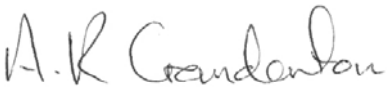
Sault Area Hospitals

Peer Review Report

Final

Respectfully Submitted,



A. Rik Ganderton, President & CEO
Rouge Valley Health System

March 24, 2011

Ruth Hawkins
Acting Assistant Deputy Minister
Ministry of Health and Long-Term Care
and
Louise Paquette
Chief Executive Officer
North East Local Health Integration Network

Executive Summary

The Sault Area Hospital (SAH), with 291 beds, serves a population of approximately 120,000 residents across the Algoma District. Prior to the new hospital being built and opened on March 6, 2011, the SAH was comprised of two very old sites, Plummer and General in Sault Ste. Marie, which are contiguous to each other. There are also two satellite hospital sites: Matthews Memorial, an emergency and outpatient hospital on St. Joseph Island, 64 kilometres southeast of Sault Ste. Marie; and Thessalon Hospital, a four-bed hospital 88 kilometres southeast of Sault Ste. Marie.

In 2002, the Plummer and General Hospitals amalgamated to create the Sault Area Hospital (SAH) although they had been operating as one entity since the mid 90s. In 2007, construction of the new SAH project began on a greenfield site; the new hospital opened on March 6, 2011 with approval to operate the same bed complement.

Peer Review Terms of Reference

On December 8th, 2010, the Ministry of Health and Long Term Care (MOHLTC) and the North East Local Health Integration Network (NE LHIN) appointed Rik Ganderton, President and Chief Executive Officer, Rouge Valley Health System as Peer Reviewer for the Sault Area Hospital. The terms of reference for the peer reviewer included:

1. The peer reviewer will review the September 2010 Hospital Improvement Plan (HIP) and assess the feasibility of it resulting in a balanced budget for the Sault Area Hospital (the 'hospital') in a timeframe acceptable to the North East Local Health Integrated Network (NE LHIN);
2. The peer reviewer, with oversight of the LHIN, will work with the hospital to develop an implementation plan for the HIP;
3. The peer reviewer will assess the readiness and capacity of the hospitals management team to implement the HIP and account for its results;
4. The peer reviewer will assess the readiness and capacity of the hospital's management team to successfully implement the move to the new facility;

5. The peer reviewer will review the relationship between the hospital and its stakeholders including the LHIN, physicians in the hospital and community, and other hospitals in the community.

Peer Review Process

The Peer Review Team conducted numerous interviews of individuals and groups including all members of the senior management team, various Board members, physician leaders, managers, NE LHIN, community leaders and members of community organisations such as the Community Care Access Centre and Group Health Centre. From internal and external sources, numerous reports and analysis were received, including extensive financial and statistical information which were compared to information available through the Ministry of Health and Long-Term Care (MOHLTC) HIT tool. The team also reviewed extensive documentation related to the new facility and the readiness of SAH to physically relocate to the new site.

Findings

We recognize that SAH faces challenges that are different than most other hospitals.

- Isolation from other major urban centres (at least 3.5 hours by road) and other health care system supports means higher utilization of hospital resources.
- Isolation means that the size of some programs is suboptimal from an economy of scale perspective but necessary from a community point of view.
- SAH has historically operated on two very old and very inefficient sites.

However, the imperative for financial health is no different than any other hospital.

Because of the hospital's ongoing deficits, the NE LHIN required SAH to develop, in 2008, a Hospital Improvement Plan (HIP). The original HIP submitted in May 2009 did not bring the hospital into balance within a 12-month window and was not approved by the NE LHIN in September 2009. SAH was told to continue implementation of the identified initiatives and clearly some successes have been achieved on those initiatives. A second HIP that brought SAH into balance was requested in late 2009. This has led to the development of the 2010/12 HIP, the primary focus of the Peer Review Team.

Since the 2006/07 fiscal year, the hospital has made some operational improvements identified through the series of its own as well as external reviews, which have had a positive effect on the cost per weighted case. The deficit has not changed, however, averaging approximately $12 million over the past four

fiscal years. In consequence, SAH has now accumulated a working capital deficit in excess of $60 million, which is the worst in the province.

Over at least the last 5 years SAH have been experiencing intense pressure on operations because of growing alternative level of care (ALC) issues which have resulted in the institution operating almost constantly at over its rated capacity. At any point in time SAH is housing more than 70 ALC patients and has rarely been able to get below this number despite significant efforts. This has resulted in significant staff and operational inefficiencies. Many staff efficiency measures have been identified by SAH, but remained largely unaddressed until the last 24 months.

The lack of post-acute accommodation capacity has been a fundamental driver of the ALC and overcapacity issues at SAH and has contributed significantly to the deficit at SAH. Once this post-acute capacity is resolved, then SAH can balance its budget without any significant service reductions.

The Peer Review Team strongly recommended that the 68 ALC patients not be moved to the new facility. The NE LHIN had been working on a strategy to retain space at the Plummer site on a short-term basis and to develop additional long-term care capacity on a permanent basis; on February 15, 2011 the MOHLTC announced $6.6 million in additional annual funding to support this strategy.

