



REVISED HOSPITAL IMPROVEMENT PLAN (R-HIP)

ADDRESSING THE CHALLENGE: KEEPING PACE WITH CHANGING NEEDS OF OUR PATIENTS & SUSTAINING QUALITY CARE WITH A SUSTAINABLE FUTURE

November 2009

Background

Over the past several months, together with the support and advice from the Waterloo Wellington Local Health Integration Network (WWLHIN), Cambridge Memorial Hospital (CMH) has undertaken to develop a revised Hospital Improvement Plan (R-HIP). This document outlines the improvement plan; one that is practical, effective and sustainable and one that positions CMH to continue to provide excellent acute health care services to the community. The plan is consistent with the goals and priorities of the WWLHIN, protects the acute care capacity of the organization and positions the organization for sustainable improvement and growth.

The initiatives in this plan have been developed by staff, and reviewed in the organization by medical staff, front line staff, managers, physician leaders and administrators. The plan has been endorsed by the Board of Governors and the Supervisor, and CMH is anxious to proceed with the implementation of its initiatives as soon as possible.

It is important to note that the initial parameters established by the WWLHIN for the hospital's improvement plan served as the guiding direction in the development of the R-HIP, namely:

- To balance the operating budget;
- To eliminate the reliance on a line of credit;
- To be consistent with the WWLHIN Integrated Health Service Plan;
- To submit voluntary integration solutions for any divestiture of patient services; and
- To ensure reasonable access to care.

Between September and November 2009, the hospital engaged in a comprehensive process to identify additional cost savings opportunities. Through this process, CMH undertook a broad internal consultation process to revisit its current financial situation and to look at sustaining quality care with a sustainable future. A concerted effort by the

medical and hospital staff leadership, in consultation with their colleagues and all staff throughout the organization, identified new initiatives that are now incorporated into the R-HIP.

Approximately \$11M in cost improvements are needed to balance the budget in 2010/11 based on an approximately \$3M opening deficit and \$8M in new cost pressures (including capital and restructuring costs). New sources of funding are neither assumed nor included in the R-HIP.

Key Initiatives

CMH has identified a number of initiatives to balance the budget in 2010/11 including the following categories:

- Reduce overhead costs, including creating a leaner management structure
- Increase non-government revenue
- Reduce waste of supplies
- Reduce costs of supplies through improved contract negotiations
- Improve the use of paid hours and dollars, through decreased overtime and improvements to sick time
- Better align skill mix with patient care need
- Lessen impact of internal inefficiencies due to small units
- Adopt a performance improvement philosophy including using benchmark information to identify opportunities for improvement

The R-HIP builds on the previous initiatives that began last year with the December 2008 “Closing the Gap” cost recovery strategies, and the June 2009 Hospital Improvement Plan (HIP) submitted to the WWLHIN. The R-HIP is made up of 3 components:

1. Initiatives approved in August 2009 – referred to as Phase 1 HIP initiatives (see Figure 1)
2. New initiatives identified between September and October 2009 – referred to as Phase 2 initiatives (see Figure 2)
3. Initiatives originally submitted in the June 2009 HIP that required further analysis – referred to as Phase 3 initiatives (see Figure 3)

In August, 2009, the WWLHIN approved over 30 of the 53 initiatives from the HIP totaling approximately \$4.0M of which \$3.5M have been implemented. These initiatives are referred to as “Phase 1 HIP initiatives” and are detailed in the figure below.

