	increased case weights and reduced LOS (within benchmark), reduced readmissions, reduced ALC and achieve conservable bed days (target to be confirmed based on prior year(s) data)	Build collaborative relationships with community providers (see below). In partnership with WWLHIN Home & Community Services, continue to explore new models (bundled care for CHF/COPD) that align with goals	Risk -Practitioner reluctance to apply standards. Mitigate through engagement during the drafting process and use of data to demonstrate efficiencies and reinforce quality standards met

Appendix 13

Medicine 4-Year Program Plan
2017/18 to 2020/21

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
o CHF, COPD order sets, pathways per partnerships/cQIP below o ALC best practices and standards o Palliative care/Serious Illness Conversation			of admission avoidance, ALC avoidance/best practices or transition planning. *see partnerships cQIP below	
• Quality and Operations committee that invites regular input from clinical, decision support	Target completion of evaluation, sustainability 2020/21	Supports staff engagement, reinforces QI as an organizational priority, allows for utilization of process improvement tools, building leadership capacity among teams,	Scorecard/dashboard to measure and repot performance. Clinical Unit huddles to show staff how unit improvement goals and action plans contribute to corporate quality indicators. Requires leader(s) time and structure to focus and to coach.	Risk-sustaining gains. Mitigate by building in leader standard work to support performance improvement and coaching, and measure this.
• Medication reconciliation at discharge for 100% Medicine patients o PDSA o sustainability	Commenced spring 2018 Confirm sustainability and target completion of this initiative 2020/21	Patient safety, Accreditation standard, improved transition of care/reduce risk of readmission	Reporting for compliance/ feedback to teams to support quality improvement and sustainability	
• Build Medicine service to support care needs and quality outcomes o Medicine Program bed needs	Draft complete December 2018 Target implement last phase (post construction) 2020/21	Improved efficiency with planned services vs ad hoc. Improved staff and physician satisfaction with planned team vs. transient	Physical Plant/space plan during next phase construction. Full model realized when construction complete.	Risk new service with limited capacity. Mitigate with clear admission and discharge criteria and monitor utilization and case mix data.
o Add Level 2 Critical Care	Initiate model 2019/20 Target full model in place by 2020/21 Evaluate using data for utilization, standards of care, and consider	Improved clinical outcomes through access to right bed/right resources (most cost efficient). Increase capacity for level 3 beds without expanding. Increase case	Included in WWLHIN Critical Care capacity plan, submitted to CCSO December 2018 CCSO approval for bed expansion Staff training and support to build	

Medicine 4-Year Program Plan
2017/18 to 2020/21

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
	resource revision and/or expansion to include in 2021-2025 initiatives.	weights. Improve staff satisfaction and attract new recruits though opportunity to advance skills.	skills/competency before full effects realized	
Rapidly and effectively deploy technology enablers • Implement e-notification that notifies Home & Community Services and primary Care of discharges • Implement My Chart patient portal for personal health information • Implement Co-Health application	Target to have fully implemented 2019/20 Reassess by June 2020 for gaps, improvements and future needs 2021-2025	Reduce gaps in care transition across the continuum and reduce readmission rates Improve patient access to their personal health information. Improve transparency and patient satisfaction Improve patient engagement in their plan of care during and post discharge, improve communication and coordination/reduce gaps in follow up between hospital and community	Privacy and confidentiality across LHIN, signed documents Health Care Professional reminder about quality documentation and standards Standard and up to date patient education material	Risk that the creation/agreement of evidence or content takes longer than planned. Mitigate by starting with LHIN or regional materials and seek consensus for adoption rather than create new.
Create community trust by becoming a high reliability organization that values input from patients & consistently provides quality care. • Recruit family and patient advisor members to planning meetings and quality meetings	Target to be part of normal operations 2020/21. Assess for evolution of role for 2021-2025 plan	Improve input from patient/family perspective to create new opportunity to improve patient satisfaction	Support for patient and family advisors in this role Support for team to consider best opportunities to engage patients and families in a new way	Risk that roles are not clearly understood and experience is not positive. Mitigate by learning from others and educating the member and team in advance.
LHIN Partnership				
Strengthen community partnerships • One Team approach with Home and Community Care to	Target to have fully implemented 2019/20 Reassess by June 2020 for gaps, improvements and future needs 2021-2025	Improve acute bed capacity by limiting ALC days	Community partner active participation Collaboration with LHIN partners to apply standards	Risk that ALC volumes continue to rise and community resources continue to lag behind needs

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Medicine 4-Year Program Plan
2017/18 to 2020/21

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
keep ALC rates low o Standard ALC definitions and data capture o Discharge planning and escalation standards • Meet diversity needs or cultural specific needs of the patient populations served	Target implementation January 2020 Include PDSA and further development in 2021-2025 initiatives	Improve patient experience and satisfaction	Data to confirm populations served. Organizational commitment to change and ensure standards align across programs.	Risk of conflict between cultural needs and patient/staff safety. Mitigate by learning from how other hospitals have met needs with similar populations.
Create new models of service delivery				
Medicine Program Accountable Care model • Medicine A • Medicine B	Target to have fully implemented 2019/20. Assess for expansion to other units in 2020/21	Improve discharge planning process to reduce LOS. Meet benchmark LOS –confirm target with data from previous year(s), increase medicine bed capacity, and improve patient and family engagement. Improve patient satisfaction. Improve staff satisfaction and retention.	Physician staffing and model to allow for geographic assignment to ACU. LHIN Home and Community resources to support model 7 days per week Review and realignment of other resources to support 7 day/week progression plan and discharge i.e. mobility assessment and treatment to progress plan of care	Risk that team members do not buy in to the model and/or critical milestones required to achieve success. Mitigated through investment in consultant resource, content expert and experienced clinicians. Investment in up front staff and physician education, leadership presence during implementation and the application of process improvement tools to support continuous improvement and sustainability
Strengthen sub-region partnerships. Leverage existing partnerships, internal and external to CMH to foster cQIP • Decrease readmissions for CHF and COPD o Innovative models of care o Medication reconciliation o Transitions of care	CHF commenced 2017/18 COPD added and planning among 3 work streams 2018/19 Target for Implementation 2019/20 PDSA 2020/21, including evaluation against stated metrics. Draft initiatives for inclusion in the 2021-2025 plan	Reduce variation in care for CHF and COPD. Reduce gaps in care. Reduce readmissions	CMH medication reconciliation process including community pharmacists and primary care Standard patient education materials. Implementation of pre-printed order sets at CMH Establish patient pathway that crosses all points of patient transition in the healthcare system Consider in plans-- new partner, Community Paramedic Program Changes to LHIN home and	Risk that efforts and models are not sustained. Mitigate by capturing and sharing relevant data among the teams, to support change efforts.

Appendix 13

Medicine 4-Year Program Plan
2017/18 to 2020/21

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
			community care resources to avoid admissions	

Appendix 14 CMH Mental Health 4 Year Program Plan

Appendix 14

CMH Mental Health 4-Year Program Plan
2017/18 to 2020/21

CMH is positioned for growth with PCOP funding, new physical space and a revised clinical services plan. Inherent in this growth strategy is a desire to do things differently, embed patient and family experience into all interactions with providers and partners, achieve quality metrics for mental health and gain recognition as an exceptional program for the residents of Cambridge and North Dumfries. This plan will be reviewed and updated annually to reflect the changing health care environment and new emerging priorities or timelines.