The 2010 HIP has many achievable targets and initiatives, but more needs to be done and a multiyear financial restructuring strategy needs to be developed and implemented quickly. High level benchmarking data by the hospital indicate that the opportunity for further cost reduction does exist and that there is scope to achieve at least modest surpluses in the future.

The current Senior Management Team with the exception of the CEO and Chief of Staff (COS) are new appointments in the last 18 months. The Board has been transitioning from a community representative Board to one that is skills based. Relationships with physicians are a key to success and pose some ongoing risk to the organization as some of the Medical Leadership has not accepted that they have to be part of the solution.

The capital building project, along with a number of other pervasive issues, has required the leadership team of the Board, management and physicians to focus away from addressing the core operational issues. SAH had undertaken extensive planning for the move to the new site. At the time of this report, the plans were documented, they were in the process of being implemented and risk mitigation plans were in place or were being developed. SAH was well prepared for the move although rank and file physicians were not fully prepared even at the end of January 2011.

The post-construction operating plan (PCOP) process is not geared to dealing with greenfield sites, so much negotiation will be required in this regard. The existing PCOP is not adequate to fund normal operations at the new facility. On February 15, 2011, the MOHLTC provided SAH with $11.2 million in PCOP funding to support transition to the new hospital. SAH should continue to work constructively with the NE LHIN and MOHLTC to ensure an appropriate funding level for the new hospital under the PCOP.

This report makes 30 recommendations which focus on:

- Governance, accountability;
- Post acute care capacity, community health plan, ALC beds;
- Clinical utilization, scope of satellite facilities;
- Physician integration plans for new site, funding arrangements for Hospitalists and Internal Medicine;
- Requirement for a balanced budget, operating plans that create multiyear surpluses, contingency plans;
- Transition funding, PCOP development/negotiation;
- Transition plans and physician orientation, post move recovery plan, IT schedule, mental health capital retrofit;
- Group Health Centre.

Recommendations addressed after writing this report have been acknowledged; as the peer review final report to be issued to the MOHLTC and the NE LHIN by January 21, 2011 was subsequently extended by mutual agreement to March 25, 2011.

Appendix C provides a list of recommendations numerically and Appendix D by the above themes.

Summary

The peer review of the SAH focussed on the period 2006/07 to date. During this period the SAH financial situation has deteriorated dramatically as it has been spending more than $1 million per month in excess of its funding. Concurrently it has been approved for, contracted for and built a greenfield hospital on time and on budget.

The Board, senior management, and some of the medical leadership are aligned and recognise the need and urgency for decisive action. The first step to building credibility with the MOHLTC and the NE LHIN is to balance operations. We believe the leadership, management and governance talent and capacity exists at SAH to resolve the financial situation and, that this needs to be done urgently.

Appointment

The Peer Reviewer for Sault Area Hospital (SAH) was appointed on December 8, 2010 with a final report to be issued to the Ministry of Health and Long-Term Care (MOHLTC) and the North East Local Health Integration Network (NE LHIN) by January 21, 2011. This was subsequently extended by mutual agreement to March 25, 2011.

Peer Review Team

Rik Ganderton
Brian Edmonds
Rick Gowrie
Patricia Petryshen

Brief bios for each team member are included in Appendix A.

Terms of Reference

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Process Followed

The peer review focussed on the period 2006/07 to date. During this period the SAH financial situation has deteriorated dramatically as it has been spending more than $1 million per month in excess of its funding. Concurrently it has been approved for, contracted for and built a greenfield hospital on time and on budget.

The Peer Review Team conducted numerous interviews of individuals and groups over the course of the review. We interviewed all members of the Senior Management Team, various SAH Board members, physician leaders, managers, NE LHIN, community leaders and members of community organisations such as the Community Care Access Centre (CCAC) and Group Health Centre (GHC). A Listing of interviews is included in Appendix B.

We obtained, from internal and external sources, numerous reports and analyses that are germane to the analysis of the SAH situation. These were reviewed and synthesised as part of the Peer Review Team's analysis.

The team requested and received extensive financial and statistical information provided by management and the NE LHIN. This information was compared to information available through the MOHLTC HIT tool and was reviewed and evaluated based on the experience and expertise of the Peer Review Team.

The team also reviewed extensive documentation related to the new facility and the readiness of SAH to physically relocate to the new facility on March 6, 2011.

Background

Geographic Location

One very important piece of background information relates to the geographic isolation of Sault Ste. Marie. The Algoma region comprises some 120,000 residents while the Sault itself has some 75,000 residents. The area is very geographically isolated – it is not an understatement to say that they are 3 ½ hours from anywhere. Consequently as a community they must be self-reliant and able to deal with most situations locally as they do not have the luxury of the geographically proximate safety valves enjoyed in southern/central Ontario. This is obviously exacerbated in winter, when travel to other communities may be severely restricted. Consequently over the years the hospital has developed services that might not be optimally sized for economies of scale compared to hospitals in urban regions such as the diagnostic Cardiac Catheterisation laboratory and obstetrical services with some 800 deliveries annually.

Physical Sites

Prior to the new hospital opening on March 6, 2011, the SAH operated on two very old sites (Plummer and General) that are contiguous to each other near the downtown core. There are also two satellite hospital sites - Matthews Memorial, an emergency and outpatient hospital on St. Joseph Island (30 minutes southeast) and Thessalon Hospital, a four-bed hospital in Thessalon (one hour southeast). SAH also runs the Riverview Centre and an external laundry facility, which will be combined into the new facility.