Figure 1: Summary of Phase 1 HIP Initiatives

item	Initiative	Description	FTE	Financial Impact 09/10	Financial Impact 10/11
1	Management, supervisory and non union support staff changes	Includes initiatives #1, 5, 6, 12, 13, 14, 19, 21, 27 (these have been combined to protect the privacy of affected individuals)	11.5	265,251	929,450
2	Self pay - chargeable devices	Chargeable devices (i.e. procedures, crutches)		13,500	27,000
3	Differential Income	Multiple revenue optimization strategies including rate change		170,000	340,000
4	Medical fees	Enhanced OHIP recovery for services provided by Hospitalists		125,000	250,000
7	Best Practice	Decentralize the Best Practice Lead		8,683	17,367
8	Laundry	Reduction in linen inventory quotas		31,250	75,000
9	Cafeteria	Rate change, special promotions, and reduced service in summer		5,500	11,000
10	Food	Reduction in raw food cost and minimizing food waste		62,500	125,000
11	Porter	Re-alignment of Porter supporting ER and clinical units	1.0	26,042	62,500
15	Supplies: 10%	Reduction in inventory of Medical and Surgical supplies through Bar Coding and Inventory Management System		208,333	500,000
16	Housekeeping /Food Services	Re-align Housekeeping and Dietary staff to better support changes to clinical areas	3.2	34,318	137,271
17	Central Sterilization Supply	Process improvement change - reduce 1.0 FTE	1.0	11,750	47,000
18	Health Information Management	Reduction of Health Records Clerks and reliance on Electronic Health Records Management and reduced paper	3.0	52,500	210,000
20	Biomed	Contract savings through regional initiative to optimize roles		0	50,000
22	MD fees	Reduction in physician stipend support from global budget due to new OHIP payment		0	200,000
23	Education	Consolidate clinical education roles	0.9	0	80,000
24	Laboratory	Eliminate CKMB test and test utilization		9,750	39,000

item	Initiative	Description	FTE	Financial Impact 09/10	Financial Impact 10/11
25	DI Transcriptionist	Reduce transcription related to regional dictation technology	1.0	4,726	18,905
26	DI OBSP	Eliminate RN Examiner role	0.6	11,594	46,374
28	Pharmacy	Re-negotiate selected contracts		7,092	28,367
29	Poly Pharmacy & Drug utilization	Poly Pharmacy and Drug Utilization review		41,667	100,000
30	Laboratory / DI Technician	Technical reductions to align with bed plan	1.0	0	88,090
31	OR: Temporary Summer closure	Cost savings		46,200	46,200
32	OR: Float Nurse	Reduction of 1.0 Float RN	1.0	0	98,000
33	Endoscopy	Reduction of 0.4 RN	0.4	0	49,000
34	Overtime	Comprehensive overtime reduction and control plan		104,167	250,000
35	Obstetrics Clinic	Lactation counseling to be provided in community	2.4	142,100	243,600
	Phase 1 total		26.0	\$1,381,921	\$4,069,123

As noted earlier, widespread consultation was done to identify additional initiatives to be included in the R-HIP. Nearly 200 new ideas were submitted by our staff between September and October. Many of these ideas were helpful in solidifying the R-HIP, and most will be invaluable in finding more opportunities to eliminate waste of resources to sustain a balanced budget and to reinvest in service for our patients next year and beyond. The figure below outlines the new proposed new initiatives.

Figure 2: Summary of Phase 2 Initiatives

item	Initiative	Description	FTE	Financial Impact 09/10	Financial Impact 10/11
36	Finance	Process improvement to further reduce bad debts		84,000	84,000
37	Finance	Increase revenue for missed billing of misc items (e.g. crutches)		20,000	20,000
38	Human Resources	Changes to attendance management program and reduce sick time		38,000	230,000
39	Purchasing	Contract savings: improved use of MedBuy program			70,000
40	Purchasing	Additional OR and Lab items on contract			200,000
41	Purchasing	Convert supplies on floors to		150,000	