The following tables provide an overview of the multi-year pathway forward with urgency and focus on redesigned care. Service expansion occurred in year one (2017-2018) that aligns with WWLHIN and organizational priorities.

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
2017/18				
Patient Experience/Primary Care Partnerships				
Establish ECT services	Commenced July 2017.	Target of 500 patient procedures annually. March 2018 total was 417 procedures to 45 unique individuals.	Operating Room staff collaboration; Anesthesiology, Respiratory Therapy and PACU RN	OR booking time prior to OR day – M-W-F. 2 inpatient psychiatrists perform the ECT procedures.
Outreach model expansion (psychiatrist embedded into community practice) to Lang's Community Health Clinic, Grandview Clinic and Nurse Practitioner Led Clinic (NPLC)	March 2018 – Lang's and Grandview outreach established.	Lang's outreach = 64 visits Grandview outreach = 25 visits ~10 per month. Improve access for patients, create or improve provider relationships; create time for face to face case reviews	Psychiatrist recruitment, feedback from providers & patients re model (formal evaluation pending Lang's implementation)	Psychiatrist interview –gauge interest and support for this model. Recruit for this interest and experience. Advocate for sessional fees to support this model. Evaluation of model at regular intervals
Goal of 3 Medical learners per year	Continuous	> 3 learners per year – attained target	Align with McMaster University Medical School	Continuous feedback and physician mentors
Redevelopment of outpatient MH services access to reduce wait times	March 2018	Waitlist < 50 individuals	Align with Here 24/7 and CMH internal intake resources redesigned	All patients are reviewed at intake with a priority level. Appointments are given and group counselling sessions are offered to patients.
LHIN Partnership				
Active partner in system initiatives such as Rapid Access Addiction clinic (RAAC), Flexible Assertive Community Treatment Team (FACTT)	January 2018	Address community gaps and demands. Leverage existing partnerships	Psychiatrists with interest and sub specialty in addiction	If unable to attain psychiatrist, partners review ability to utilize Nurse Practitioner (NP) for RAAC
Create new models of service delivery				
Community support provided by on-call psychiatrists via telephone and email to local practitioners	March 2018	Support to primary care by psychiatry specialty	Psychiatrists willing to sign up for e-consult or engage phone consult	Psychiatry and primary care provider engagement and exchange via the outreach initiative.
Expansion of evening hours in Outpatient Department (OPD) to meet needs of the community	April 2017	Tuesday evening individual counselling and therapy sessions added. 265 sessions in 2017/18	Staff willing to work / alter schedule.	Flexible scheduling allowing for additional day off q2 weeks
Provide urgent mental health appointments to support ED and community reducing wait times	January 2018	Availability of emergent patient appointment in Outpatient MH for patients presenting to ED	Holding available slots for patient to be booked	Patient to call to receive appointment or given an appointment depending on case. If all are given to patient - the no-show rate was very high
Review of ability to offer programs in the community setting for child and youth.	February 2018	Commencement of child and youth services in the community setting for greater overall access	Willing partners and ministry approval	Continue work with home and community partners to eliminate redundancy and support child and youth in a new collaboration.

CMH Mental Health 4-Year Program Plan
2017/18 to 2020/21

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
2018/19				
Patient Experience/Primary Care Partnerships				
Expand ECT services to include maintenance care	March 2019	Target of 500 patient procedures annually. October 2018 YTD total is 388 procedures to 42 unique individuals.	Operating Room collaboration with Anesthesiology, Respiratory Therapy and PACU RN	OR dedicated booking times. Assigned ECT RN Assigned inpatient psychiatrists
Outreach model expansion (psychiatrist embedded into community practice) to Lang's Community Health Clinic, Grandview Clinic and Nurse Practitioner Led Clinic (NPLC)	Sept 2018 with addition of NPLC	YTD October 2018 Lang's Outreach = 36 visits Grandview Outreach = 46 visits NPLC Outreach = 3 visits ~12 per month	Psychiatry recruitment and retention to continue outreach work	Continue planning and gauging psychiatrists to do this work as we hire.
Continue with 3 Medical learners per year	Continuous	>3 learners in 2018/19	Align with McMaster University Medical School	Continuous feedback and physician / psychiatrist mentors
Medication Reconciliation at discharge for all mental health patients	March 2019	Goal of 100% at patient discharge. Patient safety with increased clarity of medication treatment plan by all community providers	Pharmacy, Nursing and Physician partnerships	Planning for resources, support and education for physicians
Continue evening hours in OPD to meet needs of the community	April 2018	Tuesday evening sessions continue. 309 sessions YTD Nov 2018/19	Staff willing to work / alter schedule.	Flexible scheduling allowing for additional day off q2 weeks
Partnering with addiction programs to support education to inpatient staff	December 2018	Goal to provide education to inpatient nursing staff	Collaboration with Stonehenge community to supply education	Commence with one session to interested nursing staff and plan next steps
Improve access to mental health services for children and youth in ED	December / January 2018	Improved access, less demand on acute ED visits & current admissions	Lutherwood development of an ED diversion model	Education of Psychiatric Emergency Staff to include ED diversion staff when appropriate
Expand role of Family Advisory Council including improvement of Family and Patient Experience	March 2019	Planning for stigma education for staff, knowledge café and "walk" for MH services for patients and families.	Recruitment of family advisors	Use the Family Education Series to recruit new members
LHIN Partnership				
Active partner in RAAC Cambridge North Dumfries	July 2018	Support establishment of RAAC at NPLC	Psychiatrists with interest and sub specialty in addiction	Unable to attain psychiatrist, support to hire NP for RAAC
Active Partner in FACTT program development in Cambridge North Dumfries	February / March 2019	Address community gaps and demands. Reprioritize patient streams to seize additional space.	Psychiatrist with subspecialty interest in intensive services and concurrent disorders	FACTT set up by CMHA to commence review of patient streams and start process without the psychiatry filled.
Create new models of service delivery				
Early interaction with addiction support in the ED in partnership with Stonehenge	September 2018	Improve connectivity with addictions services	Ability to hire Peer navigator with experience / education	Supportive and strengthening relationship with Stonehenge Therapeutic Community partner.
Ongoing community support provided by on-call psychiatrists via telephone and email to local practitioners	March 2019	Support to primary care by psychiatry specialty	Psychiatrists willing to sign up for e-consult and phone consult	Psychiatry and primary care provider engagement
Redeveloped Day Hospital Program	April 2018	Change from 12 week program to 6 week program	Psychiatry alignment for patient assessments	Booked appointments for patients with psychiatrist; intake occurs within 72 hours of referral

