Niagara Health System

Together in Excellence—Leaders in Healthcare

November 18, 2008

Addendum to the Niagara Health System Hospital Improvement Plan November 2008

Contents

Summary

Together in Excellence, Leaders in Healthcare.

HNHB LHIN Request for Submission of NHS Hospital Improvement Plan

On May 30, 2008, pursuant to Section 9 of the 2007/08 Hospital Accountability Agreement, the Niagara Health System (NHS) was requested by the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) to develop and submit a Hospital Improvement Plan [HIP] by July 15, 2008. In developing the HIP, the NHS was asked to provide a clinical services plan that:

- Ensures the necessary expertise and resources are available to provide accessible, quality healthcare for the citizens of Niagara;
- Identifies current and future hospital based services by site;
- Establishes timeframes and specific targets for each year of the HIP;
- Links the proposed strategies of the HIP and the public interest; and
- Achieves a balanced operating budget by 2011/12.

NHS HIP Submission

On July 15, 2008, the NHS Board of Trustees directed NHS Senior Management to submit the HIP to the HNHB LHIN. Prior to finalizing the HIP for approval and implementation, the NHS committed to undertake a process to consult its various stakeholders.

NHS HIP Consultation Summary Report

Subsequent to a community engagement process that was shared between the NHS and the HNHB LHIN, on October 21, 2008, the NHS Board of Trustees reviewed and approved the *Hospital Improvement Plan Consultation Summary Report*. The Consultation Summary Report was forwarded to the HNHB LHIN and its External Advisor and was made available to the public through the NHS website. The Consultation Summary Report reflected the views of internal and external stakeholders as well as the broader community and identified supportive as well as unsupportive perspectives.

Recommendations of the External Advisor

On October 28, 2008, the HNHB LHIN's External Advisor presented 35 recommendations in response to the NHS' HIP submission (Kitts Report). The NHS' response to each of the recommendations is outlined in Appendix 1. The NHS would like to publicly acknowledge the work of Dr. Kitts and his review team in undertaking a comprehensive review process.

Clarification Letters

In formulating the response to the Kitts Report, NHS Senior Management sought clarification on a number of aspects of the Kitts Report. These letters of clarification are included in Appendix 4.

Addendum to the HIP: Vision for the Clinical Programs at Each Site

Further to the Consultation Summary Report and the Kitts Report, this document represents an *Addendum* to the original HIP submission and reflects the *modifications* made to the vision for clinical program service delivery in Niagara. The modifications are outlined below:

Modifications to the HIP Vision for Clinical Service Delivery

- Establishment of **24 hour a day, 7 day a week Urgent Care Centres at the Fort Erie and Port Colborne sites,** with a commitment to monitor and evaluate the quality and cost-effectiveness associated with the Urgent Care Centres. There will be 3-6 beds with the capacity to monitor patients available to the Urgent Care Physician to utilize for up to 48 hours, until a determination is made on the final patient disposition. Admission to these beds will be restricted to the Urgent Care Physicians on duty.

- Establishment of the **Diabetes Centre hub at the Welland** site. This is in keeping with the Kitts Report, page 19 where the review team indicated "does not believe Port Colborne is the optimal site for the Diabetes hub due to critical mass of patients and geography." The siting of the Diabetes hub at the Welland site will also support an important clinical adjacency with the Ophthalmology Centre of Excellence as well as the dialysis satellite.

- Introduction of **slow paced *reactivation* Complex Continuing Care beds** at the Fort Erie and Port Colborne sites**.**

- The NHS will comply with the recommendation to **divest cancer-related thoracic surgery**. The NHS Physician Leadership has voiced concerns regarding timely access to both cancer and non-cancer thoracic surgery and related assessment and diagnostic services for the patients of Niagara. The NHS will continue to dialogue with St. Joseph's Healthcare Hamilton on opportunities to collaborate and develop a Thoracic Program linked with St. Joseph's to serve Niagara patients as close to home as possible.

Current State versus Future State

A comparison of the services delivered in the current state versus those that will be delivered in the future state at each of the sites is outlined in Appendix 2.

Board of Trustees Approved Hospital Improvement Plan

At its meeting of November 18, 2008, the NHS Board of Trustees received, discussed and approved the revised vision for clinical program service delivery as described within this HIP Addendum.

Vision

Every NHS Site Will Contribute to Healthcare of Niagara

The NHS maintains its key commitment that every site of the NHS will have a role that contributes to the overall healthcare of Niagara (see Appendix 2) and at the same time recognizes the healthcare needs of the local community's population that is in keeping with delivering high quality and safe patient care.

Quality as the Fundamental Driver

First and foremost, *quality* will continue to drive the delivery of patient care in Niagara – both how it is delivered and where it is delivered. The clinical service delivery vision is based on delivering the right care at the right time in the right place and having the best possible outcome.

Creating Centres of Excellence

In keeping with the commitment to quality, the NHS will move forward with the establishment of *Centres of Excellence*. This is supported by the Kitts Report as well as the Ontario Hospital Association ("…Evidence from other consolidations demonstrates that when centres of excellence are created, with larger volumes, quality gets better…This should not be seen as a threat to smaller or medium-sized hospitals. All hospitals have an important role to play. That's why the OHA is working on proposals to government to help define the appropriate roles of small hospitals, medium sized hospitals and of larger ones..." Closson, November 2008).

- ✓ **Creating Centres of Excellence** to improve care, be more efficient, and to help Niagara attract needed healthcare professionals:
  - ***Walker Family Cancer Centre*** - providing systemic/chemotherapy and radiotherapy to residents of Niagara, sited at the new healthcare complex.
  - ***Cardiac Catheterization Centre*** – working collaboratively with Hamilton Health Sciences, provide enhanced diagnostic and new treatment capabilities including a new cardiac catheterization unit that will significantly reduce the need for Niagara residents to travel to Hamilton for this service.
  - ***Stroke Centre*** – enhancing the continuum of stroke services currently offered by introducing a new, 10-bed dedicated, acute stroke rehabilitation unit, sited at the Greater Niagara General.
  - ***Centre of Excellence for Women's and Children's Health*** – a dedicated centre focusing on the health care needs of women, offering obstetrical and gynecological services; dedicated operating rooms; comprehensive specialty care for children from newborn to age 18 requiring both medical and surgical care, sited at the new healthcare complex.

- ***Centres for Continuing Complex Care with slow paced reactivation*** – for people with complex medical needs, supporting people to transition home with support or to an alternate, more appropriate care environment. These will be sited at the Port Colborne and the Douglas Memorial sites.
- ***Centre of Excellence for Mental Health Centre*** – combining long-term (tertiary) and short-term (acute) services including four pediatric beds, sited at the new healthcare complex; an Emergency Psychiatric Team and dedicated out-patient satellite programs at the Greater Niagara, Welland, Port Colborne, and Fort Erie sites.
- ***Addictions Centre*** – an integrated in-patient/residential and out-patient addictions services in a new, special purpose built location in the community of St. Catharines, with satellite programs at the Greater Niagara, Welland, Port Colborne, and Fort Erie sites.
- ***Diabetes Centre*** – a coordinated hub for care planning and patient education, located at the Welland Hospital site, with satellites at the Fort Erie, Port Colborne, Greater Niagara and St. Catharines General sites.
- ***Nephrology Centre*** – a coordinated hub of nephrology services at the St. Catharines site, with satellite services at the Welland, Greater Niagara and Fort Erie sites.

✓ ***Specialized Centres for Surgical Care*** – Exciting new technologies and techniques bring the promise of advanced care for patients requiring surgery in Niagara, and new levels of excellence at the following specialized sites, with appropriate consultation coverage plans:

- **Dental Surgery** – Greater Niagara site.
- **General Surgery and Endoscopy** – Welland, Greater Niagara and St. Catharines sites.
- **Gynaecological Surgery** – St. Catharines site
- **Orthopaedic Surgery** – two specialized centres for orthopaedic surgery at the Greater Niagara and St. Catharines sites.
- **Otolaryngological Surgery [Ear, Nose, Throat]** – delivery of ENT surgery for adults at the Greater Niagara site and for children at the St. Catharines site.
- **Ophthalmological Surgery** – Welland site.
- **Plastic Surgery** – Greater Niagara and St. Catharines sites.
- **Urological Surgery** – Welland site.
- **Vascular Surgery** - St. Catharines site

✓ **Emergency Services** –

- Emergency Departments in Welland, Niagara Falls and St. Catharines will continue to provide 24 hour, 7 day a week access to services for the acutely ill, including Clinical Decision Units for children.
- Establishment of **24 hour a day, 7 day a week Urgent Care Centres at the Fort Erie and Port Colborne sites,** with a commitment to continue to monitor and evaluate the quality and cost-effectiveness associated with the Urgent Care Centres. There will be 3-6 beds with the capacity to monitor patients available to the Urgent Care Physician to utilize for up to 48 hours, a until determination is made on the final patient disposition. Admission to these beds will be restricted to the Urgent Care Physicians on duty.

Financial Implications

Revised Financial Position at 2012/13 would be a Deficit of $3.5 million if no Additional Base Funding

The financial outlook to 2012-2013 has been revised to reflect revisions made in this Addendum to the NHS HIP originally submitted on July 15, 2008 to the HNHB LHIN, based on the feedback received through Community consultation, as summarized in the Consultation Summary Report submitted to the HNHB LHIN on October 21, 2008 and the Report of Dr. Kitts submitted to the HNHB LHIN on October 28, 2008. The projected impact on the NHS deficit from the changes proposed in this Addendum is $4.9 million. The NHS will no longer be in a balanced budget position by the end of fiscal 2012-13. The revised financial position at March 31, 2013 is a deficit of $3.5 million without any additional base funding from the HNHB LHIN.

$23 Million in HIP Savings Reliant on Investment in Primary Care, Community Resources, Alternate Placement for Patients and/or Base Funding Adjustment

The NHS HIP continues to advocate for community enablers, particularly related to reducing the number of ALC patients.

- $23 million in HIP savings are reliant either on an investment in primary care, community resources, alternate placement for patients and/or base funding adjustment.
- $12.6 million of savings identified through the HCM initiative are within NHS control.
- Dr. Kitts report confirms that:
  - *"While there are areas for improvement, the NHS will not be able to count on substantial efficiency and productivity gains to contribute materially to its financial challenges."*
  - *"The NHS will require a substantial and permanent additional cash infusion to manage its financial situation and successfully implement the Hospital Improvement Plan"*

Determine Operating and Capital Financial Support Requirements

Upon approval of the HIP and this Addendum, the NHS will work with the HNHB LHIN and MoHLTC to determine the financial support, both operating and capital, required to successfully implement and sustain the vision described herein. The NHS remains committed to achieving a balanced budget position and to continuing to support the need for significant community enablers.