item	Initiative	Description	FTE	Financial Impact 09/10	Financial Impact 10/11
		asset			
42	Health Records	Reduce coding hours	1.0	0	30,000
43	Printing	Increased revenue		7,000	10,000
44	Communications	Align community engagement costs with Foundation		0	15,000
45	Information Mgt	Service contract costs and amortization (new cost – not savings)		0	-180,000
46	Switchboard	Arrange for service to be provided by hospital partner	5.7	0	70,000 (Note 1)
47	Dietitian	Reduce dietitian holiday coverage & lead hand	0.5	18,000	89,000
48	Inpatient food	Reduce bulk waste, choices		0	50,000
49	Plant	Energy retrofit savings		70,000	140,000
50	Parking	Increased revenue due to installation of gate controlled lots		0	75,000
51	Maintenance	Reduce painter and landscape contract	1.2	29,750	51,000
52	Maintenance	Eliminate on-call standby		9,917	17,000
53	Biomed	Multi-hospital service		0	30,000
54	Lab	Autoverification of results	0.5	0	50,000
55	Lab	Consolidation of equipment, save supplies		0	50,000
56	Pharmacy	Reorganize mat leave coverage & reduce staff	1.2	0	102,700
57	Pharmacy	Automate packaging & reduce sterile compound	0.6	0	41,100
58	DI X-ray	Increase x-ray booking efficiency, new revenue		0	30,000
59	DI Ultrasound	Increased revenue with 4 th ultrasound unit		17,500	55,000
60	DI Ultrasound	New procedures and associated net revenue		0	20,000
61	DI teleradiology	Eliminate purchase service		0	20,000
62	Mammography	Increase revenue		8,000	29,200
63	Fracture clinic	Reorganize clinic schedule	0.2	0	72,000
64	Paediatrics	Co-locate paediatrics and nursery **	4.2	0	420,000
65	ICU	Clerical Reduction	0.2	0	9,600
	Sub-total		15.3	452,167	1,900,600

Note 1: This initiative will be implemented in late 2010. There will be further savings in 2011-12

** : see clinical changes section for more information on this initiative

CMH revisited the Phase 3 initiatives that were submitted as part of the original June 2009 HIP. The hospital undertook a risk assessment exploring the feasibility, legitimacy, impact and alignment (with CMH and WWLHIN IHSP goals and priorities). Most of the initiatives originally submitted still made sense given the role of the hospital

and in recognition of the magnitude of the financial challenge. The figure below outlines the resubmitted initiatives.

Figure 3: Summary of Phase 3 Initiatives (submitted in original June 2009 HIP)

item	Initiative	Description	FTE	Financial Impact 09/10	Financial Impact 10/11
66	Pharmacy	Reduce 1.0 Pharmacist and 0.5 Pharmacy Technician to align with bed plan	1.5	0	144,476
67	ER	Reduce 4.2 RN, add 4.2 RPN	4.2	0	170,000
68	Mental Health	Add 2.8 RPN to support RN, RPN ratio, reduce 2.8 RN	2.8	0	103,250
69	Medicine	Move RN:RPN ratio from 70:30 to 60:40 decrease 4.0 RN increase 4.2 RPN	4.2	0	154,000
70	SDS	Move RN:RPN ratio from 90:10 to 60:40 decrease 2.4 RN, increase 2.4 RPN	2.4	0	88,500
71	Surgery	Move RN:RPN ratio from 77:23 to 69:31, decrease 2.1 RN, increase 2.1 RPN	2.1	0	77,000
72	LDRP	Move RN:RPN ratio from 100:0 to 60:40 decrease 2.2 RN increase 2.2 RPN	2.2	0	77,500
73	11 bed Oncology merger	Re-align model of care for Oncology **	13.8	0	1,560,000
74	10 bed short-stay	Create 10 bed short-stay unit that closes on Saturdays and Sundays. Remaining 18 surgical beds are available 24/7. **	2.8	0	273,911
75	Reduction of 21 CCC beds	Save 21 beds: reduce long LOS, WWCCAC "home first", "waiting at Home", other partnerships with convalescent care providers; nursing home beds in vacant CMH space **	17.5	0	1,812,000
76	Ambulatory Rehab	Patients referred to a community-based provider **	4.8	0	334,375
77	Cardiac Rehab	Patients referred to a community-based cardiac rehabilitation provider. **	1.8	0	159,000
78	Pain Clinic	Realignment of hospital pain clinic.	0.5	0	68,800
			60.6	0	5,022,812

** : see next section for more information on these initiatives

The hospital is committed to working with staff and partners in ensuring the key clinical changes are implemented well. The figure below provides further information on some of the key clinical changes and the rationale for implementing them. The timetable for implementation allows for an effective transition and enables appropriate time for implementation planning.