CMH Mental Health 4-Year Program Plan
2017/18 to 2020/21

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
2019/20				
Patient Experience/Primary Care Partnerships				
Explore expansion and need for increased availability of ECT services	December 2019	Target of 500 patient procedures annually.	Operating Room collaboration with Anesthesiology, Respiratory Therapy and PACU RN	OR booking time prior to OR day – M-W-F. Assigned ECT RN. 2 inpatient psychiatrists perform the ECT procedures.
Outreach model expansion (psychiatrist embedded into community practice) to Lang's Clinic, Grandview Clinic and NPLC.	March 2020	~ 12 outreach visits per month	Psychiatry recruitment and retention to continue outreach work	Continue planning and gauging psychiatrists to do this work as we hire.
Goal of 3 Medical learners per year	Continuous	>3 learners per year – attained target	Align with McMaster University Medical School	Continuous feedback and physician mentors
Expand profile of Family Advisory Council by adding a Family Navigator role.	March 2020	Add 0.5 Family Navigator role to program by March 2020	Acceptance of role across and within the MH program	Research role and needs of families and patients in the program. Learn from other MH organizations with the role.
Partnering with community programs to support addiction needs of inpatients	September 2019	Adding concurrent disorders programming to inpatient unit	Willing community partners	Education, planning and implementation of program to MH staff.
LHIN Partnership				
FACTT partnership planning and implementation of model	September 2019	Closure of Injection Clinic in OPD	Psychiatry recruitment for FACTT Patient Transition plan	Support and transition of patient population from Injection clinic to FACTT
RAAC partnership planning and expansion of model	April 2019	Increase to 2 days per week	Psychiatry recruited and/ or support attained for NP	Support from addictions psychiatrist to support NP model if no psychiatrist recruited.
Create new models of service delivery				
Child and Youth Outpatient services model revamp with regional partners	September 2019	Outreach services to community partner by CMH staff / psychiatrist	Lutherwood, Ministry Social Services and Lang's partnership for space and planning	Space available; staff engagement to offer services off-site; patient volume alignment
Expand concurrent care model throughout program services	December 2019	Education to MH program including support to other departments with addictions patients	Education content and material for staff; Clinical Nurse Specialist (CNS) and partners ability to teach	Scheduling of staff well in advance; ongoing support with specific patient cases; alignment of services with education taught
Expand to weekend hours for inpatient programming	September 2019	Improved care planning by addressing gaps in mental health service programming when patients are not on passes	Develop new partnerships with community providers for service delivery; CRP space; hiring of additional staff for programs	Change of staff scheduling with long lead-in time to ease transition; planning with MH team with regards to patient needs for programming related to hiring
Redevelopment of emergency MH services and admission process to inpatient MH unit to support the ED and reduce wait times and readmissions	May 2019	Timely access to MH services once referral received from Emergency Physician including pulling patients to Psychiatric Care Unit for assessments to be completed.	Development and implementation of new model of care delivery from patient referral to patient disposition. CRP space	Hiring of CNS and Clinical Coordinator to assist in development and implementation of plan. Education to Psychiatric Emergency Service (PES) workers, psychiatrists and inpatient unit staff. Educate culture of "pull" from ED.
Growth of inpatient program	March 2020	Increase to 88% patient occupancy or 8,030 patient days (30%)	Recruitment and Implementation of new staff	Hiring of additional staff when volumes increase and are constant
Growth of Day Hospital program	March 2020	Increase patient attendances by 30% from 4,493 to 5,841	Recruitment and Implementation of new staff	Hiring of additional staff when volumes increase and are constant
Growth of Outpatient program	March 2020	Increase patient attendances by 35% from 15,230 to 20,561	Recruitment and Implementation of new staff	Hiring of additional staff when volumes increase and are constant

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
2020/21				
Patient Experience/Primary Care Partnerships				
Expand ECT services – explore advanced modalities such as Transcranial Magnetic Stimulation (TMS), Eye Movement Desensitization and Reprocessing (ENDR)	March 2021	Target of 500 patient procedures annually. Consider expanded target based on increasing patient care volumes across MH services.	Operating Room collaboration with Anesthesiology, Respiratory Therapy and PACU RN	OR booking time prior to OR day – M-W-F. 2 inpatient psychiatrists perform the ECT procedures. Consider expansion by an additional 1-2 days.
Outreach model expansion (psychiatrist embedded into community practice) to Lang's Community Health Clinic, Grandview Clinic and Nurse Practitioner Led Clinic (NPLC)	March 2021	Target ~ 12 outreach visits per month	Psychiatry recruitment and retention to continue outreach work	Continue planning and gauging psychiatrists to do this work as we hire.
Continue partnering with community programs to support addiction needs of inpatients	March 2021	Adding concurrent disorders programming to inpatient unit	Willing community partners	Education, planning and implementation of program to MH staff.
Goal of 3 Medical learners per year	Continuous	3 learners per year – attained target	Align with McMaster University Medical School	Continuous feedback and physician mentors
Family Advisory Council – continue to increase profile	March 2021	Increase to 1.0 FTE Family Navigator	Acceptance of role across and within the MH program	Research role and needs of families and patients in the program. Learn from other MH organizations with the role.
LHIN Partnership				
Continue FACTT partnership planning and implementation of model	September 2020	Ensure movement of FACTT patients to community stream	Psychiatry retention for FACTT; continued Patient Transition plan	Support and transition of patient population through community continuum of services.
RAAC partnership planning and expansion of model	October 2020	Continue at 2 days per week	Psychiatry retention and/or support attained for NP	Support from addictions psychiatrist to support NP model if no psychiatrist recruited.
Create new models of service delivery				
Continue expanded concurrent care model throughout program services	March 2021	Continued education to MH program including support to other departments with addictions patients	Continued education content and material for staff; Clinical Nurse Specialist (CNS) and partners ability to teach	Continue scheduling of staff well in advance; ongoing support with specific patient cases; alignment of services with education taught
Continued redevelopment of emergency MH services and admission process to inpatient MH unit to support the ED and reduce wait times and readmissions	March 2021	90% of patients are pulled to the Inpatient MH at 60 minutes or less.	Development and implementation of new model of care delivery from patient referral to patient disposition; CRP space	Hiring of CNS and Clinical Coordinator to assist in development and implementation of plan. Education to Psychiatric Emergency Service (PES) workers, psychiatrists and inpatient unit staff. Educate culture of "pull" from ED.
Growth of inpatient program	March 2021	Increase to 95% occupancy or 8,669 patient days (8%)	Recruitment and Implementation of new staff	Hiring of additional staff when volumes increase and are constant
Growth of Day Hospital program	March 2021	Increase patient attendances by 30% from 5,841 to 7,697 (32%)	Recruitment and Implementation of new staff	Hiring of additional staff when volumes increase and are constant. Planning for expansion of evening and/or weekend hours
Growth of Outpatient program	March 2021	Increase patient attendances by 38% from 20,561 to 28,315	Recruitment and Implementation of new staff	Hiring of additional staff when volumes increase and are constant. Planning for expansion to evening and/or weekend hours

Appendix 15 CMH Perioperative 4 Year Program Plan

Appendix 15

CMH Perioperative 4-Year Program Plan 2017/18 to 2020/21

CMH is positioned for growth with PCOP funding, new physical space and a revised clinical services plan. Inherent in this growth strategy is a desire to do things differently, embed patient and family experience into all interactions with providers and partners, achieve quality metrics, and target growth to meet identified or emerging community needs.

The following tables provide an overview of the multi-year pathway forward with expansion of service offerings and program redesign. Service expansion occurred in year one (2017-2018) to align with the anticipated completion of the capital redevelopment project.