`	2007/2008 Actual	2008/2009 Forecast	2009/2010 Plan	2010/2011 Plan	2011/2012 Plan	2012/2013 Plan
REVENUE						
MOHLTC Base Allocation	$ 284,039,781	$ 291,634,700	$ 298,211,700	$ 307,158,100	$ 316,372,800	$ 325,864,000
MOHLTC Allocation - Interest Carrying Costs			2,570,000	3,055,000	3,085,000	2,985,000
MOHLTC Allocation - Other Funding Required						4,900,000
PCOP-New Hospital and Rehab				2,600,000	2,600,000	65,482,500
One-time payments	15,256,845	8,275,150	8,275,150	9,275,150	10,275,150	11,275,150
Paymaster	8,837,100	9,448,250	9,903,950	10,382,450	10,884,850	11,381,850
Other Revenue from MOHLTC	6,779,284	7,269,850	7,269,850	7,269,850	7,269,850	7,269,850
Sub total MOHLTC	314,913,010	316,627,950	326,230,650	339,740,550	350,487,650	429,158,350
Other Revenue-Patient/Differential/Recoveries/Amortization	56,580,502	54,646,850	54,924,350	55,401,850	55,879,350	56,356,850
TOTAL REVENUE	371,493,512	371,274,800	381,155,000	395,142,400	406,367,000	485,515,200
EXPENSE						
Compensation and Benefits	244,168,679	244,281,700	245,890,200	253,355,000	257,505,600	308,780,800
Medical Staff Remuneration	35,173,312	33,817,600	33,367,600	33,367,600	33,367,600	33,367,600
Supplies and Other Expenses incl med/surg/drugs/amortization	108,330,340	109,104,700	111,115,500	114,427,000	117,772,800	138,986,300
Interest - short term	1,676,789	1,900,800	2,570,000	3,055,000	3,085,000	2,985,000
TOTAL EXPENSE	389,349,120	389,104,800	392,943,300	404,204,600	411,731,000	484,119,700
SURPLUS/(DEFICIT) FROM HOSPITAL OPERATIONS	**$ (17,855,608)**	**$ (17,830,000)**	**$ (11,788,300)**	**$ (9,062,200)**	**$ (5,364,000)**	**$ 1,395,500**
Change in Financial Position		25,608	6,041,700	2,726,100	3,698,200	6,759,500
Ratio: Total Margin as % of Revenue	**-4.8%**	**-4.8%**	**-3.1%**	**-2.3%**	**-1.3%**	**0.3%**
Working Capital Deficit	**$ (116,800,000)**	**$ (134,630,000)**	**$ (146,418,300)**	**$ (155,480,500)**	**$ (160,844,500)**	**$ (159,449,000)**

NHS Confirmed to be an Efficient Organization

The NHS has been heavily criticized recently for its financial performance. However, various benchmarking reports and a recent independent third party review shows that the NHS is performing better than most of its peer hospitals (refer to appendix 3 for a more detailed financial review). The Kitts Report further confirms that *"The NHS scores well on measures of operational efficiency compared to peer hospitals. Preliminary review of MoHLTC funding suggests that the NHS may receive less funding than peer hospitals for their level of patient activity."*

Next Steps

Passion of Niagara Residents about Hospitals and Healthcare

The residents of Niagara continue to be passionate about their local sites and their healthcare delivery. As part of the HIP development, we had an opportunity to hear from our communities. And we have heard that we need to do a better job in involving and in communicating with our internal and external stakeholders.

Strong Collaborative Working Relationships

The success of the HIP implementation will be contingent on strong collaborative working relationships between all stakeholders, including the HNHB LHIN, the Ministry of Health and Long-Term Care, Elected Officials, Physicians, staff, and community partners. The NHS Leadership – Board, Senior Management and Physician Leaders – are fully committed to renew and rebuild trust and relationships across all communities in Niagara. Transparency, inclusiveness and understanding have been adopted as the core principles that will underpin all actions, initiatives and communication undertaken by NHS to facilitate and support effective relationship building.

Advisor

In addition, the NHS will work collaboratively with the HNHB LHIN to engage an Advisor with jointly established Terms of Reference to work through the difficult issues facing the NHS.

Change Management, Monitoring and Evaluation

In moving forward, the NHS will adopt best practices in change management and will develop a comprehensive implementation plan and process to ensure that our stakeholders are fully aware of our next steps. We are poised to implement the HIP vision, along side key stakeholders, to ensure that high quality and appropriate hospital-based programs are available to Niagara residents, now and in the future. The NHS will develop a monitoring and evaluation framework that will include quality metrics to facilitate public transparency and monitoring of the HIP implementation process and outcomes.

Key relationship building and communications strategies will include:

Engagement of a Facilitator

- The engagement of a ***Facilitator*** to work with the medical staff to explore, define and address physician issues. Terms of Reference for the Facilitator will be developed jointly by the Leadership of the Board, Senior Management, Medical Advisory Committee and Medical Staff Association (MSA). The Board of Trustees of the NHS is committed to renew relations with our Medical Staff as a result of the vote of non-confidence at the MSA meeting of October 27th. On October 31st, the Board, including the President of the Medical Staff Association began discussion on how to move forward. On November 12th, the NHS Board of Trustees announced the appointment of Dr. Chris Carruthers (a member of the Kitts Review Team) as Facilitator.

HIP Implementation Stakeholder Council

- The creation of ***HIP Implementation Stakeholder Council*** to ensure dialogue with stakeholders, provide feedback and guidance to the implementation teams and act as a voice for external stakeholders. Membership would be broad-based and would include representatives from the partner health care agencies such as the HNHB LHIN, Niagara Emergency Medical Services, as well as elected members from Regional Council as well as each Municipality. NHS clinical leaders would also be members. Council's mandate would include establishing quality metrics to facilitate public monitoring and evaluation of the HIP implementation process and outcomes. Council meetings would be open to the public and media to attend as observers.

HIP Implementation Communications Plan

- The development of a comprehensive ***HIP Implementation Communications Plan*** to ensure broad based, ongoing, effective and timely communication of the changes to patient care services through the HIP implementation. Examples of communications tactics to be outlined in the communications plan include: dedicated monthly newsletter; dedicated HIP implementation web-site/microsite; patient/public education programs to support health service delivery changes as per the HIP (could include radio advertising programs; information flyers; posters; advertising; media relations etc). Metrics and tracking would be created and shared publicly as part of the communications plan.

HIP Implementation Stakeholder Relations Plan

- The development of a comprehensive ***HIP Implementation Stakeholder Relations Plan.*** To ensure inclusiveness and that needs of key stakeholder groups are addressed, the plan will be informed through focus group feedback. The plan will outline specific initiatives and tactics to improve stakeholder relations and will include monitoring and effectiveness tracking that will be shared in the public domain. Examples of initiatives and tactics incorporated into the stakeholder relations plan are: creation of a Speakers Bureau to provide face to face speaking and meeting opportunities for NHS clinical and administrative leaders in local communities; Site Open Houses to invite members of the public into NHS sites to meet local and system leaders and tour site facilities; Community Health Information Forums on key health matters for example chronic disease and women's health matters.

Communications and Relationship Committee

- Creation of a ***Communications and Relationship Committee*** of the Board to provide oversight and guidance.

Common Goal of Better Health and Better Healthcare for the People of Niagara

Our common goal is better health and better healthcare for the people of Niagara, now and in the future. We look forward to working with our stakeholders to achieve this vision.

Together in Excellence, Leaders in Healthcare.

Appendix 1: NHS Response to the Recommendations made by Dr. Jack Kitts on the Hospital Improvement Plan

	Recommendation	NHS Response
Support the Vision	1. The NHS, the municipalities and the citizens of Niagara should support the vision for quality hospital care outlined in the HIP and this report and begin immediate work towards this goal.	▪ The NHS Leadership will work with its internal and external stakeholders to realize the vision for quality hospital care in Niagara. The NHS will develop implementation and communications strategies that are guided by the following principles to ensure quality patient care and to rebuild trust across all stakeholder groups: o Commitment to quality care, o Commitment to patient safety, o Transparency, o Inclusiveness, and o Understanding. ▪ The NHS will establish a HIP Implementation Stakeholder Council which will include broad representation from our stakeholders.
Engage an Advisor	2. The NHS leadership should engage an advisor to help the Board and senior management navigate the difficult issues facing the NHS.	▪ The NHS will work collaboratively with the HNHB LHIN to engage an Advisor with jointly established Terms of Reference to work through the difficult issues facing the NHS. As per the clarification received from the Kitts review team (Appendix 4), the Advisor is not a supervisor, will have no authority over the corporation or it's leaders, will be independent and terms of reference will include rebuilding relationships.
Robust Quality Measurement and Improvement Framework	3. NHS leadership must establish a robust quality measurement and improvement framework. This framework should be at the program level, be multidisciplinary, and be monitored by the Board of Governors.	▪ In 2006, the NHS Board of Trustees endorsed a comprehensive Corporate Quality Framework. The framework is based on best practice standards and is in keeping with Accreditation Canada's quality model. ▪ A standard quality reporting template has been developed for all clinical programs. Quality metrics are

	Recommendation	NHS Response
		monitored at the Board level through the Board Quality Committee and at the Senior Management level through the Quality Council. ▪ The NHS Clinical Programs report annually to both the Quality Committee and Quality Council on corporate as well as program-specific quality metrics. ▪ The NHS is committed to ensure all members of the clinical program teams are aware of the Quality Framework and the associated monitoring, including annual and long term performance targets (see clarification letter Appendix 4). ▪ As articulated in the Hospital Improvement Plan Consultation Summary Report (October 2008), the NHS is committed to identifying quality metrics to facilitate public monitoring and evaluation of the HIP implementation process and outcomes, in keeping with its Corporate Quality Framework.
Opportunities to Overcome Challenges with New Site	4. The NHS, municipalities and citizens of Niagara identify challenges with the site of the new healthcare complex in St. Catharines and look for opportunities to overcome them.	▪ The NHS will continue to explore the introduction of a NHS operated shuttle service. The NHS will continue to encourage the development of a regional transportation strategy.
Consistent Approach to Clinical Services Planning within the LHIN	5. The HNHB LHIN adopts a consistent approach to clinical services planning across its geography.	▪ The NHS looks forward to participating in the HNHB LHIN's clinical services planning process and the opportunity to share relevant lessons learned from the HIP development and consultation process.
Proceed with the Concept of "Centres of Excellence"	6. The NHS proceed with the concept of "Centres of Excellence" and consolidate key clinical services.	▪ The NHS will proceed with the "Centres of Excellence" as identified in the HIP submission to improve care, be more efficient and help Niagara attract needed healthcare professionals.
Operate Specialty Programs as Satellites on NHS Property	7. The Hamilton academic hospitals operate specialty programs as	▪ The NHS will continue to work with its hospital partners to develop