The two previous corporations merged in 2002 to create the Sault Area Hospitals (SAH). The two predecessor hospital corporations had been operating as a single entity going back to the early 1990s.The process for development of a new hospital began in the late 1990s. Final approvals were given in 2005, a contract was awarded on August 15, 2007 and construction began on a greenfield site on August 23, 2007.

The project was structured as a build, finance and maintain project, since the hospital was advanced in the design development stage when approval was provided.

The project was delivered on time and on budget in October 2010. Of particular note is that the SAH Foundation originally established a fundraising campaign to raise approximately $13 million of local share. Due to the incredible philanthropy of the community broadly and key donors in particular, the campaign closed with a total of over $30 million raised. In addition, the City of Sault Ste. Marie contributed $29.5 million to the local share. As a result it can be said that the local share component of the redevelopment project has not been a financial drain on the resources of SAH. Indeed, the increased contributions allowed the hospital to acquire everything that it properly requires in order to open the facility with the equipment and services necessary.

Management oversight of this massive project was provided by the CEO from 2007 through to late 2010. The former and current CFO also had supporting oversight responsibility during this timeframe. Based on the experiences of the Peer Review Team, these types of projects are very complex and require very significant senior management involvement on a virtually full time basis for them to be successful – which this one was. On a day-to-day basis the project was led by the Director, New Hospital and supported by project managers, project coordinators and a cost analyst.

Management Team

During the period of review (2006/07 to date) there have been almost complete changes in the Senior Management Team. The previous CEO was removed in 2006. The then CFO was appointed firstly as acting CEO for 10 months and then subsequently as permanent President and CEO. Also in this timeframe the Senior Management Team has turned over three times. The first group was replaced through 2006/08, the second group through 2008/09 so that the current Senior Management Team with the exception of the CEO and Chief of Staff (COS) are new appointments in the last 18 months.

Medical Leadership

Prior to 2007 relations between medical leadership and administration were very strained. At that time the current COS was appointed and there has been some

stability since then. Relations between the COS and the CEO appear to be strong and the COS sits as part of the current Senior Management Team of the organisation. There have also been changes in the medical staff leadership as follows:

- Chief of Staff – July to October 2006 position was filled on a shared basis by five physicians, interim appointment (2006) and made permanent (2007)
- VP Medical Affairs – appointment (2008)
- Medical Director appointments
  - Critical Care – (2006-2010), interim (2010)
  - Medical Program – appointment 2006, vacant (2007-2008), appointment (2008)
  - Emergency – appointment (2006-2009), (2009)
  - Oncology – appointment (2008)
  - Renal – appointment (2008)
- Chief appointments
  - Maternal/Child – 2006 moved to separate roles (OB/GYN and paediatrics); OB/GYN – rotated (2006-2007), appointment (2007-2009), vacant (2010); Paediatrics – acting (2006-2008), appointment (2008)
  - Diagnostic Imaging – appointment (2006-2009), (2009)
- Chief Pathology (2006-2007); changed to Deputy Medical Director of Lab in 2007; appointment (2007-2009), (2009)
- All other Medical Directors (Mental Health, Surgical, Long Term Care) and Chiefs (Anaesthesia, Hospitalist, Family Medicine) appointments are (2006 – present)
- For the Medical Staff Association there were three different appointments of President and five different appointments of Vice President since 2006.

Governance

The Board has been transitioning from a community representative Board to one that is skills based. This takes time and is usually managed through the natural attrition of Board members at the end of their three year terms or reaching their maximum terms. The Board, by the account of its own members and input from the community, has enjoyed excellent leadership from its current Chair for the past three years. The current Chair is credited for leading and managing the transition to a skill based Board over her tenure as Chair. She is also credited, along with the CEO, with having substantially improved the communication with the community and the communities' understanding of the issues facing the hospital including ALC and its financial situation. There is clearly a strong working relationship between the Chair and the CEO and also with the Chief of Staff (COS).

As part of the natural evolution of the Board there will be 5 or 6 new independent Directors appointed this year. Active recruiting is underway for appropriate individuals with the required skills to support effective Board functioning. A new Vice-Chair and Chair-Elect was recruited last year. He is a very seasoned and experienced business leader with excellent knowledge of the health system.

One of the most important success factors is the relationship between the leadership triad of the Board Chair, Chief Executive Officer and Chief of Staff. The existing incumbents in these positions have clearly built an effective relationship based on mutual trust. If SAH is to move to the next level of success then an experienced and functioning leadership triad will be a critical.

Recommendation # 1: The Board should consider what leadership triad offers the greatest chance of success to lead SAH through the next 12 to 24 months.

System Structural Changes

During the time period there have been fundamental shifts in the accountability and leadership structure in the health system. While LHINs were created in 2005 they really became operational in April 2007 when the Accountability Agreements between hospitals and the MOHLTC were assigned to the LHINs. Since that time the LHINs' relationship with the MOHLTC, hospitals and other providers in their jurisdictions have been evolving and maturing. Part of this maturation process is reflected in changes in leadership at the NE LHIN.