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
2017/18				
Program Growth and Redesign				
Modelling of surgical operating room utilization by subspecialty versus weighted cases to determine program capacity for growth.	March 31, 2018	Calculation of weighted cases based on 16/17 volumes and current block utilization to evaluate strategies to reach annual targets with creation of new OR grid.	Provincial PCOP funding approvals to align modelling with CMH costs per case. Collaboration with Decision Support and Finance to develop and validate models.	Changes to medical manpower and case mixes affect predictive analysis. Decision Support analyzing 18/19 volumes to provide data set reflective of current work.
Growth of Surgical program in alignment with PCOP targets using 2016/17 as base year.	March 31, 2018	85 weighted cases or 1.8%	Full OR Block utilization Medical manpower Proactive Human Resources Planning Organizational capacity across perioperative program and ICU	Validation that medical manpower can achieve targets. HR planning. Predictive analysis of emergent volumes and their contributions to growth
Patient Experience				
Co-design a new workflow for the Pre-surgical Clinic in collaboration with patients and staff	Fall 2018	Improved patient experience by bringing the services to the patient.	Partnership with Laboratory Service and Cardio Diagnostics Internal Medicine presence after CRP	Clinic demand exceeds capacity requiring extended hours. Alignment with Choosing Wisely Guidelines
Review all MIS protocols for gastrointestinal surgery.	Fall 2018	Improved patient outcomes and recovery related to changes to the model of care	Staff education and auditing to validate compliance to protocols	Ongoing education to support changes in practice at both nursing and surgeon level. Meaningful data to drive change from Decision Support.
Implementation and go-live of the CoHealth application.	Fall 2018	Enhanced access to discharge instructions for surgery patients and families for elective hip, knee, and ERAS surgeries to improve patient knowledge and support transitions of care through an electronic app on any personal device.	The promotion of the tool at all service intersections commencing in the surgeon's office to promote knowledge for both patients and their families.	Ongoing education and support to embed this application in the model of care. Regular review of utilization data
LHIN & CCO Partnership				
MSK Regional Access Center	August 2018	Timely access to an Advanced Practice Physiotherapist (APP) for patients with severe hip and knee osteoarthritis leading to earlier surgical intervention.	LHIN coordinated access center	Growth beyond case load available with one Advance Practice Physiotherapist and need for additional clinical space at CMH and longer clinic hours.

CMH Perioperative 4-Year Program Plan
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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
CMH Breast Assessment Centre application at CMH	Fall 2018	Timely access for patients undergoing diagnostic imaging for suspected breast malignancy and availability to surgical team with opportunities for immediate breast reconstruction and other oncoplastic procedures.	Diagnostic Imaging General Surgery Plastic Surgery Support from regional cancer care lead & CCO approvals	Timely access to diagnosis and surgical intervention for newly diagnosed patients balanced with minimizing unused OR blocks during critical period of hospital growth.
Redesign of Clinical Processes				
Day 1 discharge for elective hip and knee surgery.	2017/18	Reduction in the length of stay from 2.25 days to 1 day for 80% of elective hip and knee surgeries	Inpatient Surgery Team Patients Surgeons LHIN	Community supports in place to support transitions of care e.g. transportation services and physiotherapy to prevent readmissions and patient dissatisfaction.
Specialized Surgery : Minimally Invasive Surgery (MIS)				
Increase volumes of MIS, General Surgery and offer new upper GI surgeries.	March 31, 2018	Increase overall blocks for General Surgery with focus on dedicated MIS time.	Referral patterns and family practice awareness of new service offerings at CMH. Block Utilization by service to ensure program growth.	Surgeons' actively engaging family practice teams to change referral patterns. Changes to protocols to reduce amount of OR time returned and quarterly monitoring of OR utilization.
Increase volumes of MIS, Urology and repatriate surgical volumes appropriate for a community hospital.	March 31, 2018	Additional OR blocks and expansion of complex MIS procedures e.g. nephrectomies	Referral patterns and family practice awareness of new service offerings at CMH.	Surgeons' actively engaging family practice teams to change referral patterns.
Increase volumes of MIS, ENT surgeries for both pediatric and adult patients and repatriate surgical volumes appropriate for a community hospital.	March 31, 2018	Growth in minimally invasive endoscopic ear surgeries and endoscopic sinus surgery.	Referral patterns and family practice awareness of new service offerings at CMH.	Surgeons' actively engaging family practice teams to change referral patterns.
Specialized Surgery : Breast Reconstruction				
Increase access to oncoplastic and reconstructive breast services in the Waterloo Wellington LHIN including a specialization in immediate breast reconstruction.	March 31, 2018	OR blocks increased by 14% from 16/17 base year.	Referral Patterns and medical manpower influences block utilization. Breast Assessment Center locations in the region drive referrals to surgical programs.	Breast assessment centers affect the referral patterns to local surgeons.

CMH Perioperative 4-Year Program Plan
2017/18 to 2020/21

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Program Infrastructure				
Development of a capital equipment plan that will support weighted case targets.	March 31, 2018	Access to capital equipment is essential to growing surgical volumes.	Surgeons Anesthesia Corporate Capital Plan MDRD	Items deferred to align with corporate budget constraints.
2018/19				
Program Growth and Redesign				
Modelling of surgical operating room utilization by subspecialty versus weighted cases to determine program capacity for growth.	January 2019	Calculation of weighted cases based on 18/19 volumes and current block utilization to evaluate strategies to reach annual targets.	Provincial PCOP funding approvals to align modelling with CMH costs per case. Collaboration with Decision Support and Finance to develop and validate models.	Changes to medical manpower and case mixes affect predictive analysis. Decision Support analyzing 18/19 volumes to provide data set reflective of current work.
Growth of Surgical program in alignment with PCOP targets using 2016/17 as base year.	March 31, 2019	400 weighted cases or 8.4%	Full OR Block utilization Medical manpower Proactive Human Resources Planning Organizational capacity across perioperative program and ICU	Realignment of operating room grid to create capacity during 2019/20 to create capacity to reach 25% target. Validation that medical manpower can achieve targets. HR planning. Predictive analysis of emergent volumes and their contributions to growth.
Patient Experience				
Implementation and go-live of the CoHealth application.	Fall 2018	Enhanced access to discharge instructions for surgery patients and families for elective hip, knee, and ERAS surgeries to improve patient knowledge and support transitions of care through an electronic app on any personal device.	The promotion of the tool at all service intersections commencing in the surgeon's office to promote knowledge for both patients and their families.	Ongoing education and support to embed this application in the model of care. Regular review of utilization data
Relaunch of MIS protocols for gastrointestinal surgery.	Fall 2018	Improved patient outcomes and recovery related to changes to the model of care	Staff education and auditing to validate compliance to protocols	Ongoing education to support changes in practice at both nursing and surgeon level. Meaningful data to drive change from Decision Support.
Pre-surgical Clinic model of Care Redesign	Fall 2018	Improved patient experience by bringing the services to the patient.	Partnership with Laboratory Service and Cardio Diagnostics Internal Medicine presence after CRP	Clinic demand exceeds capacity requiring extended hours. Alignment with Choosing Wisely Guidelines
Medication Reconciliation at discharge for all inpatient surgery patients to achieve Accreditation standard.	January 2019	Patient safety with increased clarity of medication treatment plan by all community providers	Pharmacy and Physician partnerships to build and sustain a workable model.	Planning for resources, support and education for physicians. Audit system to monitor progress to target.