	Recommendation	NHS Response
	satellites on NHS property to support human resources and quality.	innovative models of working collaboratively. This will be in keeping with the model for cancer care that was formalized in January 2008 through a signed Memorandum of Understanding between Cancer Care Ontario, Juravinski Cancer Centre/Hamilton Health Sciences and the Niagara Health System with a vision to support "a coordinated cancer program that is delivered on two sites."
HIP Evaluation Framework	8. The NHS leadership must develop a HIP evaluation framework to measure the impact on quality, specifically: access, efficiency, effectiveness, safety and patient and staff satisfaction.	▪ As identified in number 3 above, the NHS will establish quality metrics to facilitate public monitoring and evaluation of the HIP implementation process and outcomes.
24/7 Urgent Care Centres	9. The Douglas Memorial site and the Port Colborne General site operate 24/7 Urgent Care Centres. The Urgent Care Centres will care for CTAS level 3-5 patients and will no longer receive ambulances.	▪ The NHS accepts the recommendation to operate 24 hour a day, 7 day a week Urgent Care Centres at the Fort Erie and Port Colborne sites and will continue to monitor and evaluate the quality and cost-effectiveness associated with the Urgent Care Centres. [see Appendix 5 for description of Urgent Care Centres]
Ambulatory Minor Procedure Units	10. The Douglas Memorial site and the Port Colborne General site perioperative services should be converted to ambulatory minor procedure units. The scope and volume of services will be determined in the broader surgical services plan of the NHS.	▪ The NHS supports the conversion of the DMH and PCG site perioperative services to ambulatory minor procedure units, in keeping with the vision articulated in the HIP submission, to be further defined through program planning, considering key aspects of critical mass and quality.
Conversion of In-Patient Beds to CCC beds at DMH and PCG	11. The Douglas Memorial site and the Port Colborne General site should no longer operate acute care inpatient beds. The NHS may operate complex continuing care beds at these sites, but should not proceed with the planned slow paced rehabilitation beds. Each site	▪ The NHS supports the recommendation that no acute inpatient beds be operated at the Fort Erie and Port Colborne sites. ▪ The NHS supports Hotel Dieu Shaver Health and Rehabilitation Centre's (HDSHRC) primary role in the provision of rehabilitation services.

	Recommendation	NHS Response
Observation Beds *Direct Admission to an Inpatient Bed*	should operate a 3-6 bed monitored holding unit adjacent to the Urgent Care Centre. The unit would be designed for patients requiring a 24-48 hr observational length of stay. If patients require admission beyond this point they would be transferred to one of the 3 larger NHS sites, with direct admission to an inpatient bed.	The NHS will explore its vision for complex continuing care and slow stream *reactivation* services with HDSHRC, in keeping with the HNHB LHIN ALC Steering Committee Right Level of Care Report (July 2008). ▪ As per the clarification letter in Appendix 4, there will be 3-6 beds with the capacity to monitor patients available to the Urgent Care Physician to utilize for up to 48 hours, until a determination is made on the final patient disposition. Admission to these beds will be restricted to the Urgent Care Physicians on duty. ▪ The NHS will establish appropriate direct admission/transfer protocols from the small sites to one of the three larger NHS sites for patients requiring admission to an acute in-patient bed.
Chronic Disease Prevention and Management Strategy	12. The NHS should work with community organizations and other health care providers to develop a chronic disease prevention and management strategy, particularly in Fort Erie and Port Colborne. Fort Erie and Port Colborne should serve as valuable spokes in a hub and spoke model.	▪ The NHS recognizes the critical role that community providers play in chronic disease and prevention and management (CDPM). The NHS will work with those community leaders to support CDPM initiatives as a key enabler to achieving the HIP vision.
Detailed Implementation Plan	13. The NHS must develop a detailed implementation plan for the HIP that is timely, includes the appropriate stakeholders and identifies the projected impact on service delivery, human resources, operating and capital costs. Elements of the HIP should be implemented immediately. The entire plan need not wait for construction of the new healthcare complex.	▪ The NHS will develop a comprehensive implementation plan to support the transition over a five year period. This will include the identification of a formal structure to oversee the HIP implementation as well as dedicated implementation resources to support the complex change and transition processes required to realize the HIP vision. ▪ To effectively implement the clinical changes that result from the HIP, the NHS will develop a clear, transparent and inclusive process driven by the clinical programs which will include: o Providing strong and visible leadership across all levels of the

	Recommendation	NHS Response
		organization; ○ Ensuring participation of a broad cross section of internal and external stakeholders in the overall implementation; ○ Building from the best practices in change management; ○ Embracing transparency in the overall implementation; and ○ Encouraging and facilitating community dialogues through a variety of ongoing communication tactics and mechanisms. ▪ The NHS will establish a HIP Implementation Stakeholder Council which will include broad representation from our stakeholders.
Consolidation of the Maternal Child Program	14. The maternal child program should be consolidated to the new St. Catharines healthcare complex. The NHS should adopt a formal planning structure that ensures all members of the care team are involved in planning and developing the consolidated maternal child program. The NHS should ensure that all professionals work towards their full scope of practice.	▪ The NHS is committed to the vision for a consolidated maternal child program at the new healthcare complex. ▪ The NHS will continue with its program planning structure where all members of the care team are involved in planning for and developing the consolidated program model. ▪ The NHS supports all healthcare professionals working towards their full scope of practice.
Strong Relationship with the Academic Hospital Paediatric Program	15. The NHS should develop a strong relationship with the academic hospital to support its paediatric program.	▪ The NHS will continue to further its relationship with Hamilton Health Sciences in the delivery of a continuum of pediatric services for the children of Niagara.
Expedite Re-development of the Operating Rooms at the Greater Niagara General Site	16. The NHS and the MoHLTC should work together to expedite re-development of the operating rooms at the Greater Niagara General site.	▪ The NHS will engage a consultant to develop a Master Plan for the Greater Niagara General site, which will include opportunities to redevelop the Operative Suites and supportive services as well as introduce new

	Recommendation	NHS Response
		programs as outlined in the HIP (e.g, dialysis satellite).
Planned Consolidation of Perioperative Services	17. The NHS should proceed with the planned consolidation of perioperative services as outlined in the HIP with the exceptions described in recommendations 18, 19, 20, and 21.	▪ The NHS will proceed with the planned consolidation of perioperative services as outlined in this recommendation.
Feasible Coverage Plans	18. Consolidated NHS surgical specialties must develop feasible coverage plans with a response time of 24 hours or less for alternate sites in the event an off-site inpatient requires consultation.	▪ The Operative/Perioperative Program leadership will ensure that there are feasible coverage and response time plans for off-site inpatient consultations, in keeping with current regional on-call arrangements.
Urology Coverage Plan	19. Urology should be consolidated to the Welland site, but must develop a coverage plan that addresses clinical dependencies with Gynaecology, to be located at the new St. Catharines healthcare complex and those services at the Greater Niagara General site.	▪ As above, the Operative/Perioperative Program leadership will ensure that there are feasible coverage and response time plans for urology consultations related to the Women's Health Program.
Vascular Surgery Program	20. Hamilton Health Sciences Centre should operate the Vascular Surgery program as a satellite on the NHS St. Catharines site, both to facilitate human resource challenges and to ensure quality of care.	▪ The NHS will continue to work within the LHIN 3 and 4 Vascular Working Group's endorsed model (hub and spoke) of one vascular program delivered on two sites (Hamilton and St. Catharines).
No Thoracic Surgery	21. The NHS should not operate a Thoracic Surgery program as it does not meet the provincial standards for Thoracic surgery.	▪ As per the clarification letter in Appendix 4, the NHS will comply with the recommendation to divest cancer-related thoracic surgery. The NHS Physician Leadership has voiced concerns regarding timely access to both cancer and non-cancer thoracic surgery and related assessment and diagnostic services for the patients of Niagara. The NHS will continue to dialogue with St. Joseph's Healthcare Hamilton on opportunities to collaborate and

	Recommendation	NHS Response
		develop a Thoracic Program linked with St. Joseph's to serve Niagara patients as close to home as possible.
Interventional Cardiology Program as a Satellite	22. Hamilton Health Sciences Centre should operate the interventional cardiology program as a satellite on the NHS St. Catharines site, both to facilitate human resource challenges and to ensure quality of care.	▪ The NHS and Hamilton Health Sciences are currently partnering in the planning for the introduction of cardiac catheterization in Niagara (see clarification letter Appendix 4).
Mental Health and Addictions Outpatient Satellites	23. The NHS should include mental health and addictions outpatient satellites as part of its ambulatory care programs in Niagara Falls, Welland, Port Colborne and Fort Erie.	▪ The NHS will deliver of out-patient mental health and addiction satellite services in Niagara Falls, Welland, Port Colborne, and Fort Erie.
Proceed with Remaining Service Delivery Improvements	24. The NHS should proceed with the remaining service delivery improvements outlined in the Hospital Improvement Plan.	▪ The NHS will proceed with the remaining service delivery improvements as outlined in the HIP submission through a transparent, collaborative, and inclusive process driven by the clinical programs
Rebuild Trust	25. NHS leadership must work to rebuild the trust relationship with its health professionals, beginning with effective communication and collaborative planning processes.	▪ The NHS Leadership is committed to rebuilding trust and relationships with its health professionals as well as external stakeholders. The NHS will develop clear and transparent communication strategies for all stakeholders as well as: o Provide strong and visible leadership across all levels of the organization; o Ensure participation of a broad cross section of internal and external stakeholders in the overall implementation; o Build from the best practices in change management; o Embrace transparency in the overall implementation; and o Encourage and facilitate community dialogues through

	Recommendation	NHS Response
		a variety of ongoing communication tactics and mechanisms.
Transparent and Effective Management of Physician Issues	26. The NHS must address issues in its medical structure and medical operations to ensure equitable, transparent and effective management of physician issues.	▪ The NHS has engaged a ***Facilitator*** to work with the medical staff to explore, define and address physician issues. Terms of Reference for the Facilitator will be developed jointly by the Leadership of the Board, Senior Management, Medical Advisory Committee and Medical Staff Association (MSA). The Board of Trustees of the NHS is committed to renew relations with our Medical Staff as a result of the vote of non-confidence at the MSA meeting of October 27th. On October 31st, the Board, including the President of the Medical Staff Association began discussion on how to move forward. On November 12th, the NHS Board of Trustees announced the appointment of Dr. Chris Carruthers (a member of the Kitts Review Team) as Facilitator.
Substantial and Permanent Cash Infusion	27. The MoHLTC will likely need to provide the NHS with a substantial and permanent cash infusion for the NHS to manage its financial situation and successfully implement the Hospital Improvement Plan.	▪ The NHS will work with the HNHB LHIN and MoHLTC to determine the financial support, both operating and capital, required to successfully implement and sustain the Hospital Improvement Plan.
Advanced Care Paramedics	28. Niagara EMS providers should ensure that advanced care paramedics are available in communities located greater distances from an Emergency Department.	▪ The NHS will continue to work with its partner Niagara EMS related to the availability of advanced care paramedics, particularly in the communities of South Niagara.
Improve Ambulance Off-Load Delays	29. The NHS should continue working with EMS providers and the provincial government to improve ambulance off-load times. Niagara EMS and the NHS should consider innovative solutions to this	▪ The NHS will continue to work with its partners Niagara EMS and the HNHB LHIN Emergency Services Steering Committee to identify strategies and opportunities to improve ambulance off-load delays.