Relations between SAH and the NE LHIN prior to 2010 can best be described as adversarial with each claiming that the other was responsible for various issues especially the ALC issues faced in Algoma region. Based on more recent discussions there appears to be a more positive relationship emerging particularly around the ALC issues and the work of the Sault Ste. Marie ALC Solutions Group. However, the ongoing financial situation at SAH will remain an issue until a balanced budget is achieved.

Something unique in the healthcare setting of the Algoma Region is the Group Health Centre (GHC), which is a multi-specialty, ambulatory care organization. It is organized as a partnership between the Sault Ste. Marie and District Group Health Association (GHA) (originally, a labour-sponsored community organization) and Algoma District Medical Group (ADMG), a group of independent physicians practicing in a group setting. The members of ADMG are general practitioners (GPs) or family practitioners, specialists and subspecialists. GHC is governed by a Joint Management Committee drawn from the two sponsoring groups. GHA owns the physical facility, equipment, furnishings and hires all of the more than 300 non-physician staff, including allied health professionals. Its operations are funded by the MOHLTC. The physician group is funded primarily as an Alternative Funding Arrangement (AFA) and since 2003 (when funding relationships were fundamentally changed) has paid the SSMDGHA a portion of its revenue in return for various services

(nurses, dieticians etc., as well as administrative support, facilities and office overhead). A new governance structure and funding arrangements are currently under development and have been for the last two years.

Alternative Levels of Care (ALC)

Post-acute Care System Capacity

The NE LHIN commissioned a report on "*Aging at Home Strategy Seniors' Residential/Housing Options - Capacity Assessment and Projections*" (March 2009)[1]. Seniors over the age of 65 represent about 17% of the total population, and is expected to increase to 29% by 2031. The housing study examined current and future needs of seniors for long-term care, retirement or assisted living, and supportive housing. As well, the report notes that a portion of the future need for long-term care could potentially be met through supportive housing.

The Table below provides supply estimates for post-acute/seniors housing beds/units in Sault Ste. Marie (it does not account for gaps in number of individuals/couples on waiting list for each form of accommodation).

Sault Ste. Marie Housing Form	Supply Estimate (2008)
Long-Stay Long-Term Care Beds	788
Retirement Home Beds/Suites	402
Supportive Housing Units	113
Convalescent Care Beds	12
Residential Hospice Beds	10

Source: NE LHIN Aging at Home Strategy Seniors' Residential/Housing Options – Capacity Assessment and Projections (Final Report Revised March 16, 2009)

The Table below provides projected demand estimates for seniors' housing beds/units required to keep pace with projected growth, based on "status quo" (current patterns of eligibility and placement).

[1] *North East Local Health Integration Network Aging at Home Strategy Seniors' Residential/Housing Options – Capacity Assessment and Projections* (Final Report Revised March 16, 2009), Prepared by: SHS Consulting, In association with: Balance of Care Research Group, University of Toronto.

Housing Form	Projected Demand Estimate (2008)	Projected Demand Estimate (2011)	Projected Demand Estimate (2016)	Projected Demand Estimate (2021)	Projected Demand Estimate (2026)	Projected Demand Estimate (2031)
Long-Stay Long-Term Care Beds *(for Sault Ste Marie)*	1,119	1,187	1,300	1,436	1,632	1,817
Retirement Home Beds/Suites *(for Algoma Planning Area)*	488	550	660	798	989	1,197
Supportive Housing Units *(for Sault Ste Marie)*	150	159	179	200	225	247
Convalescent Care Beds *(for Sault Ste Marie)*	9	10	11	12	15	17
Residential Hospice Beds *(for Sault Ste Marie)*	6	7	7	8	10	11

Source: NE LHIN Aging at Home Strategy Seniors' Residential/Housing Options – Capacity Assessment and Projections (Final Report Revised March 16, 2009)

Bed changes that have occurred include:

- MOHLTC funding 88 Interim Long-Term Care beds at various locations: 83 beds at Great Northern Nursing Centre (GNNC) (October 2006); 3 beds at the Ontario Finnish Rest Home; 1 bed at Van Daele; 1 bed at Extendicare Tendercare;
- NE LHIN funded 12 transitional beds at GNNC (October 2008); in 2012 when the new Extendicare facility opens there will be a reduction of these beds at GNNC;
- 50 retirement home beds closed at Windsor Park Retirement Home (January 2010);
- LHIN approved the Assess and Restore Unit at SAH (26 beds opened fall 2010) through a combination of NE LHIN "Aging at Home" funding ($646,000) and MOHLTC 2010/11 criteria based funding ($427,000).

The NE LHIN has been working on a strategy to retain space at the Plummer site on a short term basis and to develop additional long-term care capacity on a permanent basis. On February 15, 2011, the Minister of Health and Long Term Care announced $6.6 million in additional annual funding toward these endeavours.

There are a number of community committees whose priority is related to ALC:

- NE LHIN CEO and hospital CEOs (Sudbury Regional, Timmins, North Bay, and Sault Area Hospital) and Board Chairs – meet quarterly;
- Sault Ste Marie ALC Solutions Group – created in April 2010 to address increasing number of ALC patients at SAH and in community; developed a plan to address short and long term demands for services;
- Partners in Care Committee – provides a forum for communication among participating agencies to improve continuum of care for clients transitioning from hospital to community and vice versa;

- Regular meetings between CCAC CEO and SAH CEO – to review metrics related to ALC and required actions.