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
LHIN & CCO Partnership				
Bundled Care in Elective Hip and Knee Surgery	Spring 2019	Improved patient experience and improved transitions of care for patients undergoing elective hip and knee surgery by working with external rehabilitation providers to ensure appropriate postoperative care.	Establish contractual and collaborative partners with external providers to ensure access to Rehabilitative services.	Risk of loss of revenue unless well-established pathways for patient care in place to support transitions of care. Detailed planning and monitor of pathways. Regular review of patient outcomes, financial monitoring
Redesign of Clinical Processes				
Participation in Coordinated Access & eReferral for cataract surgery central intake model.	Spring 2019	Development of one centralized intake process across the WW LHIN to provide patients with access to the shortest wait time, preferred geography for care, and specific provider requested by the patient.	WWLHIN, optometrists, EHealth, Ophthalmologists	Delay in launching project due to the complexity and processes required to support the change. Unable to provide timely access to surgery if volumes exceed capacity.
Acute Pain Service model, Nurse Practitioner and Anesthesia aligned with best practice for multi-modal opioid sparing analgesia regimens.	March 31, 2019	Practice changes supporting multi-modal regimes less dependent on intravenous medications are fundamental to decreasing length of stay.	Nursing education Patient education Pharmacy Surgeons	Patients may influenced by previous surgical experiences perceiving a lesser standard of care when not receiving intravenous medications. Staff education to ensure patients multi-modal medications.
Specialized Surgery : Minimally Invasive Surgery (MIS)				
Increase volumes of MIS, General Surgery and offer new upper GI surgeries.	March 31, 2019	Increase overall blocks for General Surgery with focus on dedicated MIS time.	Referral patterns and family practice awareness of new service offerings at CMH. Block Utilization by service to ensure program growth.	Surgeons' actively engaging family practice teams to change referral patterns. Changes to protocols to reduce amount of OR time returned and quarterly monitoring of OR utilization.
Increase volumes of MIS, Urology and repatriate surgical volumes appropriate for a community hospital.	March 31, 2019	Additional OR blocks and expansion of complex MIS procedures e.g. nephrectomies	Referral patterns and family practice awareness of new service offerings at CMH.	Surgeons' actively engaging family practice teams to change referral patterns.
Increase volumes of MIS, ENT surgeries for both pediatric and adult patients and repatriate surgical volumes appropriate for a community hospital.	March 31, 2019	Growth in minimally invasive endoscopic ear surgeries and endoscopic sinus surgery.	Referral patterns and family practice awareness of new service offerings at CMH.	Surgeons' actively engaging family practice teams to change referral patterns.
Specialized Surgery : Breast Reconstruction				
Increase access to oncoplastic and reconstructive breast services in the Waterloo Wellington LHIN including a specialization in immediate breast reconstruction.	March 31, 2019	0% increase in OR blocks	Referral Patterns and medical manpower influences block utilization. Breast Assessment Center locations in the region drive referrals to surgical	Breast assessment centers affect the referral patterns to local surgeons. Recruitment of new resource and improved use of OR time after November, 2018.

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			programs.	
Specialized Surgery : Orthopedics				
Growth and expansion of orthopedic services including hand, shoulder, and foot/ankle in addition to already established hip and knee procedures. Exploration of adding limited scope spinal surgery.	March 31, 2019	Timely access for patients to a full range of orthopedic services close to home.	Surgeon recruitment (2018) foot and ankle specialization. Referral patterns and family practice awareness of new service offerings at CMH.	Growth of surgeon referrals for specialized foot and ankle surgery will take time to change long-standing referral patterns. Spinal surgery capital equipment costs offset by a reduction to another service area and possible challenges funding equipment.
Program Infrastructure				
Upgrade Operating room health information system (PICIS) to improve functionality and reduce charting time for staff.	March 31, 2019	Improved system level data to support program quality. Reduction in nursing documentation through building charting modules aligned with complexity of care.	Information technology and perioperative team working collaboratively to dedicate resources to maintaining and optimizing the PICIS system.	Resources required supporting PICIS, planning forward for expansion with program growth.
Development of a 3-year capital equipment plan that will support weighted case targets.	March 31, 2019	Access to capital equipment is essential to growing surgical volumes.	Surgeons Anesthesia Corporate Capital Plan MDRD	Items deferred to align with corporate budget constraints. Fiscal year 2020/21 may require additional capital investment to weighted cases.
Quality and Safety				
Enrollment into the National Surgical Quality Program with Health Quality Ontario	Fall 2018	Improved surgical outcomes, comparing hospital data to peer organizations.	Clinical Reviewer training and surgeon leadership to disseminate outcomes. Engagement of Clinical Educators to engage staff in quality improvement initiatives.	Develop mechanisms to share information with Surgeons and influence practice change.
Optimization of Cataract Surgery procedures to improve surgical Wait Times to meet funded volumes	2018/19	CMH currently unable to complete allocated volume of patients within budget and operating room time.	Medical manpower capacity to increase throughput Workflow redesign	Process redesign for cataract workflows completed Medical manpower to improve through-put maximized. Risk to other surgical specialties if additional OR time required.
2019/20				
Program Growth and Redesign				
Growth of Surgical program in alignment with PCOP targets using 2016/17 as base year.	2019/20	100 weighted cases *based on return of plastic surgery medical manpower	Full OR Block utilization Medical manpower Proactive Human Resources Planning Organizational capacity across perioperative program and ICU	Realignment of operating room grid to create capacity during 2019/20 to create capacity to reach 25% target. Validation that medical manpower can achieve targets. HR planning. Predictive analysis of emergent volumes and their contributions to growth.

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Modelling of surgical operating room utilization by subspecialty versus weighted cases to determine program capacity for growth.	January 2020	Calculation of weighted cases based on 18/19 volumes and current block utilization to evaluate strategies to reach annual targets.	Provincial PCOP funding approvals to align modelling with CMH costs per case. Collaboration with Decision Support and Finance to develop and validate models.	Changes to medical manpower and case mixes affect predictive analysis. Decision Support analyzing 18/19 volumes to provide data set reflective of current work.
Redesign of Clinical Processes				
Growth and redesign of the Cystoscopy Clinic.	CRP Handover	Increased access to diagnostic testing for patients in the region who may require surgical interventions. Build future capacity for urodynamic studies for specialized Urogynecologist.	Staffing Model Equipment redundancies	Increased capital equipment needs to create capacity with larger cystoscopy volumes.
Enhancement of Regional Anesthesia Model	March 31, 2020	Adopt a regional anesthesia "block room" to improve OR block utilization and increase efficiency.	Hiring Anesthesia Assistant to support new model of care	Enhancement approved to hire resource to support Anesthesiologists.
Specialized Surgery: Minimally Invasive Surgery (MIS)				
Increase volumes of MIS, General Surgery and offer new upper GI surgeries.	March 31, 2020	Increase overall blocks for General Surgery with focus on dedicated MIS time.	Referral patterns and family practice awareness of new service offerings at CMH. Block Utilization by service to ensure program growth.	Surgeons' actively engaging family practice teams to change referral patterns. Changes to protocols to reduce amount of OR time returned and quarterly monitoring of OR utilization.
Increase volumes of MIS, Urology and repatriate surgical volumes appropriate for a community hospital.	March 31, 2020	Additional OR blocks and expansion of complex MIS procedures e.g. nephrectomies	Referral patterns and family practice awareness of new service offerings at CMH.	Surgeons' actively engaging family practice teams to change referral patterns.
Increase volumes of MIS, Gynecology to provide timely access to gynecological surgery and align with best practice in accordance with Health Quality Ontario standards.	March 31, 2020	Growth of gynecology surgical services will improve hospital and regional wait times, providing access to service for both cancerous and benign gynecological conditions.	Physician recruitment Referral patterns	Ability to attract a Gynecologist, skill set aligned to growth. Surgeons' actively engaging family practice teams to change referral patterns.
Increase volumes of MIS, ENT surgeries for both pediatric and adult patients and repatriate surgical volumes appropriate for a community hospital.	March 31, 2020	Growth in minimally invasive endoscopic ear surgeries and endoscopic sinus surgery.	Referral patterns and family practice awareness of new service offerings at CMH.	Surgeons' actively engaging family practice teams to change referral patterns.
Specialized Surgery : Breast Reconstruction				
Increase access to oncoplastic and reconstructive breast services in the Waterloo Wellington LHIN including a specialization in immediate breast reconstruction.	March 31, 2020	Increase immediate breast reconstruction cases from 14-21 Increase delayed breast reconstruction volumes from 76 to 110 cases.	Referral Patterns and medical manpower influences block utilization. Breast Assessment Center locations in the region drive referrals to surgical programs.	Breast assessment centers affect the referral patterns to local surgeons. Recruitment of new resource and improved use of OR time as of November, 2018.