	Recommendation	NHS Response
	problem, including paramedics assuming responsibility for more than one patient if multiple ambulances are in off-load delay.	
Reduce Current Volumes of Accompanied Transports	30. Niagara EMS providers and Fire Departments should review the current policy and practice of accompanied transport, with a goal to reduce the current volume of accompanied transports**.**	▪ The NHS will work with its partner Niagara EMS and Fire Departments related to the recommendation to reduce the volume of accompanied transports.
Regional Transportation Strategy	31. Niagara transportation stakeholders, including funders, should begin working together to address medical transportation needs as part of the greater regional transportation strategy. Hospital service redesign should happen in parallel with transportation improvements rather than subsequently.	▪ The NHS will continue to encourage the development of a regional transportation strategy.
Inter-Site Transportation Shuttle	32. The NHS should establish an inter-site transportation shuttle for staff, physicians, students and volunteers.	▪ The NHS recognizes that transportation is one of the most critical enablers to support the HIP vision. The NHS will continue to explore the introduction of a NHS operated Shuttle Service to facilitate transport of staff, physicians, students and volunteers from NHS site to NHS site.
Reduce the Number of Beds Occupied by ALC Patients	33. The MoHLTC and the HNHB LHIN must work with the NHS to drastically reduce the number of hospital beds occupied by alternative level of care patients (ALC).	▪ The NHS will to continue to collaborate with the HNHB LHIN and MOHLTC regarding opportunities to reduce the number of ALC patients.
Leverage Distance Technologies	34. The NHS should leverage distance technologies such as the Ontario Telemedicine Network and video conferencing to enable satellite clinics, remote consultation and multi-site meetings such as continuing medical education or program planning.	▪ The NHS will continue to leverage its existing distance technology infrastructure to support satellite clinics. Currently, all NHS sites have videoconference capability to facilitate remote consultation, multi-site meetings as well as continuing education.

Collaborative Working Relationship

Recommendation	NHS Response
35. The NHS leadership must build a collaborative working relationship with the communities of Niagara.	▪ The NHS Leadership – Board, Senior Management and Physician Leaders – are fully committed to renew and rebuild relationships across all communities in Niagara. Transparency, inclusiveness and understanding are recognized as the core principles that will underpin all actions, initiatives and communication to support relationship building.

Appendix 2: Current versus Future State of the Niagara Health System Sites (Reflecting the NHS Consultation Summary Report and the Recommendations from the Kitts Report)

1.1 Douglas Memorial Site

❋ Denotes NEW service

Douglas Memorial Site Services		Current State	Future State
Emergency	Emergency Department	✓ (19,339 visits)	
	24/7 Urgent Care		✓ (18,908 visits)
	Monitored/Observation Beds		✓ (3-6 beds, see page 3)
Medicine	Inpatient Medicine Beds	✓ (32 beds)	
	Complex Continuing Care Beds	✓ (24 beds)	✓ (40 beds)
	Cardiac Monitored Beds	✓	
	Electrocardiogram	✓	✓
Operative/ Peri-Operative	General Surgery (e.g. scopes)	✓	
	Ophthalmology	✓	
Mental Health	Outpatient Mental Health	✓	✓ Enhanced
Addictions	Outpatient Addictions		❋ (Satellite)

Douglas Memorial Site Services		Current State	Future State
Pharm-Acy	Pharmacy	✓	✓
Laboratory Medicine	Core Lab	✓	
	Point of Care Testing		✓
	Specimen Collecting	✓	✓
Diagnostic Imaging	Ultrasound	✓	✓
	Mammography	✓	✓
	Breast Screening (OBSP)	✓	✓
	General Radiology	✓	✓
	Fluoroscopy	✓	
Amb	Ambulatory Clinics	✓	✓
Chronic Disease Prevention & Management	CDPM Clinics (e.g. COPD, Heart Function, Asthma)		✱
	Home Hemo-Dialysis	✓	✓
	Diabetes spoke		✱

1.2 Port Colborne General Site

❋ Denotes NEW service

Port Colborne General Site Services		Current State	Future State
Emergency	Emergency Department	✓ (25,516 visits)	
	24/7 Urgent Care		✓ (24,560 visits)
	Monitored/Observation Beds		✓ (3-6 beds, see page 3)
Medicine	Inpatient Medicine Beds	✓ (32 beds)	
	Complex Continuing Care Beds	✓ (24 beds)	✓ (46 beds)
	Cardiac Monitored Beds	✓	
	Electrocardiogram	✓	✓
Operative/ Perl-Operative	General Surgery (e.g. scopes)	✓	
	Ophthalmology	✓	
Mental Health	Outpatient Mental Health	✓	✓ Enhanced
Addicti-ons	Residential Addictions	✓	
	Outpatient Addictions	✓	✓ (Satellite)
Phar-macy	Pharmacy	✓	✓
orat ory Me dici	Core Lab	✓	

Port Colborne General Site Services		Current State	Future State
	Point of Care Testing		✓
	Specimen Collecting	✓	✓
Diagnostic Imaging	Ultrasound	✓	✓
	Mammography	✓	✓
	Breast Screening (OBSP)	✓	✓
	General Radiology	✓	✓
	Fluoroscopy	✓	
Amb	Ambulatory Clinics	✓	✓
Chronic Disease Prevention & Management	CDPM Clinics (e.g. COPD, Heart Function, Asthma)		✱
	Diabetes Spoke		✱

1.3 Niagara-on-the-Lake Site

Niagara-on-the-Lake Site Services		Current State	Future State
Emergency	Walk-in Clinic	✓	✓
Medicine	Inpatient Medicine Beds	✓ (9 beds)	
	Complex Continuing Care Beds	✓ (13 beds)	✓ (22 beds)
	Observation Beds	✓ (2 beds)	
Laboratory	Private Lab Outpatient Services	✓	✓
Diagnostic Imaging	Ultrasound	✓	✓
	Breast Screening	✓	✓
	General Radiology	✓	✓
FHT	Family Health Team	✓	✓

1.4 Greater Niagara General Site

❋ Denotes NEW service

Greater Niagara General Site Services		Current State	Future State
Emergency	Emergency Department	✓	✓
	Adult Clinical Decision Unit		❋
	Pediatric Clinical Decision Unit		❋
Mat Child	Maternal / Women's Health	✓	
	Pediatrics	✓	
	Level 2 Nursery	✓	
Medicine	Inpatient Medical Beds	✓	✓
	Level 2 Intensive Care Beds	✓	✓
	Complex Continuing Care Beds	✓	✓
	Hospitalist	✓	✓
	Regional Geriatric Assessment	✓	✓
Oncology	Oncology Clinic	✓	✓
Cardiology	District Stroke Centre	✓	✓
	Stroke Rehabilitation Beds		❋
	Cardio Diagnostics	✓	✓
	Pacemaker	✓	✓

Greater Niagara General Site Services		Current State	Future State
Operative/Peri-Operative	Inpatient Surgical Beds	✓	✓
	General Surgery – Inpatient and Ambulatory	✓	✓
	Total Joint Replacement Centre	✓	✓
	Orthopedics - Inpatient	✓	✓
	Orthopedics –Ambulatory	✓	✓
	Ear, Nose and Throat – Inpatient and Ambulatory	✓	✓
	Plastics – Adult Inpatient and Ambulatory	✓	✓
	Ophthalmology	✓	
	Urology	✓	
	Oral and Dental – Inpatient and Ambulatory	✓	✓
	Endoscopies	✓	✓
	Urology Clinics	✓	✓
	Surgical Ambulatory Clinics	✓	✓
Mental Health	Inpatient Mental Health Beds	✓	
	Outpatient Mental Health Clinics	✓	✓ Enhanced
Addicti-ons	Outpatient Addictions		✱ (Satellite)
Pharmacy	Daily Onsite and After Hours Pharmacy Coverage	✓	✓
Laboratory Medicine	Frozen Sections, Surgical Pathology & Cytology	✓	✓

Greater Niagara General Site Services		Current State	Future State
	Chemistry	✓	✓
	Transfusion Medicine	✓	✓
	Hematology	✓	✓
Diagnostic Imaging	MRI	✓	✓
	CT	✓	✓
	Ultrasound	✓	✓
	Bone Densitometry	✓	✓
Diagnostic Imaging	Mammography	✓	✓
	Breast Screening	✓	✓
	Nuclear Medicine	✓	✓
	Interventional Radiology	✓	✓
	C-Arm (Mobile Fluoroscopy)	✓	✓
	Fluoroscopy	✓	✓
	General Radiology	✓	✓
Ambulatory	Ambulatory Clinics (TBD)	✓	✓
Chronic Disease Prevention & Management	CDPM Clinics (e.g. COPD, Heart Function, Asthma)		✱
	Dialysis (Satellite)		✱
	Diabetes Spoke		✱