The Sault Ste. Marie ALC Solutions Group is co-chaired by NE LHIN and Extendicare Tendercare and includes representatives from SAH, NECCAC, Ontario March of Dimes, Group Health Centre, City of Sault Ste. Marie, and Blind River District Health Centre. A six-point action plan was developed:

1. Identify any additional space SAH could use to relieve ALC (within/outside hospital);
2. Expansion of cluster care by March of Dimes and introduction of Home First;
3. Human resource needs analysis and collaboration with the community college regarding PSWs and RPNs in community;
4. Long Term Care Sub-Committee to focus on processes for early return from hospital to home and factors causing admission to hospital from nursing homes;
5. Emergency Department wait times and optimizing GEM nurse, working with CCAC to create ED case management role, and exploring options to best meet needs of orphan patients;
6. Development of community geriatric services plan.

As can be seen from the above information there is and has been a significant deficit in the inventory of post-acute accommodation capacity. While there is a significant rebuild program for 256 beds that will open in 2012 this will not create new capacity as the beds that are being replaced are planned to close. Furthermore the shortage of capacity is anticipated to further increase through to 2031. The MOHLTC, NE LHIN, SAH and other providers are working on diversion strategies including significant investments through "Aging at Home" initiatives including the Home First programs. The NE LHIN report looks at the impact of diversion and even with quite aggressive diversion success it suggests an ongoing capacity shortfall.

The impact of this is that SAH has become the de facto safety valve for the provision of post-acute accommodation capacity. In fact this is what the SAH ALC problem represents. During the review period SAH has faced major over capacity issues on an almost daily basis because of the inability to flow ALC patients to the appropriate care setting whether that is home, retirement home, nursing home or supportive living. We comment further on the impact of this later in the report.

Recommendation # 2: The NE LHIN should develop a Post Acute Care Capacity plan by April 30, 2011 and submit it to the MOHLTC. The plan should consider whether the 256 beds that will be vacated in 2012, through the replacement program, offer an opportunity to catch up on the significant post-acute accommodation shortages that are driving the ALC issue at SAH.
(RECOMMENDATION UPDATE – The NE LHIN has been working on a strategy to retain space at the Plummer site on a short term basis and to develop additional

long-term care capacity on a permanent basis. On February 15, 2011, the MOHLTC provided $6.6 million in additional annual funding to support this strategy.)

C. difficile Outbreak

In August 2006, a C. difficile outbreak resulted in the deaths of several patients. This was a traumatic occurrence for the community, patients, SAH and all its physicians, employees and volunteers. It consumed considerable time and energy of the management team particularly the CEO, who was newly appointed. It resulted in significant new investments in infection control procedures, which were funded on an ongoing basis in the amount of $2 million. Also since the RFP for the new hospital had been initiated, it also resulted in a significant concurrent redesign of the new hospital to reflect the latest infection control design principles.

As a separate issue, to ensure sustainable high quality laboratory service, there was a complete reorganisation of laboratory services including the outsourcing of management to a Southern Ontario teaching hospital.

Socio-economic and health status of Algoma Region

The following italicized description is extracted from the Hospitals 2009 HIP. It provides an excellent summary of the socio and health economic situation in the Sault.

According to the 2006 census, Sault Ste. Marie boasts a higher proportional population of seniors (age 65+), Aboriginals and unemployed individuals than the provincial averages, coupled with lower median household incomes and relatively lower education levels (percentage of population with post-secondary education). Additionally, residents of the Algoma region exhibit a significantly higher prevalence of obesity and lifestyle practices such as heavy drinking and smoking (including exposure to second hand smoke). To varying degrees, each of these is related to poorer health status and outcomes, both in terms of morbidity and mortality.

In fact, Algoma's rates for chronic diseases such as arthritis/rheumatism, high blood pressure, diabetes and heart disease are significantly higher than the province as a whole. When coupled with an older population demographic and the prevalence of chronic diseases among this group (80% of Canadians 65+ have some form of chronic disease; 70% suffer from two or more), a higher burden is placed on the health care system in general and SAH specifically.

Primary and Specialist Health Care and Hospital Utilization

This situation is exacerbated by a lack of primary care physicians and access to same in the community. Sault residents either wait long periods of time to see

their physician or, in the case of the thousands without a family physician, are forced to use the SAH Emergency Department (ED) or walk-in clinic for minor ailments, follow up care or other non-urgent matters.

As a result, SAH utilization is significantly higher than provincial utilization figures (59% higher based on separations), and higher than average rates for Algoma, the NE LHIN and the North region as a whole. The data also indicates that the hospital's EDs are being accessed at a 90% greater rate than the average hospital in the province on a per capita basis, with many of those visits being of the less urgent or non-urgent type.

Alternate Level of Care (ALC)

ALC issues continue to be the single greatest challenge facing SAH and many hospitals throughout the NE LHIN and the province. ALC patients regularly occupy 25 to 30% of SAH's total beds, contributing to the need for the hospital to operate more than its 291 funded bed complement approximately 50% of the time. The average number of acute care beds occupied by ALC patients at SAH has increased by 72% over the past two years. This adversely impacts both the ALC patients themselves, whose recovery and long term health would benefit more by the appropriate level of care for their specific situation, and for inpatients and those awaiting admission into an acute care bed.