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Program Infrastructure				
Upgrade Operating room health information system (PICIS), developing data analytics capabilities.	March 31, 2020	Improved system level data to support program quality. Development of perioperative dashboards to monitor surgical costs and program efficiency.	Decision Support and perioperative team working collaboratively to develop dashboards to inform decision-making.	Dedicated resources required from Decision Support to build and support planned infrastructure.
Review and monitor capital equipment plan to ensure that it aligns and supports weighted case targets.	March 31, 2020	Access to capital equipment is essential to growing surgical volumes.	Surgeons Anesthesia Corporate Capital Plan MDRD	Items deferred to align with corporate budget constraints. Fiscal year 2020/21 may require additional capital investment to weighted cases.
Quality and Safety				
Utilization of Cambridge Memorial hospital data from National Surgical Quality Program with Health Quality Ontario to launch one quality improvement initiative.	March 31, 2020	Improved surgical outcomes, comparing hospital data to peer organizations.	Clinical Reviewer training and surgeon leadership to disseminate outcomes. Engagement of Clinical Educators to engage staff in quality improvement initiatives.	Develop mechanisms to share information with Surgeons and influence practice change.
2020/21				
Program Growth and Redesign				
Modelling of surgical operating room utilization by subspecialty versus weighted cases to determine program capacity for growth.	March 31, 2020	Calculation of weighted cases based on 16/17 volumes and current block utilization to evaluate strategies to reach annual targets with creation of new OR grid.	Provincial PCOP funding approvals to align modelling with CMH costs per case. Collaboration with Decision Support and Finance to develop and validate models.	Changes to medical manpower and case mixes affect predictive analysis. Decision Support to analyze 2019/20 volumes to provide data set reflective of current work.
Growth of Surgical program in alignment with PCOP targets using 2016/17 as base year.	March 31, 2018	500 weighted cases	Full OR Block utilization Medical manpower Proactive Human Resources Planning Organizational capacity across perioperative program and ICU	Validation that medical manpower can achieve targets. HR planning. Predictive analysis of emergent volumes and their contributions to growth
Specialized Surgery : Minimally Invasive Surgery (MIS)				
Increase volumes of MIS, General Surgery and offer new upper GI surgeries.	March 31, 2021	Increase overall blocks for General Surgery with focus on dedicated MIS time.	Referral patterns and family practice awareness of new service offerings at CMH. Block Utilization by service to ensure program growth.	Surgeons' actively engaging family practice teams to change referral patterns. Changes to protocols to reduce amount of OR time returned and quarterly monitoring of OR utilization.

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Increase volumes of MIS, Urology and repatriate surgical volumes appropriate for a community hospital.	March 31, 2021	Additional OR blocks and expansion of complex MIS procedures e.g. nephrectomies	Referral patterns and family practice awareness of new service offerings at CMH.	Surgeons' actively engaging family practice teams to change referral patterns.
Increase volumes of MIS, ENT surgeries for both pediatric and adult patients and repatriate surgical volumes appropriate for a community hospital.	March 31, 2021	Growth in minimally invasive endoscopic ear surgeries and endoscopic sinus surgery.	Referral patterns and family practice awareness of new service offerings at CMH.	Surgeons' actively engaging family practice teams to change referral patterns.
Specialized Surgery : Breast Reconstruction				
Increase access to oncoplastic and reconstructive breast services in the Waterloo Wellington LHIN including a specialization in immediate breast reconstruction.	March 31, 2021	Increase immediate breast reconstruction cases 24 cases. Increase delayed breast reconstruction volumes 120 cases.	Referral Patterns and medical manpower influences block utilization. Breast Assessment Center locations in the region drive referrals to surgical programs.	Breast assessment centers affect the referral patterns to local surgeons. Breast program growth dependent on regional planning and model for access to breast cancer surgery.

Appendix 16 CMH Women & Child 4 Year Program Plan

Appendix 16

CMH Women & Child 3-Year Program Plan
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CMH is positioned for growth with PCOP funding, new physical space and a revised clinical services plan. Inherent in this growth strategy is a desire to do things differently, embed patient and family experience into all interactions with providers and partners, achieve quality metrics, and target growth to meet identified or emerging community needs within the Women and Children's program.

The following tables provide an overview of the multi-year pathway forward with expansion of service offerings and program redesign.

TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
2017/18				
Program Growth and Redesign				
Repatriation of births to the program, increasing from 1441 births (776 weighted cases) in 2016/17 base year.	2017/18	Births: 1402 Maternal Case Weight: 769 Newborn Case Weight: 536 Total Weight: 1306	Capital redevelopment Project attracting patients to modern facility for birthing experience. Attracting medical manpower to the program with ongoing recruitment of two new physicians. Growth of nursing resources in the labor and delivery program.	Delays to Capital Redevelopment Program create uncertainty for the community. Challenges attracting medical manpower to the team with Chiefs reviewing current state and reposting at a later date. Competitive environment and active recruitment underway. Nursing staffing model increased to support program growth.
Increased access to pediatric surgery in the WWLHIN for oromaxillofacial (6 cases) and explore capital equipment to support minimally invasive ear surgeries at CMH.	2017/18	10 oromaxillofacial cases MIS ENT surgery plan TBD	Recruitment of new ENT Medical Manpower in 2017 Approval to purchase of new MIS endoscopic ear surgery equipment.	Delays in sourcing capital equipment reducing access to surgical procedures. Purchasing underway. Surgeons' actively engaging family practice teams/Dentists to change referral patterns. Website refresh to assist marketing for this program.
Plan to advance the Special Care Nursery from Level 2A to 2B to repatriate infants sooner from tertiary care and prevent transfers of infants from the Women and Children's program appropriate for Level 2B care.	January 2018	Holdover days in tertiary care (infants ready to return to their home region) have risen from 513 in 2016/17 to 722 in 2107/18 in the WWLHIN. 2017/18: 35 infants transferred back from Level 2B programs suggests that cohort would be direct admission from tertiary care.	Nursing Education continuous feeds (October, 2018). Nursing Education CPAP (February 15, 2019). Capital equipment procurement Medical Manpower support LHIN support and approval of Provincial Council for Maternal & Child Health	Ability to admit patients exceeds program capacity as births increase. Currently developing a surge capacity plan to manage mild and moderate surge. Ability to recruit nursing resources to support growth of the nursery program. Working with unions to allow dual appointments (Pediatrics/Nursery) to build staffing capacity.