Figure 4 Key Clinical Changes

INITIATIVE	RATIONALE	WHEN
<p>Consolidate 11 oncology/palliative beds by either</p> <ul style="list-style-type: none"> a) moving acute oncology to medicine and consolidate palliative service on 3rd floor b) moving program to 3rd floor and expanding program to accommodate other palliative care patients. Acute care oncology patients would be cared for on the 3rd floor as part of this program. 	<ul style="list-style-type: none"> • Palliative care services are provided across 3 units: complex care 3-5 patients; medicine 1-2 patients and oncology/palliative 4 patients • 11 oncology/palliative care unit mainly provides palliative care with an average length of stay > 12 days • Propose to move 11 oncology/palliative beds to a mixed model of acute and post-acute care beds to better support the longer stay palliative model of care • New model of care supported by physician group 	<p>May 2010</p>
<p>Reduce 10 surgical beds on weekend to support short stay surgical unit concept.</p>	<ul style="list-style-type: none"> • Avoids “scramble” early in the week to place elective surgical patients 	<p>May 2010</p>
<p>Close 32 ALC long term care/other beds on 3rd floor: discharge patients via Home First or to a “restore access” program</p>	<ul style="list-style-type: none"> • WWLHIN mandate to reduce ALC rate across LHIN to 9.6%. CMH is currently at 36% with 50+ ALC patients. WWLHIN target is that CMH has only 15 ALC patients at any one time. • Right now, about 36 of 42 complex continuing care (CCC) beds are occupied by ALC patients. • Of these 36 patients, 30 waiting for a place in a long-term care (LTC) home • Our approach will be to improve access to CCAC Home First program and linkage to “restore access” partnerships with retirement homes and interim LTC beds. • This will allow us to close beds. • This could include the possible access to LTC beds on 5th floor at CMH. We would rent space to a LTC provider. This option is still under exploration with the WWLHIN and the LTC provider 	<p>May 2010 & Fall 2010 (this would be phased in)</p>
<p>Divest ambulatory care clinics to community provider (hand clinic, cardiac rehab, ambulatory rehab)</p>	<ul style="list-style-type: none"> • In an integrated system, ambulatory care should be provided outside of an acute care hospital, whenever possible 	<p>January 2010</p>

INITIATIVE	RATIONALE	WHEN
	<ul style="list-style-type: none"> • CMH has entered discussions with a community provider who will offer this service. 	
Consolidate paediatrics and nursery	<ul style="list-style-type: none"> • Address small unit size and low paediatric census (<70 % occupancy) • This will require some renovation to accommodate this change. • Staff are currently engaged in discussions about the potential options 	May 2010

Bed Configuration

The change to the CMH bed configuration is summarized below.

Figure 5: Proposed Bed Configuration

CMH Beds	Jan 2010	Spring 2010	future	change
medicine (40+11)	51	40	45	-6
surgery	28	25	25	-3
icu	7	7	7	
paed	7	7	7	
obstetrics	10	10	10	
mental h	10	10	10	
complex care alc	32	6	0	-32
med complex care	6	0		-6
ccc/rehab/pall	4	15	31	27
TOTAL	155	120	135	-20
CCC/rehab	42	21	31	-11

The table includes a “future” state. CMH has an operating budget request for rehabilitation beds, supported by the WWLHIN, awaiting approval by the MOHLTC. The functional program includes 31 rehabilitation beds. The phasing of the capital redevelopment project provides for early implementation of rehabilitation beds within the existing space. The current plan is to convert the existing 42 bed complex care space on 3rd floor to accommodate 31 rehabilitation beds.