In addition to the stress placed on patients, increased ALC patient numbers also result in extremely high occupancy rates (2008/09 overall occupancy rate was 98.75% versus the funded rate of 87.5%), overworked physicians and staff, and higher sick time, overtime and lost productivity, all of which have a significant negative financial impact. Clearly, ALC challenges must be addressed to facilitate the implementation and success of any recovery or improvement plan.

Footnote from Peer Review Team: Updated occupancy rates for 2010/11 suggest that the hospital is currently running at 108% occupancy (October 2010). During the period of the review we were made aware that the hospital was running more than 40 beds above capacity of 291 on many days. The 87.5% referred to above represents the planning parameter used by the Health Services Restructuring Commission in 1996 when it recommended SAH should have 289 beds. This planning parameter assumed that there would be no ALC patients. Generally accepted standards and research literature from the industry would indicate that as hospitals reach occupancy rates above 95% there is a demonstrated decrease in efficiency arising from patient flow issues and increased patient risks due to staffing ratios, use of overtime to manage the excess volumes, delays in accessing diagnostic resources, and other patient flow issues.

SAH's Role

From a broader perspective, there has been a gradual restructuring of the health care system over the last few decades, with a considerable amount of hospital-based care – and the attendant financial resources – shifted from inpatient to

ambulatory and other settings such as home care. Once largely perceived as synonymous with the health care system, hospitals are now viewed as simply one component of a complete health system, albeit a very important one.

Unfortunately, while this might be the general view in Ontario, the same cannot be said for SAH. Due to the relative lack of alternative care facilities/services in the community and shortages in family/primary care physicians and specialists, residents have come to rely on the hospital as the de facto default for the majority of their health care needs, spanning the continuum from critical care to more mundane services such as prescription refills. The ability to alter this perception and allow SAH to focus on its core function of providing acute care to those most in need will be a key in making the most efficient use of limited available financial and human resources.

Recommendation #3: The NE LHIN should enhance the current structure that includes the major health providers in Sault Ste. Marie including SAH, Group Health Centre, Family Health Teams, the North East Community Care Access Centre, Long Term Care Representatives, other community providers and the municipality. This group should develop a community health plan that allows SAH to focus on its core role of acute care services and that ensures other providers make available the appropriate services, in appropriate locations and at appropriate times to ensure SAH is not the "default" provider. This should be completed by March 31, 2012 and implemented as soon as possible thereafter.

Financial and Statistical Overview

Over the last 5 years there has been broad internal and external recognition that SAH is facing significant operational and financial challenges.

	2006/07	2007/08	2008/09	2009/10	2010/11
	Audited	Audited	Audited	Audited	Projected
NE LHIN Funding (incl CCO)	$ 124,489	$ 129,583	$ 132,114	$ 131,970	$ 136,583
Other Funding	$ 19,924	$ 20,230	$ 22,424	$ 22,304	$ 21,903
MOH revenue % increase					
Total Funding	$ 144,413	$ 149,813	$ 154,538	$ 154,274	$ 158,486
MOH Base % of total	86.2%	86.5%	85.5%	85.5%	86.2%
Total Expenses	$ 151,398	$ 161,635	$ 166,151	$ 167,169	$ 171,245
Surplus (Deficit) from hospital operations	$ (6,985)	$ (11,822)	$ (11,613)	$ (12,895)	$ (12,759)

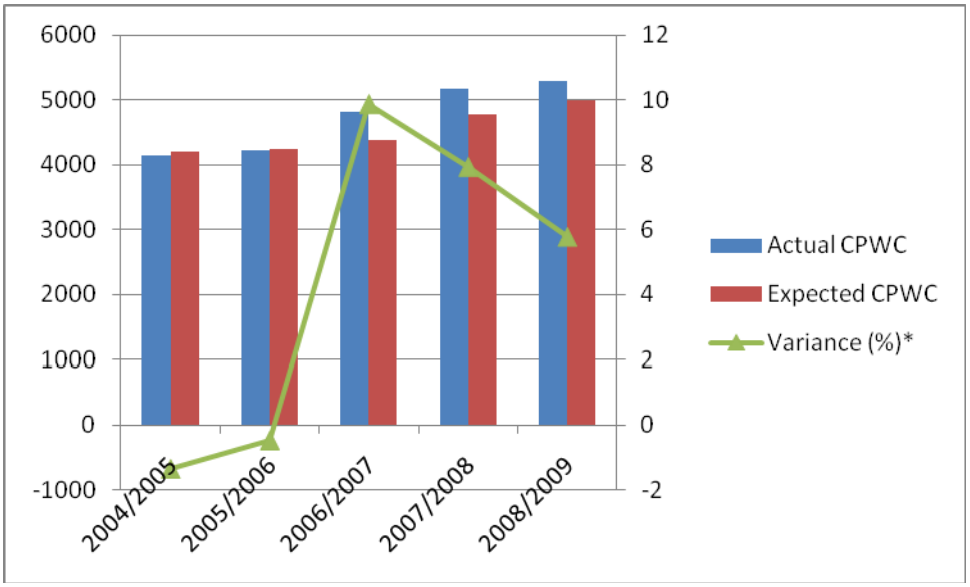
The hospital has undertaken a number of internal and external reviews to determine the causal factors and possible solutions to their issues. These include:

- The Grant Thornton Report for the year ended March 31, 2008 (external)
- The Geyer and Associates Report In Depth Analysis (IDA) January 2009 (external)

- Budget Improvement plan 2008 (internal)
- Hospital Improvement Plan 2009 based on the Geyer report (internal)
- Hospital Improvement Plan 2010 (internal)

These reports have identified a number of initiatives, and while it would be unfair to conclude that nothing has been done, there continue to be large deficits from operations. The Grant Thornton report identified a number of internal control and reporting issues that have been addressed.