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Patient Experience				
Participation in the Baby Friendly Initiative to make hospital and Women and Children's program a baby friendly environment supportive of breastfeeding.	2017/18	Achieving new milestones in the BFI Implementation Status Report Tool each year to support breastfeeding practices within the program.	Physician & Midwifery engagement Ongoing nursing engagement and education Parent involvement and education	Cost of receiving designation and perceived value of participation. Program to review the value of costly accreditation process versus aligning with the best practices. Loss of formula funding that supports program education initiatives as per BFI criteria. Ensure that new hires meet the mandatory education requirements and have breastfeeding course to reduce cost to organization. Enhancement approved to hire a non-nursing Lactation Consultant, a mandatory requirement for BFI designation.
Host a patient and community focus group to gather feedback from patients and families regarding their experiences with the Women and Children's program.	April 2017	Improve community perception of the Women and Children's program and overcome negative social media to increase the number of births at CMH.	Staff Patients Media External Partners e.g. Breastfeeding buddies	Poor attendance and therefore no traction on the initiative. Find alternative ways to engage the community and improve the patient experience.
Explore the creation of a partnership with Breastfeeding Buddies, a peer support network working within the Women and Children's program.	Fall 2017	Community partnership to support breastfeeding in the Women and Children's program while creating linkages to community resources to support transitions of care.	Waterloo-Wellington Public Health Unit and ongoing funding of the program. Staff Nurses Breastfeeding Mothers	Program funding cut and linkages to community lost. Research underway to validate real/perceived benefits to the program to maintain this new program.
Redesign of Clinical Processes				
Midwifery expansion of scope of practice to include epidural management.	2017/18	Improved patient experience and increased access to epidurals for Midwifery patients choosing to deliver at CMH.	Anesthesia approval to move to new model of care Midwifery education Midwifery patients	Achieving anesthesia consensus and program cannot provide the service. Chief of Staff to move initiative. Increase nursing staffing levels to ensure access to epidurals for patients choosing to deliver at CMH.
Evaluate the clinical criteria and use of the Air-vo system for pediatric patients to optimize hospital resources while supporting quality outcomes.	2017/18	Increased staffing while patient on system leading to significant operational costs.	Assessment of patient acuity and complexity Nursing education Physician support	Education and information sharing not supported by staff.
Develop plan for staff in the labor and delivery program to obtain competencies to support caesarean sections within the program improving continuity of care.	2017/18	Improved patient experience and preparation for the division of the program in the new physical space.	Ongoing education and training for staff. Support of surgeons and Anesthetists to build capacity within the team.	Anesthesia support for the new model of care either in the current operating rooms or on the Women and Children's unit.

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Capital Equipment				
Research and develop plan to adopt new fetal central monitoring for the labor and delivery program.	2017/18	Adoption of a new approach to fetal monitoring with archived electronic records for improved record retention.	IT infrastructure projects Capital Redevelopment Project	Lack of budget for this project and unable to move forward. Explore if not accepted if it can be added for future consideration.
Quality & Safety				
Developing and maintaining a culture of safety within the program.	2017/18	Enrollment in the MORE OB™ and other educational strategies support safety within the Obstetrical program.	80% staff participation Running monthly educational sessions in neonatal resuscitation Physician participation	Discontinuation of MORE OB™ and reliance on internal educational programs to support a culture of safety.
2018/19				
Program Growth and Redesign				
Repatriation of births to the program, increasing from 10 to 15 Obstetrical beds aligning with planned growth attached to the provincial PCOP funding.	2018/19	Births: 1500 Maternal Case Weight: 861 Newborn Case Weight: 572 Total Weight: 1433	Capital redevelopment Project attracting patients to modern facility for birthing experience. Attracting medical manpower to the program with ongoing recruitment of two new physicians. Growth of nursing resources in the labor and delivery program.	Delays to Capital Redevelopment Program create uncertainty for the community. Challenges attracting medical manpower to the team with Chiefs reviewing current state and reposting at a later date. Competitive environment and active recruitment underway. Nursing staffing model increased to support program growth.
Increased access to pediatric surgery in the WWLHIN for oromaxillofacial (6 cases) and explore capital equipment to support minimally invasive ear surgeries at CMH.	2018/19	10 oromaxillofacial cases MIS ENT surgery plan TBD	Recruitment of new ENT Medical Manpower in 2017 Approval to purchase of new MIS endoscopic ear surgery equipment.	Delays in sourcing capital equipment reducing access to surgical procedures. Purchasing underway. Surgeons' actively engaging family practice teams/Dentists to change referral patterns. Website refresh to assist marketing for this program.
Advancement of the Special Care Nursery from Level 2A to 2B to repatriate infants sooner from tertiary care and prevent transfers of infants from the Women and Children's program appropriate for Level 2B care.	February 15, 2019	Holdover days in tertiary care (infants ready to return to their home region) have risen from 513 in 2016/17 to 722 in 2107/18 in the WWLHIN. 2017/18: 35 infants transferred back from Level 2B programs suggests that cohort would be direct admission from tertiary care.	Nursing Education continuous feeds (October, 2018). Nursing Education CPAP (February 15, 2019). Capital equipment procurement Medical Manpower support LHIN support and approval of Provincial Council for Maternal & Child Health	Ability to admit patients exceeds program capacity as births increase. Currently developing a surge capacity plan to manage mild and moderate surge. Ability to recruit nursing resources to support growth of the nursery program. Working with unions to allow dual appointments (Pediatrics/Nursery) to build staffing capacity.

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Patient Experience				
Participation in the Baby Friendly Initiative to make hospital and Women and Children's program a baby friendly environment supportive of breastfeeding.	2017/18	Achieving new milestones in the BFI Implementation Status Report Tool each year to support breastfeeding practices within the program.	Physician & Midwifery engagement Ongoing nursing engagement and education Parent involvement and education	Cost of receiving designation and perceived value of participation. Program to review the value of costly accreditation process versus aligning with the best practices. Loss of formula funding that supports program education initiatives as per BFI criteria. Ensure new hires meet mandatory education requirements and have breastfeeding course to reduce cost to organization. Enhancement approved to hire a non-nursing Lactation Consultant, a mandatory requirement.
Breastfeeding Buddies, a peer support network working within the Women and Children's program.	Fall 2018	Community partnership to support breastfeeding in the Women and Children's program while creating linkages to community resources to support transitions of care.	Waterloo-Wellington Public Health Unit and ongoing funding of the program. Staff Nurses Breastfeeding Mothers	Program funding cut and linkages to community lost. Research underway to validate real/perceived benefits to the program to maintain this new program.
Approval in principle of Midwifery program participation in education to expand scope of practice to include epidural management.	Spring 2019	Improved patient experience and increased access to epidurals for Midwifery patients choosing to deliver at CMH.	Anesthesia approval to move to new model of care Midwifery education Midwifery patients	Achieving anesthesia consensus and program cannot provide the service. Chief of Staff to move initiative. Increase nursing staffing levels to ensure access to epidurals for patients choosing to deliver at CMH.
LHIN & CCO Partnership				
Co-Health App	Fall 2018	Enhanced access to health promotion materials and discharge instructions for patients and families giving birth at CMH and families accessing the pediatric surgery program. Partner with patients and families to support transitions of care through an electronic app on any personal device.	The promotion of the tool at all service intersections commencing in the Obstetricians' office to promote knowledge for patients and families. Ongoing resources to support the maintenance of the app.	Ongoing education and support to embed this application in the model of care. Regular review of utilization data
Redesign of Clinical Processes				
All staff in the labor and delivery program obtains competencies to support caesarean sections within the program improving continuity of care.	Fall 2018	Improved patient experience and preparation for the division of the program in the new physical space.	Ongoing education and training for staff. Support of surgeons and Anesthetists to build capacity within the team.	Anesthesia engagement to support new model of care either in the current operating rooms or on the Women and Children's unit.