Human Resource Impact

Our most valued resource is our people and to that end, an effective human resources strategy is critical to our success in meeting our core business needs. This will ensure that quality patient care will be enhanced throughout and following the implementation of our initiatives.

We are fortunate to have a strong working relationship with our union leadership. They have partnered with us to ensure the ongoing development and sustainability of our workforce. We have engaged employees, volunteers and physicians to assist in developing a number of strategies to minimize the impact on staff. The strategies we will employ include:

- Use of vacancies for reassignment and deployment. Positions that have become vacant through attrition since early in 2009 have been held for employees affected during implementation.
- Offers of voluntary exit and early retirement will be invoked as per the respective Collective Agreements.
- Additional Resource (float pool) positions have been created for affected staff.
- Reduction of scheduled hours (maintain employee commitments), creation of job share, weekend worker, modified full-time and dual-unit positions will be utilized where appropriate to minimize position elimination.

To ensure a successful change effort, we are supporting our employees and leaders throughout the corporate transformation so that we are able to continue to develop and sustain a healthy organization.

The impact of the R-HIP on staff levels is summarized by fiscal year below. The change to the total FTEs, implemented over two fiscal years, is a reduction of 109 FTE and an increase of 22 FTE for a net decrease of 87 FTE. At this stage, the actual number of staff who will leave the organization is unknown as CMH has not yet undertaken the above strategies. It is anticipated that the actual number of staff who will leave will be significantly lower. The hospital currently has approximately 20 nursing vacancies.

Figure 6: Summary of R-HIP FTE Increases and Decreases

Grouping of Initiatives	# of Initiatives	2009/10			2010/11		
		# of FTEs Impacted		Financial Impact	# of FTEs Impacted		Financial Impact
		Reductions	Increases		Reductions	Increases	
Closing the Gap Initiatives (December 2008)	32	7.1	0	1,400,000 ongoing	-	-	
WWLHIN-Phase 1 HIP Initiatives (July & August 2009)	35	8.7		1,400,000	17.3		2,100,000

Grouping of Initiatives	# of Initiatives	2009/10			2010/11		
		# of FTEs Impacted		Financial Impact	# of FTEs Impacted		Financial Impact
		Reductions	Increases		Reductions	Increases	
Newly-identified HIP Initiatives (November 2009)	30	0	0	450,000	15.3	0	1,450,000
Revised and Resubmitted HIP Initiatives (November 2009)	13				60.6	22.2	4,600,000
TOTAL	110	15.8	0.0	3,250,000	93.2	22.2	8,150,000

Summary of Financial Position

Figure 7 provides a summary of the financial recovery that will put CMH in a balanced position by March 31, 2011.

Figure 7: Summary of Financial Recovery

	2009/10	2010/11	Dollar Impact By Mar 2011
Opening deficit	\$(5,700,000)	\$(2,800,000)	
New expense	\$ (450,000)	\$(5,100,000)	
Growth (Sept. 2009)	\$ 99,000		
Closing the Gap (April 2009)	\$ 1,400,000		\$1,400,000
Phase 1 HIP (Aug. 2009)	\$ 1,400,000	\$ 2,100,000	\$3,500,000
Phase 2 HIP (Nov. 2009)	\$ 450,000	\$ 1,450,000	\$1,900,000
Phase 3 HIP (May 2010)		\$ 4,600,000	\$4,600,000
Surplus/(deficit)	\$(2,800,000)	\$ 250,000	\$11,400,000
Urgent capital need	\$250,000	\$ 1,000,000	
Balance		\$ (750,000)	

Financial Impact and Recovery Plan

Figure 8 presents the multi-year trend in revenue and expense actual and plan. The multi-year recovery plan is constructed in two phases:

- Balanced budget by 2010/11.
- Eliminate line of credit within 7 years

Restructuring costs will be in the \$3M range. Moreover, CMH must also find capital dollars for urgent equipment replacement and building repairs annually, which has been estimated at \$1M per year.