1.5 St. Catharines General Site

❋ Denotes NEW service

St. Catharines General Site Services		Current State	Future State
Emerg-Ency	Emergency Department	✓	✓
	Adult Clinical Decision Unit	✓	✓
	Pediatric Clinical Decision Unit		❋
Mat Child	Maternal / Women's Health	✓	✓
	Pediatrics	✓	✓
	Level 2 Nursery	✓	✓
	Pediatric Mental Health Inpatient Beds (4)		❋
Medicine	Inpatient Medicine Beds	✓	✓
	Level 3 Intensive Care	✓	✓
	Inpatient Nephrology Beds		✓
	Hospitalist	✓	✓
Oncology	Inpatient Oncology	✓	✓
	Oncology Clinic	✓	✓
	Systemic Therapy (Chemotherapy)	✓	✓

St. Catharines General Site Services		Current State	Future State
	Radiation Therapy		❋
Cardiology	Cardio Diagnostics	✓	✓
	Pacemaker	✓	✓
	Interventional Cardiology		❋
Operative/Peri-Operative	Inpatient Surgical Beds	✓	✓
	General Surgery – Inpatient and Ambulatory	✓	✓
	Total Joint Replacement Center	✓	✓
	Orthopedics – Inpatient	✓	✓
	Orthopedics - Ambulatory	✓	✓
	Ear, Nose and Throat – Adult and Pediatric Inpatient and Ambulatory	✓	✓
	Plastics – Pediatric Inpatient and Ambulatory	✓	✓
	Thoracic	✓	
	Vascular	✓	✓
	Gynecology – Inpatient and Ambulatory	✓	✓
	Ophthalmology	✓	
	Urology	✓	
	Oral and Dental	✓	
	Endoscopies	✓	✓
	Urology Clinics	✓	✓
	Surgical Ambulatory Clinics	✓	✓

St. Catharines General Site Services		Current State	Future State
Mental Health	Tertiary and Acute Mental Health	✓	✓
	Outpatient Mental Health Clinics	✓	✓
Addictions	Residential and Outpatient Addictions – NOT Located at the New Healthcare Complex but in the City of St. Catharines	✓	✓
Pharmacy	Daily Onsite and After Hours Pharmacy Coverage	✓	✓
Laboratory Medicine	Frozen Sections, Surgical Pathology & Cytology, Autopsies	✓	✓
	Chemistry	✓	✓
	Histology Processing, Cytology Screening, Immuno-histochemistry	✓	✓
	Transfusion Medicine	✓	✓
	Hematology	✓	✓
Diagnostic Imaging	MRI	✓	✓
	CT	✓	✓
	Ultrasound	✓	✓
	Bone Densitometry	✓	✓
	Mammography	✓	✓
	Breast Screening	✓	✓
	Nuclear Medicine	✓	✓
	Interventional Radiology, Angiography	✓	✓
	C-Arm (mobile Fluoroscopy)	✓	✓
	Fluoroscopy	✓	✓

St. Catharines General Site Services		Current State	Future State
	General Radiology	✓	✓
Ambulatory	Ambulatory Clinics (TBD)	✓	✓
Chronic Disease Prevention & Management	CDPM Clinics (e.g. COPD, Heart Function, Asthma)	✓	✓
	Dialysis – Hub	✓	✓
	Dialysis – Community Satellite		✱
	Diabetes Spoke		✓

1.6 Welland Site

❋ Denotes NEW service

Welland Site Services		Current State	Future State
Emer-gency	Emergency Department	✓	✓
	Adult Clinical Decision Unit		❋
	Pediatric Clinical Decision Unit		❋
Mat Child	Maternal / Women's Health	✓	
	Pediatrics	✓	
	Level 2 Nursery	✓	
Medicine	Inpatient Medicine Beds	✓	✓
	Inpatient Nephrology Beds	✓	
	Level 2 Intensive Care	✓	✓
	Complex Continuing Care	✓	✓
	Hospitalist	✓	✓
Oncol-ogy	Oncology Clinics	✓	✓
Cardio-logy	Cardio Diagnostics	✓	✓
	Pacemaker	✓	✓
	Inpatient Surgical Beds	✓	✓
Operative/ Peri-Operative	General Surgery – Inpatient and Ambulatory	✓	✓
	Total Joint Replacement	✓	

Welland Site Services		Current State	Future State
	Orthopedics - Inpatient	✓	
	Orthopedics – Ambulatory	✓	✓
	Ear, Nose and Throat	✓	
	Plastics	✓	
	Ophthalmology	✓	✓
	Urology – Inpatient and Ambulatory	✓	✓
	Oral and Dental	✓	
	Endoscopies	✓	✓
	Urology Clinic	✓	✓
	Surgical Ambulatory Clinics	✓	✓
Mental Health	Inpatient Mental Health Beds	✓	
	Outpatient Mental Health Clinics	✓	✓ Enhanced
Addicti-ons	Outpatient Addictions		✱ (Satellite)
Pharmacy	Daily Onsite and After Hours Pharmacy Coverage	✓	✓
Laboratory Medicine	Frozen Sections, Surgical Pathology & Cytology	✓	✓
	Chemistry	✓	✓
	Transfusion Medicine	✓	✓
	Hematology	✓	✓
gno stic Ima gin	CT	✓	✓

Welland Site Services		Current State	Future State
	Ultrasound	✓	✓
	Bone Densitometry	✓	✓
	Mammography	✓	✓
	Breast Screening	✓	✓
	Nuclear Medicine	✓	✓
	Interventional Radiology	✓	✓
	C-Arm (mobile Fluoroscopy)	✓	✓
	Fluoroscopy	✓	✓
	General Radiology	✓	✓
Ambulatory	Ambulatory Clinics (TBD)	✓	✓
Chronic Disease Prevention & Management	CDPM Clinics (e.g. COPD, Heart Function, Asthma)		✱
	Dialysis (satellite)	✓	✓
	Diabetes Hub		✱

Appendix 3: Financial Background

Upon amalgamation in March 2000, the Niagara Health System (NHS) inherited significant operating as well as short- and long-term debts from its predecessor organizations (these were largely related to lack of sound financial practices and budget control mechanism). Since that time, the NHS has developed several recovery plan strategies that have resulted in reduced costs, reduction in some long and short-term debt as well as budget control improvements. However, significant cost pressures continue to impact on the organizations ability to achieve sound financial health.

1.6.1.1 Summary of Financial Pressures:

The Niagara Health System financial pressures stem from a number of issues:

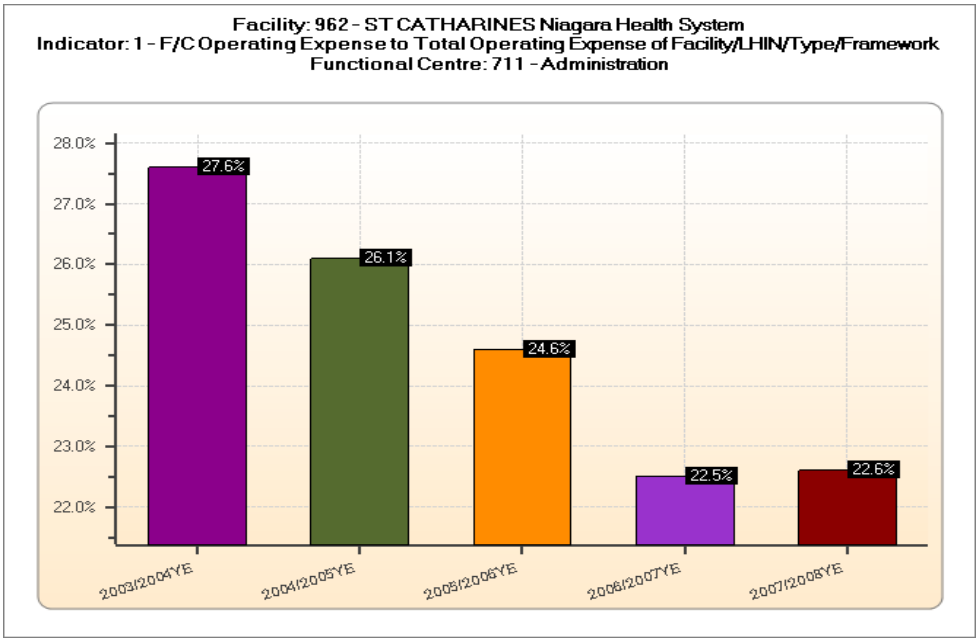
- **Amalgamation Issues:**
  - Discontinuance of restructuring reimbursement (85%) by the provincial government resulting in increased operating and working capital deficits for NHS
  - Approximately $7.5 million of annual salary and benefit costs for pay equity/wage harmonization is incurred for consolidation of all bargaining unions as a result of amalgamation and not funded until three years later
  - Inherited long term debt of $23.6 million upon amalgamation
  - Inherited short term debt of $5.3 million upon amalgamation
  - Inherited working capital deficit of $12.4 million upon amalgamation
  - Capital investment required in plant, equipment and information systems
- **Niagara Issues:**
  - Challenges with physician recruitment, due to corresponding shortages especially evident in Niagara.
  - Shortage in physician specialists in key areas such as psychiatry, anaesthesia, paediatrics and Emergency medicine.
  - Niagara's shortage of family physicians and therefore lack of primary care is evident in the higher use of our emergency departments.
  - Large numbers of Alternate Level of Care (ALC) patient days, due to lack of appropriate community settings i.e. long term care, rehabilitation and supportive housing
  - Inability to make changes in the health system delivery due to public expectations to maintain status quo
- **General Hospital Issues:**
  - Growing debt and interest costs. The NHS inherited a negative working capital deficit of $30M as a result of the transfer with Hotel Dieu Hospital (HDH), for a total 07/08 working capital deficit of $116M. At the time of the program transfer there was an understanding that the provincial budget would address hospitals' working capital deficits however this did not occur. The negative working capital has increased the NHS operating deficit by $1.6 million due to an increase in interest expense.

- Recruitment and retention of professional staff is a constant concern especially in the nursing areas. Vacancy rates experienced are generally above the provincial average. Human Resources are developing strategies to help address the recruitment issues (e.g. Recruitment fairs, web site, critical internship programs, retention initiatives, employer branding, etc.).

Efficiency

Benchmarking – Administrative and Support

The NHS has concentrated efforts to reduce expenses in administrative and support areas by benchmarking to PEER hospitals and targeting performance below the 50th percentile. Based on the Ministry of Health and Long Term Care (MOHLTC) Health Indicator Tool (HIT), the NHS has made significant improvements in benchmarking of Administrative and Support Services. The HIT measurement is based on the percentage of expense in a particular department to the total hospital expenditure. As illustrated in the graph below, administrative and support service expenditures have decreased by 5.0% since 2003-2004 year end. At 22.6%, the NHS is well below the 50th percentile.