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Capital Equipment				
Technological advances to improve patient and staff experience within the Capital Redevelopment Project staggered roll out allowing for adaptation to new care environment and model of care.	Building Handover and 6 months post move	Program move into the new space prior to rolling out new fluid waste management and infant security (HUGS) system relying on old practices until launched.	Staff education CRP Team	Education of all staff in timely and efficient manner in alignment with targets.
Quality and Safety				
Ongoing approaches to staff engagement to support a culture of safety within the program.	Ongoing	Enrollment in the MORE OB™ and other educational strategies support safety within the Obstetrical program.	80% staff participation Running monthly educational sessions in neonatal resuscitation Physician participation	Discontinuation of MORE OB™ and reliance on internal educational programs to support a culture of safety.
Medication Reconciliation at discharge for all patients in the Women & Children's program to achieve Accreditation standard	January 2019	Patient safety with increased clarity of medication treatment plan by all community providers	Pharmacy and Physician partnerships to build and sustain a workable model.	Planning for resources, support and education for physicians. Audit system to monitor progress to target.
2019/20				
Program Growth and Redesign				
Repatriation of births to the program, increasing from 10 to 15 Obstetrical beds aligning with planned growth attached to the provincial PCOP funding.	2019/2020	Births: 1752 Maternal Case Weight: 1005 Newborn Case Weight: 668 Total Weight: 1673	Capital redevelopment Project attracting patients to modern facility for birthing experience. Attracting medical manpower to the program with ongoing recruitment of two new physicians. Growth of nursing resources in the labor and delivery program.	Changes to medical manpower over time and ability to grow births. Nursing staffing model increased to support program growth.
Increased access to pediatric surgery in the WWLHIN for oromaxillofacial and minimally invasive ear surgeries.	2019/2020	Increase in weighted cases in a small program to improve program efficiency.	Staffing Model Surgeons Community	Surgeons' actively engaging family practice teams/Dentists to change referral patterns. Medical manpower remains unchanged. Reputation and knowledge in the community of the MIS ENT program and the oromaxillofacial program.
Increase nursery patient days related to growth in deliveries and advancement to a level IIB nursery over 2016/2017 base year.	2019/2020	Patient days: 1630 increased from 1367 in 2016/2017	Staffing Model Community Obstetricians Pediatricians	Births do not increase at the expected rate after program move. Increase advertising with family physicians to attract families to the program. Ability to recruit nursing resources to support growth of the nursery program with appropriate skill set. Working with unions to allow dual appointments (Pediatrics/Nursery) to build staffing capacity.

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Patient Experience				
Participation in the Baby Friendly Initiative to make hospital and Women and Children's program a baby friendly environment supportive of breastfeeding.	2019/2020	Achieving new milestones in the BFI Implementation Status Report Tool each year to support breastfeeding practices within the program.	Physician & Midwifery engagement Ongoing nursing engagement and education Parent involvement and education	Cost of receiving designation and perceived value of participation. Program to review the value of costly accreditation process versus aligning with the best practices. Loss of formula funding that supports program education initiatives as per BFI criteria. Ensure that new hires meet the mandatory education requirements and have breastfeeding course to reduce cost to organization. Enhancement approved to hire a non-nursing Lactation Consultant, a mandatory requirement for BFI designation.
Quality and Safety				
Ongoing approaches to staff engagement to support a culture of safety within the program.	Ongoing	Enrollment in the MORE OB™ and other educational strategies support safety within the Obstetrical program.	80% staff participation Running monthly educational sessions in neonatal resuscitation Physician participation	Discontinuation of MORE OB™ and reliance on internal educational programs to support a culture of safety.
2020/21				
Program Growth and Redesign				
Continued growth of the obstetrical program to expand beds from 10 to 15 in alignment with provincial PCOP funding.	2020/2021	Births: 1800 Maternal Case Weight: 1033 Newborn Case Weight: 686 Total Weight: 1719	Capital redevelopment Project attracting patients to modern facility for birthing experience. Attracting medical manpower to the program with ongoing recruitment of two new physicians. Growth of nursing resources in the labor and delivery program.	Changes to medical manpower over time and ability to grow births. Nursing staffing model increased to support program growth.
Explore the advancement of the Special Care Nursery from Level 2B to 2C to repatriate infants sooner from tertiary care and prevent transfers of infants from the Women and Children's program appropriate for Level 2B care.	2020/2021	Review holdover days, in tertiary care and infants sent to level 2C beds from CMH region. Patient days: 1700 increased from 1367 in 2016/2017	Nursing Education skills Capital equipment plan Medical Manpower competencies LHIN support and approval of Provincial Council for Maternal & Child Health Pharmacy capacity	Assurance of Pediatric medical manpower to support the program with appropriate skills alignment. Ability to admit patients exceeds program capacity as births increase. Currently developing a surge capacity plan to manage mild and moderate surge. Ability to recruit nursing resources to support growth of the nursery program with appropriate skill set. Working with unions to allow dual appointments (Pediatrics/Nursery) to build staffing capacity.

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TACTIC / INITIATIVE	TARGET DATE	IMPACT (PCOP /WGTED CASES/VOLUMES) QUALITATIVE/QUANTITATIVE	CO-DEPENDENCIES	RISKS & MITIGATION STRATEGIES
Patient Experience				
Participation in the Baby Friendly Initiative to make hospital and Women and Children's program a baby friendly environment supportive of breastfeeding.	2019/2020	Achieving new milestones in the BFI Implementation Status Report Tool each year to support breastfeeding practices within the program.	Physician & Midwifery engagement Ongoing nursing engagement and education Parent involvement and education	Cost of receiving designation and perceived value of participation. Program to review the value of costly accreditation process versus aligning with the best practices. Loss of formula funding that supports program education initiatives as per BFI criteria. Ensure that new hires meet the mandatory education requirements and have breastfeeding course to reduce cost to organization. Enhancement approved to hire a non-nursing Lactation Consultant, a mandatory requirement for BFI designation.
Quality and Safety				
Ongoing approaches to staff engagement to support a culture of safety within the program.	Ongoing	Enrollment in the MORE OB™ and other educational strategies support safety within the Obstetrical program.	80% staff participation Running monthly educational sessions in neonatal resuscitation Physician participation	Discontinuation of MORE OB™ and reliance on internal educational programs to support a culture of safety.