Figure 8 Multi-year recovery plan revenue and expense with restructuring (2009/10 to 2016/17)

7 Year Projected Operating Statement ProForma: 2009/10 to 2016/17

	FY0910	FY1011	fy 2011/12	fy 2012/13	fy 2013/14	fy 2014/15	fy 2015/16	fy 2016/17	2010-2017 7 yr
	FY0910	fy 2010/11	fy 2011/12	fy 2012/13	fy 2013/14	fy 2014/15	fy 2015/16	fy 2016/17	
Operating Income	84,759,005	84,658,005	84,658,005	86,351,165	88,078,188	89,839,752	91,636,547	93,469,278	
	200,000	-	-	-	-	-	-	-	
Billable Patient Services	13,057,854	13,424,429	13,827,162	14,241,977	14,526,816	14,817,353	15,113,700	15,415,974	
Recoveries and Other Revenue	6,203,878	6,334,878	6,334,878	6,334,878	6,334,878	6,334,878	6,334,878	6,334,878	
Amort'n of Deferred Equip Capital C	1,309,214	1,309,214	1,309,214	1,309,214	1,309,214	1,309,214	1,309,214	1,309,214	
MoH Special Votes Revenue	3,054,560	3,054,560	3,054,560	3,054,560	3,054,560	3,054,560	3,054,560	3,054,560	
Total	108,584,511	108,781,086	109,183,819	111,291,794	113,303,657	115,355,757	117,448,899	119,583,904	
Salaries & Wages	53,096,123	49,397,555	50,358,946	51,366,125	52,393,447	53,441,316	54,510,142	55,600,345	
Employee Benefits	14,474,771	13,162,780	13,461,135	13,730,357	14,004,964	14,285,064	14,570,765	14,862,180	
Medical Remuneration	13,589,833	13,655,872	13,792,430	13,930,355	14,069,658	14,210,355	14,352,458	14,495,983	
Medical & Surgical Supplies	6,780,962	6,204,386	6,289,762	6,415,558	6,543,869	6,674,746	6,808,241	6,944,406	
Drug Expense	4,088,948	4,170,727	4,295,849	4,381,766	4,469,401	4,558,789	4,649,965	4,742,964	
Other Supplies & Expenses	12,556,792	12,843,930	13,100,809	13,362,825	13,630,082	13,902,683	14,180,737	14,464,352	
Equipment Depreciation	3,547,131	3,697,131	3,697,131	3,697,131	3,697,131	3,697,131	3,697,131	3,697,131	
MoH Special Votes Expense	3,068,195	3,068,195	3,129,559	3,192,150	3,255,993	3,321,113	3,387,535	3,455,286	
Contingency, restructuring	200,000	2,330,000	-	-	-	-	-	-	
Total	111,402,755	108,530,576	108,125,621	110,076,266	112,064,545	114,091,197	116,156,975	118,262,647	
Surplus(Deficit)	(2,818,244)	250,511	1,058,198	1,215,528	1,239,111	1,264,560	1,291,924	1,321,257	4,822,844

Next Steps

The R-HIP has been built with strong input and leadership from staff, medical staff and administrative leaders throughout the organization. For the implementation, CMH will continue to live by the principles of strong staff engagement, effective communication with our staff and community and to proceed in a timely manner.

Our implementation will be guided by the Senior Management Committee, which will serve as the Implementation Steering Committee, providing overall direction, monitoring, coordination and evaluation of the changes.

Backing up our Steering Committee and task groups will be two support groups – our communications group and a change management-transition group. The communications group will be responsible for ensuring good internal and external communication is undertaken. The change management-transition group will support the leaders and staff during the change process by providing education and development opportunities to help all staff through the human side of change. Change, even when it is seen positively, can be difficult for staff. Understanding and supporting our staff in this transition is important and has been recognized as a key implementation need.