Cost per Equivalent Weighted Case Trends

- The NHS has traditionally been under or very close to its expected cost per equivalent weighted case, as illustrated in the table below:

Fiscal Year	ACPWC	ECPWC	Variance Over/(Under)	Variance %
2006-07	4,441	4,422	19	0.43%
2005-06	4,339	4,250	89	2.09%
2004-05	3,929	4,040	(111)	-2.75%
2003-04	3,904	3,973	(68)	-1.72%
2002-03	3,315	3,262	52	1.61%
2001-02	2,938	2,930	8	0.28%
2000-01	2,504	2,636	(132)	-5.01%

- The NHS has performed well in the rate formula even though the calculation still does not recognize an adjustment for multi-sites. Over the last two year the volume formula has identified the NHS as over servicing, affecting its performance against the expected cost per equivalent weighted case. Although the volume formula takes into consideration some of the pressures facing Niagara in its aging population and lower social-economic factors, it does not consider other pressures that are increasing the utilization of hospital services such as under servicing of community at home support services, long term care beds and shortage of family physicians.

Accomplishments:

The NHS has achieved some significant accomplishments as outlined below:

- Successful completion of August 8, 2005 governance and management transfer between NHS and HDH
- Successful completion of clinical program transfers from August to October 2005:
  - Medical, surgical, intensive care beds to St. Catharines General (SCG)
  - Outpatient Oncology clinic to SCG
  - Dialysis inpatient and hemo dialysis stations to Welland
  - Medical Daycare to St. Catharines General
  - Prompt Care conversion at Ontario Street Site (OSS)
- Wait list initiatives
  - Achievement of additional volumes – cataracts, hips/knees, MRI, CT, cancer surgery & chemo visits

  - Reduction of wait times in Niagara
  - Implementation of a second MRI at Greater Niagara General (GNG) site
- Reduction in the average length of stay in clinical utilization below the 50th percentile benchmark
- Reduction in Administrative & Support overhead costs by more than 5%
- Implementation of Human Resources strategy to avoid lay-offs, in keeping with our core values of Compassion, Professionalism and Respect (153 full time equivalent budget reduction with no layoffs)
- Opening of 40 Interim Long Term Care beds at the Welland Hospital site (WHS)
- Introduction of a Hospitalist program at the 3 large sites.
- Expanding capacity in dialysis Niagara and bringing care closer to home through Satellite Dialysis at the Welland Site and plans for Niagara Falls site.
- Extension of Ontario Breast Screening Clinics to the Port Colborne and Fort Erie Sites making it available at 5 of our sites.
- Addition of 40 new interim long term care beds at the Welland site.
- Implementation of a Regional Stroke Centre at GNG.
- Addition of a new ED/Ambulatory Care Centre at GNG.
- Development of a common ICT platform with major emphasis on clinical information systems implementation to enable access to timely and accurate patient information across the sites and with key community partners (CCAC and Hotel Dieu).
- Development of a partnership with McMaster University to teach and train doctors locally at all sites.
- Creation of a well established relationship with the Clinical Education Campus with McMaster.

Recovery Plan Initiatives:

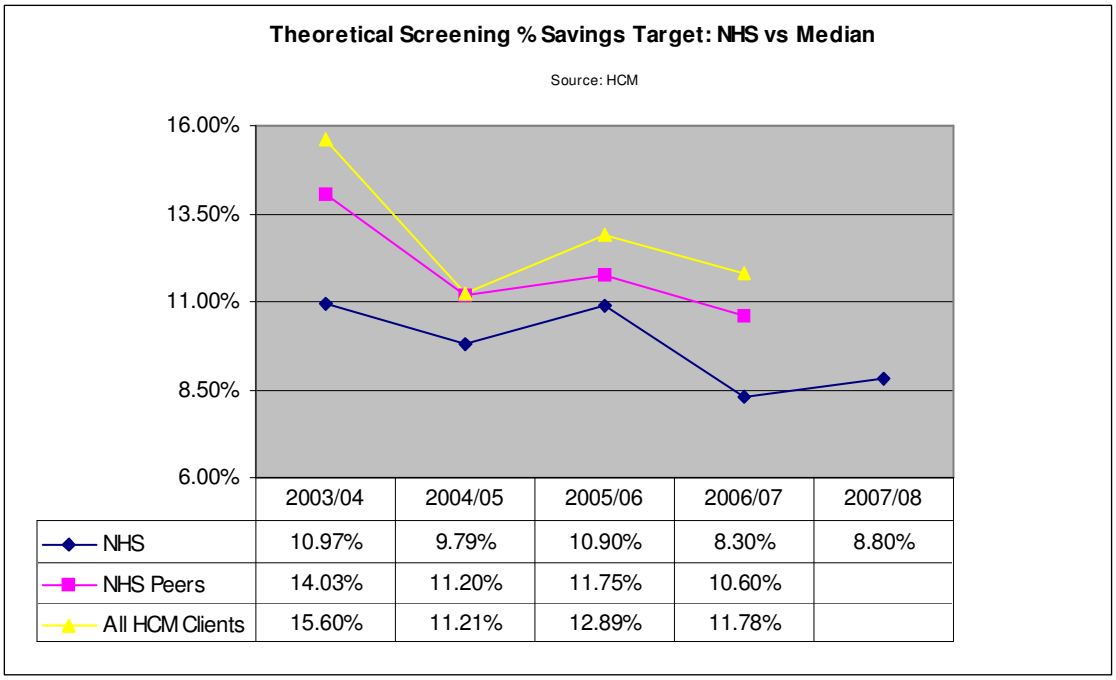
- In 2000, the NHS developed a three-year recovery plan to address inherit deficits and inefficiencies. The recovery plan targeted savings in administration and non-patient related areas as well as clinical efficiencies. Savings of over $11 million were realized by 2003/04.
- An additional $19 million of savings was identified as part of the Hospital Accountability Plan Submission (HAPS) process in 2005-06. Summary of savings below:

NHS Savings Summary	HAPS 2005/06 & 2006/07	HAPS 2007-08	Total Savings
Revenue Generation	658,900	144,000	802,900
Efficiencies in Administrative and Support	4,535,680	294,300	4,829,980
Efficiencies in DI, Pharmacy, Lab and Ancillary	1,844,250	188,500	2,032,750
Clinical Services/Program Efficiencies	1,512,500	2,161,500	3,674,000
Bed Utilization Improvement	4,590,000	114,000	4,704,000
Program Consoliation-Transfer between HDH and NHS	3,127,000	-	3,127,000
Grand Total	**$ 16,268,330**	**$ 2,902,300**	**$ 19,170,630**

Major Savings/Opportunities for 2008-10 HAPS

The NHS engaged Health Care Management (HCM) Consulting, a leading Canadian specialist in hospital performance benchmarking and advisor to the Ministry of Health and Long-Term Care and the Local Health Integration Network (LHIN), in an operational improvement process:

- The comprehensive research and analysis completed by the HCM demonstrates that solely implementing operational efficiencies will not reverse the NHS' deficit position. The review demonstrates that the NHS is performing better than 85% its peer hospitals and that year over year since amalgamation, the organization has shown consistent improvement in the use of financial resources.
- Through the HCM Operational Improvement Process and other savings initiatives, the NHS identified **savings of $12.3 million for 2008-10.** The savings identified exceed the maximum percentage achieved by other hospitals that have completed similar reviews over the past four years.
  - ✓ $6.3 million in operational efficiencies
  - ✓ $3.0 million in product standardization and regional supply chain integration
  - ✓ $2.4 million through various other initiatives including revenue generation.



	2003/04	2004/05	2005/06	2006/07	2007/08
NHS	10.97%	9.79%	10.90%	8.30%	8.80%
NHS Peers	14.03%	11.20%	11.75%	10.60%	
All HCM Clients	15.60%	11.21%	12.89%	11.78%	

At, 8.3% and 8.8%, the NHS is better than the median/mean in 2006/07 and 2007/08 budget respectively. The potential for savings for the NHS are less than the majority of peer hospitals and HCM clients.

Summary of HCM Initiatives

NHS-Summary of HCM Savings Initiatives Identified		Timing 2008-09	2009-10	Total
Finance-Materials Management/Accounts Payable	Regional Supply Chain Integration Initiative - Focus on Hospital Supply Chain Initiative (FOHSCI)		(1,836,938)	(1,836,938)
Finance-Materials Management	Product Standardization/Regional Contract Initiatives	(575,000)		(575,000)
Surgical OR	Staffing operating rooms to comply with provincial benchmark of 2.5 staff per room. Currently at 3 staff per room. Includes related savings in day surgery, CSR and ambulatory care clinics.	(288,111)	(137,573)	(425,684)
	Operating Room Supply Chain Initiative-Supported by Ontario Buys Funding	(400,000)	(400,000)	(800,000)
Surgical-Combined OR/PARR	Consolidate surgical block times at Fort Erie and Port Colborne sites to 2 full days a week rather than 5 days per week.	(31,046)	(93,138)	(124,184)
Surgical-Inpatient	Staffing to comply with provincial benchmarks	(92,250)	(30,750)	(123,000)
Endoscopy	Consolidate Ontario Street and Queenston Street Endoscopy to Queenston Site	(29,815)	(89,445)	(119,260)
Pre-Admit Clinic	Consolidate Ontario Street and Queenston Street Pre-Admission Clinic to Queenston Street Site	(70,697)	(70,697)	(141,394)
	Efficiencies at Greater Niagara General and Welland Hospital Sites Pre-Admission Clinics	(25,797)	(25,797)	(51,594)
Diagnostic Cardio and Respiratory Therapy	Change in staffing patterns	(70,686)	(127,253)	(197,939)
	Expand Sleep Lab services from 4 nights to 7 nights/week	(89,485)		(89,485)
Information Technology	Reduce dependency on consultants by training in-house staff; reduce number of printers and replace with multi-functional units; consolidate communications vendors	(202,500)	(88,200)	(290,700)
Housekeeping	Change in staffing pattern to benchmark; standardize office cleaning	(210,790)		(210,790)
Plant Operations	Change in staffing pattern to benchmark	(192,800)		(192,800)
Utilities	Energy Audit RFP-reduce energy consumption and utility expense (net of consulting fees)		(200,000)	(200,000)
Patient Food Services	Change food model at Port Colborne and Fort Erie from bulk retherm to "restaurant menu" similar to NOTL-improves patient satisfaction and	(180,650)	(60,200)	(240,850)