The IDA report identified a number of Board and Management accountability issues, which have also been addressed. The IDA identified that the hospital has a low percentage of budget directed to administrative and support services, and this continues to be true. The IDA made recommendations regarding staffing efficiency (sick, OT, and dependence on full-time nurses), utilization management (e.g., conservable days) and other elements which when combined with the operational impacts of dealing with a major C. difficile breakout in 2006/07 have had a deteriorating impact on overall actual cost per weighted case. As will be noted in numerous portions of this report, the ALC issue has also been a contributing factor to the hospital effectively dealing with its deficit position.



*MOH value schema shows favourable variance as a negative and unfavourable variances as positive results. Last published data from MOH is 2008/09.

Since the 2006/07 fiscal year, the hospital has made some operational improvements identified through the series of its own as well as external reviews, which have had a positive effect on the cost per weighted case, as noted above. The deficit has not changed, however, averaging approximately $12 million over the past four fiscal years. The cost per weighted case must also continue to improve significantly in order for the hospital to position itself to receive funding that may be available and related to hospital efficiency.

The original HIP submitted in May 2009 did not bring the hospital into balance within a 12 month window and was not approved by the NE LHIN in September 2009. SAH was told to continue implementation of the identified initiatives and clearly some successes have been achieved on those initiatives. One initiative that the hospital chose to defer, in consultation with the NE LHIN, was the closure of the Matthews Memorial Hospital. We understand that the NE LHIN is undertaking a review of the North Shore Hospitals and their services and roles and that these SAH Satellites will be included in this review.

Recommendation # 4: When SAH has achieved a balanced operating position, SAH and the NE LHIN should re-examine the scope of service provided at these satellite facilities (Thessalon and Matthews Memorial).

The above discussion and charts demonstrates that SAH has been incurring deficits at the rate of approximately $1 million per month since March 2007 (and ½ million $ per month in the year prior to that). SAH has not had a balanced budget since prior to legal amalgamation in 2002. Also, during this time period they have been experiencing intense pressure on operations because of the severe and growing impact of ALC as set out further below. The hospital has also faced a number of unusual challenges such as C. difficile. More recently, the capital building project has required the leadership team of board, management and physicians to focus away from addressing the core operational issues.

The ALC pressures and staff efficiency measures have remained largely unaddressed until the last 12 to 24 months as the new leadership team has started work on improving results. This has led to the development of the 2010/12 HIP which will be described more fully in the following pages. The 2010 HIP has been the primary focus of the Peer Review Team.

One thing is patently clear from this summary – a normal commercial organization, in this financial state, would have been forced into bankruptcy or a court overseen restructuring.

	2006/07	2007/08	2008/09	2009/10	2010/11
	Audited	Audited	Audited	Audited	Projected
Current assets	$ 6,968	$ 8,807	$ 7,912	$ 7,759	$ 11,126
Current liabilities	$ 33,605	$ 45,191	$ 51,878	$ 65,343	$ 77,886
Working capital	$ (26,637)	$ (36,384)	$ (43,966)	$ (57,584)	$ (66,760)
Long-term Debt	$ 7,441	$ 12,575	$ 15,598	$ 11,524	$ 12,459
MOH Advances*			$ 25,000	$ 32,000	$ 37,000
* due to the process of accounting for MOH advances, these do not appear in working capital results at year-end					

The ongoing operating deficits and the consequent working capital deficiency rival the worst that has been seen in the Ontario healthcare industry in the last 25

years. In fact, given the relatively small size of SAH and its budget, its situation is proportionally worse than most.

If SAH were to be able to turn its operations around and operate as efficiently as the best hospitals in the province it should expect to generate a surplus of 1.5% to 2% per annum or approximately $2.5 million per year. To repay its short term lenders (banks and NE LHIN) would therefore take more than 25 years, to rebuild its working capital to zero would take 27 years. The situation is compounded by all of this needing to be undertaken during what is likely to be, the most prolonged and unprecedented curtailment of available funding from government because of the recession and the disproportionately high consumption of the provincial budget by health.