NHS-Summary of HCM Savings Initiatives Identified		Timing 2008-09	2009-10	Total
	reduces costs			
	Eliminate disposable dishware	(105,000)		(105,000)
	New model for food delivery on evenings and weekends	(33,500)	(75,000)	(108,500)
Administration-Medical Staff	Reduce locums for anesthesia, pediatrics, radiology	(257,550)		(257,550)
Laboratory	Reduce lab call back hours at Port Colborne and Fort Erie Sites using taxi method-specimens would be sent to Greater Niagara or Welland by taxi. Results would be available on-line.		(97,770)	(97,770)
	Close the Ontario Street Site Lab. Taxi method would be used. Specimens would be sent to Queenston Street Site for testing and resulting. Results are available on-line.		(304,100)	(304,100)
	Other laboratory efficiencies		(400,000)	(400,000)
Diagnostic Imaging	Change staffing pattern to benchmark	(108,845)	(149,000)	(257,845)
Pharmacy	Pharmacy Unit Dose Implementation	(214,000)		(214,000)
Other Initiatives	Various initiatives identified across remaining areas/programs	(1,089,394)	(646,019)	(1,735,413)
Total HCM Initiatives for 2008-10		**(4,267,916)**	**(4,831,880)**	**(9,099,796)**

OTHER HAPS INITIATIVES				
Admin/Support	Implement Alternate Funding Arrangements in Emergency Depts.	(1,400,000)	(500,000)	(1,900,000)
Diagnostic Imaging	Picture Archiving and Communication System (PACS) Savings	(272,370)	-	(272,370)
Pharmacy	Pharmacy Unit Dose	(126,000)	(32,100)	(158,100)
Revenue	Parking Rates Increased	(479,012)	(169,439)	(648,451)
Revenue	Increase Retail Revenue		(300,000)	(300,000)
Materials Management	Supply Chain/Regional Contracts	(150,000)	(50,000)	(200,000)
Grand Total Savings Initiatives		**(6,695,298)**	**(5,883,419)**	**(12,578,717)**

Appendix 4: Clarification Letter Regarding the Kitts Report

Mr. Gino Picciano
Senior VP and COO
Ottawa Hospital
1053 Carling Avenue
Ottawa, Ontario K1Y 4E9

November 6th, 2008

Dear Gino,

At the outset, I would like to thank you and the Review Team for taking the time to review our Hospital Improvement Plan (HIP) submission and conduct the extensive stakeholder engagement and to work with our leadership team to clearly understand the rationale for our recommendations. Performing such a demanding task while managing a very large and complex tertiary teaching hospital is very commendable and we appreciate and acknowledge the effort and commitment of the entire team.

Having had the opportunity to review your recommendations to the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) Board on our HIP, I am seeking clarification on the following points to better understand the recommendations as we work to amend our HIP submission with a view to obtaining Board approval in the near future.

Recommendation Reference	Clarification Sought
2. The NHS leadership should engage an advisor to help the Board and senior management navigate the difficult issues facing the NHS.	This recommendation is being perceived by some stakeholders in the community to be the same as the appointment of a Supervisor under the Public Hospitals Act. Could you please provide some clarity around the role of the Advisor and any further thoughts you may have with respect to the process for appointing such an advisor.

Recommendation Reference	Clarification Sought
3. NHS leadership must establish a robust quality measurement and improvement framework. This framework should be at the program level, be multidisciplinary, and be monitored by the Board of Governors.	During the consultation process additional information was sought and provided to the review team on our quality framework including a sampling of the type of reports each program or service area produce, the reporting schedule of each program as well as the overall quality framework. We have enclosed the quality framework and the reporting cycle and would like to draw your attention to the role of our Quality Committee of the Board of Trustees and their focus on quality. Is your recommendation intended to highlight a specific aspect of our quality framework which merits/warrants our focused attention? If so, please clarify.
11. The Douglas Memorial site and the Port Colborne General site should no longer operate acute care inpatient beds. The NHS may operate complex continuing care beds at these sites, but should not proceed with the planned slow paced rehabilitation beds. Each site should operate a 3-6 bed monitored holding unit adjacent to the Urgent Care Centre. The unit would be designed for patients requiring a 24-48 hr observational length of stay. If patients require admission beyond this point they would be transferred to one of the 3 larger NHS sites, with direct admission to an inpatient bed.	We would like to clearly understand the function of the proposed 3-6 monitored holding/observation unit adjacent to the Urgent Care Centre. The major function of these recommended beds might be interpreted as transition beds. Could you please confirm the function as well as share with us the staffing ratio you envision.
22. Hamilton Health Sciences Centre should operate the interventional cardiology program as a satellite on the NHS St. Catharines site, both to facilitate human resource challenges and to ensure quality of care.	Currently, we work collaboratively with other hospital corporations in HNHB LHIN to deliver services for the residents of Niagara. One such example is our Memorandum of Understanding with CCO and HHS related to the Cancer Program. The model we have establish is one of single program delivered on two sites with common clinical standards and protocol, etc. Can you clarify if this recommendation is supportive of the approach of a single program delivered on two sites
21. The NHS should not operate a Thoracic Surgery program as it does not meet the provincial standards for Thoracic surgery.	Similar to the approach described above, would your recommendation support the concept of a single thoracic program delivered on two sites

Recommendation Reference	Clarification Sought
	There is inconsistency between the Power Point presentation Dr. Kitts's made to the HNHB LHIN Board and the Recommendations Report with respect to the Surgical Program Future state in the Douglas Memorial Site. In slide #12 under the bullet point "Surgery Program", Scoping Procedures in minor procedure units has been identified signalling the delivery of scoping procedures in the Douglas Memorial Site. However the report does not make reference to this procedure. Can you please clarify if the Review Team is recommending maintaining scoping procedure at the Douglas Memorial Site.

In closing, I would personally like to thank you again and welcome your comments on the above as we set out to prepare our implementation plan, working collaboratively with the HNHB LHIN and our stakeholders to achieve improved health care for the residents of Niagara.

Sincerely,

Bala Kathiresan
Chief Operating Officer

cc: Betty Lou Souter, Board Chair, NHS
Juanita Gledhill, Board Chair, HNHB LHIN
Debbie Sevenpifer, CEO NHS
NHS Senior Executive Team

The Ottawa Hospital | L'Hôpital d'Ottawa

Niagara Health System
155 Ontario St.
St. Catharines, ON L2R 5K3

November 7th, 2008

Dear Bala,

The review team received your request to clarify several of our recommendations. Below is our response to your enquiry.

Clarification of NHS HIP Review Team Recommendations

Recommendation Reference	Clarification
2. The NHS leadership should engage an advisor to help the Board and senior management navigate the difficult issues facing the NHS.	This recommendation is not equivalent to recommending a Supervisor under the Public Hospitals Act. • This individual would work in collaboration with the NHS Board of Governors, Senior Management Team, Medical Leadership and Medical staff; • The Advisor would not have authority over the corporation or its leaders; • Our preliminary thoughts are that the Advisor would be jointly engaged by the

Recommendation Reference	Clarification
	NHS and the HNHB LHIN and report to both the NHS and HNHB LHIN. This will be confirmed later this week; • The Advisor would be independent; • Key roles include: listening to the needs of various stakeholder groups; facilitating effective dialogue between the NHS and the community; assisting the NHS in developing a plan to rebuild relationships with the medical community and citizens of Niagara; assisting the NHS in establishing an effective process for community and physician engagement; assisting the Board in reviewing its governance practices and recommending appropriate changes. • Terms of reference would be developed by the HNHB LHIN with the Advisor and in collaboration with NHS.
3. NHS leadership must establish a robust quality measurement and improvement framework. This framework should be at the program level, be multidisciplinary, and be monitored by the Board of Governors.	The review team recognizes that the NHS has developed a quality improvement framework and that the Board of Governors Quality Committee is active in this area. The review team received the terms of reference for the Quality Committee; the Board Quality Committee Workplan; the NHS Quality Framework Overview; and an example of reporting on HSMR. Despite the current activities and work completed to date, the review team did not see evidence of a robust, bottom up quality monitoring and improvement program. The NHS has a quality monitoring system, but not a quality improvement program. The NHS requires a program with set annual and long-term targets to drive quality improvement in the organization. This

Recommendation Reference	Clarification
	program would also link back to the recommended HIP evaluation framework. Quality improvement targets and metrics would be embedded in evaluation framework and would be transparent and accountable to the citizens of Niagara. In addition, interviews revealed that many programs do not meet regularly (all members, all sites) to review quality data and determine next steps. The review team is concerned that if there is limited discussion at the program level, including medical departments and divisions, the Board cannot be receiving appropriate information.
11. The Douglas Memorial site and the Port Colborne General site should no longer operate acute care inpatient beds. The NHS may operate complex continuing care beds at these sites, but should not proceed with the planned slow paced rehabilitation beds. Each site should operate a 3-6 bed monitored holding unit adjacent to the Urgent Care Centre. The unit would be designed for patients requiring a 24-48 hr observational length of stay. If patients require admission beyond this point they would be transferred to one of the 3 larger NHS sites, with direct admission to an inpatient bed.	The 3-6 bed monitored holding unit is intended for patient observation. Details are as follows: • The unit would be designed for short-term admissions; • The beds would be monitored; • There are two potential patient populations: 1) Patients who are known to require a short, limited duration of acute care; 2) Patients whose length of stay requirements are unclear at the time of admission. These patients may be ready for discharge after 24-48 hours or may require a longer length of stay. The monitored holding unit would allow physicians to make that assessment in the patient's home community. • The 3-6 bed monitored unit would avoid patient transfers to one of the

Recommendation Reference	Clarification
	larger NHS sites for a 1-2 day length of stay. • The unit is not designed for patients who are known to require length of stays beyond 48 hours. Once a patient is determined to require a length of stay beyond 48 hours he or she should be transferred directly to an inpatient bed at the appropriate facility. • We envision a staffing ratio of 1 RN for every 3 beds.
22. Hamilton Health Sciences Centre should operate the interventional cardiology program as a satellite on the NHS St. Catharines site, both to facilitate human resource challenges and to ensure quality of care.	This recommendation supports a single cardiology program operated on two sites (Hamilton Health Sciences Centre and the NHS). The program would be the HHSC program. Clinical standards, protocols, health human resources planning and quality accountability would rest with Hamilton Health Sciences in a collaborative model with the NHS. Physicians would be jointly privileged at HHSC and the NHS. Employees would be employees of the NHS. Assets would belong to the NHS.
21. The NHS should not operate a Thoracic Surgery program as it does not meet the provincial standards for Thoracic surgery.	This recommendation does not support the concept of a single thoracic program delivered on two sites (St. Joseph's Healthcare Hamilton and the NHS). The review team feels that the NHS is not an appropriate site for thoracic surgery as the NHS does not meet the Cancer Care Ontario standards for a thoracic surgery program.
Scoping procedures at the Douglas Memorial site	There should be no surgical suites at either the Douglas Memorial site or the Port Colborne site. However, scoping could be performed in a minor procedure room if patient volumes were appropriate for quality

Recommendation Reference	Clarification
	and efficiency.

Please do not hesitate to contact me should you or the NHS team require further clarification. We wish you well as you work to achieve improved health care for the residents of Niagara.

Thank you,

Gino Picciano
Senior VP and Chief Operating Officer

NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA
TOGETHER IN EXCELLENCE—LEADERS IN HEALTHCARE

Mr. Gino Picciano
Senior VP and COO
Ottawa Hospital
1053 Carling Avenue
Ottawa, Ontario K1Y 4E9

November 12th, 2008

Dear Gino,

I would like to thank you and Mary Boutette for taking the time to have the teleconference with Anne Atkinson and I earlier today. I would like to confirm the following points we discussed during our conference call.

Recommendation Reference	Clarification
7: The Hamilton academic hospitals operate specialty programs as satellites on NHS property to support human resources and quality.	This recommendation is to be interpreted consistent with the clarification we received for recommendation #22 in that the program will be delivered in a collaborative model where the physicians would be jointly privileged at HHSC and the NHS. Employees would be employees of the NHS. Assets would belong to the NHS.
11. The Douglas Memorial site and the Port Colborne General site should no longer operate acute care inpatient beds. The NHS may operate complex continuing care beds at these sites, but should not proceed with the planned slow paced rehabilitation beds. Each site should operate a 3-6 bed monitored holding unit adjacent to the Urgent Care Centre. The unit would be designed for patients requiring a 24-48 hr observational length of stay. If patients require admission beyond this point they would be transferred to one of the 3 larger NHS sites, with direct admission to an inpatient bed.	The 3- 6 beds recommended in the report for the Port Colborne General Site and Douglas Memorial Site Urgent Care Centers to monitor patients is available for those patients who present themselves to the Urgent Care Center. Admission to these beds will be restricted to the Urgent Care Physicians on duty. Patients are to be monitored for up to 48 hours, until a determination is made on the final patient disposition.

Please confirm that I have accurately captured our telephone conversation.

Thank you.

Sincerely,

Bala Kathiresan
Chief Operating Officer

cc: Betty Lou Souter, Board Chair, NHS
Juanita Gledhill, Board Chair, HNHB LHIN
Pat Mandy, CEO HNHB LHIN
Debbie Sevenpifer, CEO NHS

Appendix 5: Urgent vs. Emergent Care

Niagara Health System Info Sheet — Autumn 2008

The difference between...

Emergency Departments and Urgent/Prompt Care Centres

Many of the ongoing discussions about the Niagara Health System's (NHS) Hospital Improvement Plan and the recommendations by expert advisor Dr. Jack Kitts centre around the differences between a full-service Emergency Department and an Urgent or Prompt Care Centre. Please read on for important information and details.

Be Informed

The Niagara Health System was requested to submit a Hospital Improvement Plan to our Local Health Integration Network on July 15, 2008.

The Plan makes a number of recommendations to provide quality and safe health care to Niagarans and make the best use of our resources.

We invite you to learn more about the recommendations in the Hospital Improvement Plan, as well as the review and recommendations by Dr. Jack Kitts at www.niagarahealth.on.ca. Click on the green Hospital Improvement Plan box.

Quick Facts

- From April/07 to March/08 there were 19,450 visits to Douglas Memorial Hospital Site Emergency Department and 22,860 visits to Port Colborne General Site Emergency Department.
- Between 95% and 97% of adults and children will continue to receive treatment in the proposed Urgent/ Prompt Care Centres for Port Colborne and Fort Erie, open seven days per week.

A full-service Emergency Department takes every level of patient, from those suffering a life-threatening heart attack or car accident, to those with a minor ear infection or sprained ankle. Ambulances take patients to Emergency Departments and Emergency physicians admit patients to acute care (medical/surgical) beds or mental health beds.

Urgent or Prompt Care Centres (these terms are interchangeable) are for those patients who have bumps and bruises, mild infections or injuries. Urgent Care Centres do not accept ambulances or critically-ill patients and Urgent Care physicians

do not admit patients to an inpatient unit, although they may keep a patient for several hours for observation. Patients who come to an Urgent Care Centre but require more detailed diagnostic tests or treatment are transferred to a full-service Emergency Department.

"Knowing where to go is very important," explains Pat Morka, NHS Health Program Director of the Emergency Program. "Sometimes patients and their families are unsure about which site or service they should use when they need medical help. The public needs the right information and the right location for their medical treatment, based on what they or their family member are experiencing. We want people to be treated as quickly as possible whether they have non-life threatening concerns or more serious symptoms."

Canadian Triage Acuity Scale (CTAS)

Triage Nurses are usually the first person patients will see in either an Urgent Care Centre or Emergency Department. Triage, or head-to-toe

over ...

Urgent Care Centres Treat ...	Emergency Departments Treat ...
• Broken bones, sprains, sports injuries • Cuts that may need stitches • Minor burns • Minor abdominal pain (nausea, vomiting, flu) • Ear, nose and throat problems • Coughs and colds • Eye problems Urgent Care Centres have access to on-site services such as x-rays, lab tests and pharmacy. Ambulances do not bring patients to Urgent Care Centres. Urgent Care Centres are staffed by Physicians and Nurses.	• Chest pain (especially for those with a history of heart problems) • Shortness of breath • Severe abdominal pain • Dizziness • Stroke symptoms • Numbness in arms or hands • Major injuries • Mental health issues Call 911 with severe chest pain, stroke symptoms or a serious condition which may be worsening. Ambulances bring patients to Emergency Departments. Emergency Departments are staffed by Physicians and Nurses.

The difference between...

Emergency Departments and Urgent Care Centres *cont'd ...*

assessment, is done using the Canadian Triage Acuity Scale (CTAS), to determine who needs to be seen immediately, based on their medical need.

Here are the CTAS levels used:

Level 1 – Resuscitation (Critical), e.g. cardiac arrest, shock, major trauma

Level 2 – Emergent, e.g. asthma, altered mental state

Level 3 – Urgent, e.g. abdominal pain

Level 4 – Less-urgent, eg. vomiting and diarrhea with no dehydration, earache

Level 5 – Non-urgent, eg. vomiting, sore throat

Ambulance Paramedics use the same triage scale when assessing patients.

Level 1 and 2 patients should ALWAYS go to a full-service Emergency Department or call 911. Right now, most patients in Niagara with serious emergencies are seen at Greater Niagara General Site, St. Catharines General Site and Welland Hospital Site.

Level 3, 4 and 5 patients are treated at Urgent/ Prompt Care Centres, as well as Emergency Departments. In fact, the vast majority of patients coming to Emergency Departments are in these categories – not true emergency cases, but adults and children requiring a physician's assessment and diagnosis.

For advice on the right place to receive the care you need, consult your family physician or call Telehealth Ontario at 1-866-797-0000.

Be Prepared for Your Visit

- Bring your up-to-date Ontario Health Card.
- Bring a list of all medications being taken on a regular basis, along with any other important information such as allergies.
- While waiting for treatment, please do not eat or drink without first checking with a nurse.
- If patients decide to leave the hospital before being seen by a doctor, please speak with a nurse.

Be Prepared At Home

- Check medications and medical equipment. Make sure that all family members have enough of their medications, both prescription and non-prescription. Don't forget needles, alcohol swabs, etc. Also check inhalers, respirators, oxygen, and glucose testing machines.
- Have extra batteries on hand for equipment such as electric wheelchairs.
- Update all emergency telephone numbers and post them in a visible place (eg. refrigerator).

Frequently Asked Questions

Q: Why are you recommending Urgent/Prompt Care Centres for Fort Erie and Port Colborne?

A: We want to get patients to the right place for the right care.

The statistics show that over 95% of all the adults and children coming to the Fort Erie and Port Colborne Emergency Departments are CTAS Level 3, 4 and 5. All of these patients would continue to be treated at the proposed Urgent Care Centres in these communities.

Many of the serious patient cases who now arrive at these two smaller Emergency Departments by ambulance are transferred to a larger hospital centre.

Under the proposed model, ambulances would take all emergency cases directly to the larger centres in Niagara and beyond as necessary, saving valuable time.

Q: Will Niagara Falls and Welland Emergency Departments be able to handle the extra patients?

A: Most serious cases are transported to a larger centre now, and both Niagara Falls and Welland would be able to continue managing patient volumes in the future.

Fully 95% to 97% of adults and children in Fort Erie and Port Colborne would continue to receive their treatment in the proposed Urgent Care Centres in these communities.

Q: What happens in a snow storm if the QEW is closed - how will ambulances get to the bigger centres?

A: *(Answer provided by Niagara Emergency Medical Services)* In the rare event that weather or any other incident was to cause the closure of the QEW to the public, ambulances would still be permitted to travel on the highway.

Options to assist with travel to Niagara Falls or Welland may involve taking alternate routes and/or requesting snowplows to help clear the way.

For instance, during the October 2006 snow-storm, ambulances continued to travel, despite the QEW being closed.

Niagara EMS would also immediately add additional resources and commit them to the areas affected by the incident.

Next Steps ... *In the weeks ahead, the NHS Board will review Dr. Kitts' report, along with community consultations, to develop and approve the final Hospital Improvement Plan for submission to our Local Health Integration Network Board. The LHIN Board is expected to make its decision by year-end. The Plan will be implemented over five years, with much dialogue with communities and stakeholders.*

Appendix 6: References

Closson, T. (November 5, 2008). OHA President's Address at OHA HealthAchieve 2008. Metro Toronto Convention Centre, Toronto Canada.

Hamilton Niagara Haldimand Brant Local Health Integration Network (July 2008). ALC Steering Committee, Right Level of Care Report.

Kitts, J. (October 28, 2008). Review of the Niagara Health System Hospital Improvement Plan. Submitted to the Hamilton Niagara Haldimand Brant Local Health Integration Network.

Niagara Health System (October, 2008). Hospital Improvement Plan Consultation Summary Report.

Niagara Health System (July 15, 2008). Hospital Improvement Plan. Submission to the Hamilton Niagara Haldimand Brant Local Health Integration Network.