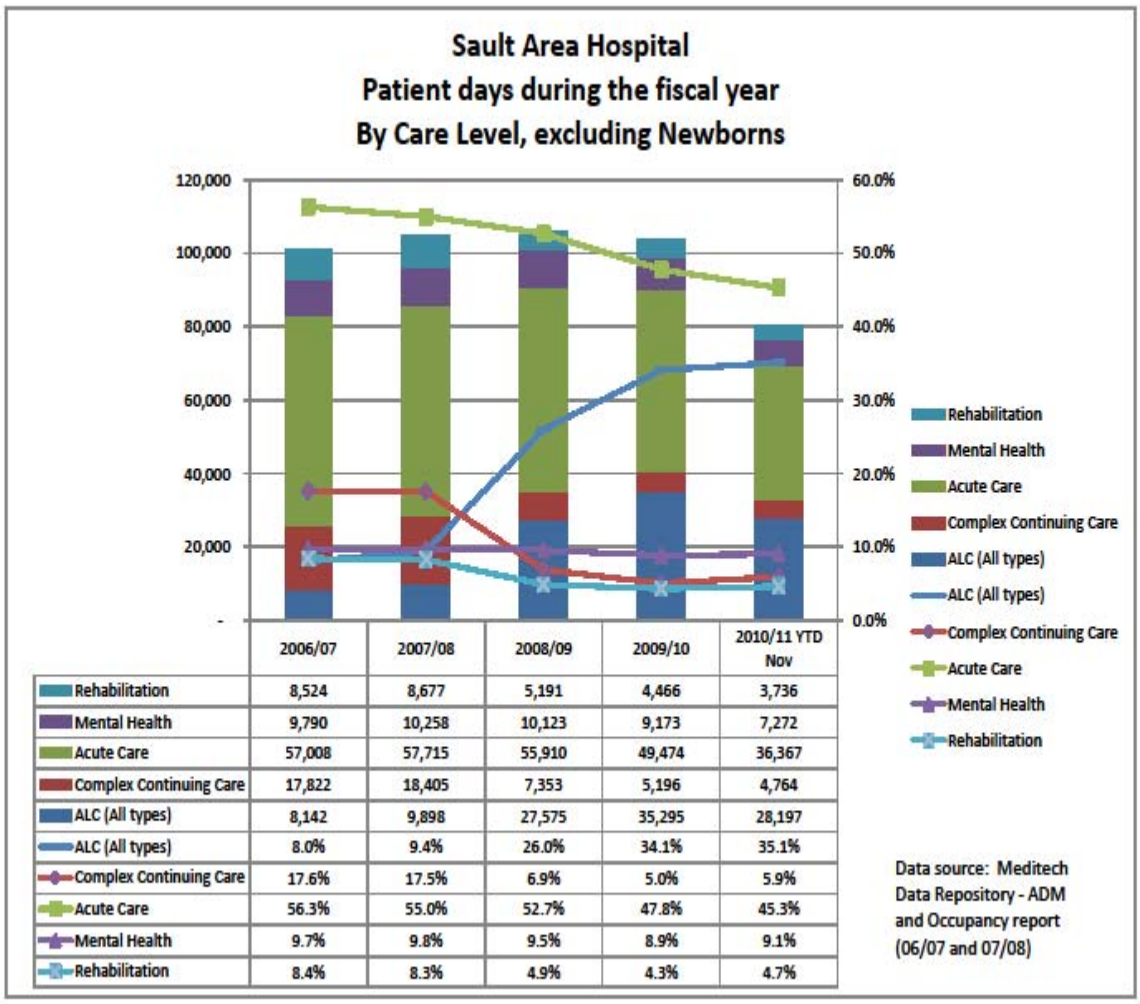
As will be elaborated further below, the HIP is an excellent start, but much more is required for the long term. The current HIP will balance operations to funding for the coming year, but does nothing to improve the working capital position. With anticipated funding increases lower than inflation (foreseeable for several years to come), a need to reduce the carrying costs of the debt, and to rebuild the balance sheet, many more initiatives will be required to be developed and implemented. While it must seem a near herculean task, process improvement techniques, benchmarking and other tools offer some suggestions for further efficiencies in the long-run.

Because this is a public institution the solution will need to be found between SAH, the NE LHIN and the MOHLTC. SAH cannot resolve its problems alone and in isolation. The MOHLTC is currently studying the working capital deficit situation across all Ontario hospitals with a view to identifying possible solutions and remedies.

Recommendation # 5: SAH should develop operating plans that create surpluses in future years to rebuild working capital and pay off debt and to allow it to have sustainable operations going forward. We do not recommend any special treatment for SAH to support the working capital position beyond what the NE LHIN is doing today through cash advances and what the MOHLTC may develop as a potential provincial-wide working capital solution.

Alternative Level of Care (ALC)

The ALC issue is so pervasive at SAH that it warrants a more detailed analysis here.



	2006/07	2007/08	2008/09	2009/10	2010/11 YTD Nov
Rehabilitation	8,524	8,677	5,191	4,466	3,736
Mental Health	9,790	10,258	10,123	9,173	7,272
Acute Care	57,008	57,715	55,910	49,474	36,367
Complex Continuing Care	17,822	18,405	7,353	5,196	4,764
ALC (All types)	8,142	9,898	27,575	35,295	28,197
ALC (All types)	8.0%	9.4%	26.0%	34.1%	35.1%
Complex Continuing Care	17.6%	17.5%	6.9%	5.0%	5.9%
Acute Care	56.3%	55.0%	52.7%	47.8%	45.3%
Mental Health	9.7%	9.8%	9.5%	8.9%	9.1%
Rehabilitation	8.4%	8.3%	4.9%	4.3%	4.7%

Prepared by Decision Support Services 23/12/2010

In late 2007/08 SAH completed an analysis that showed a large number of its patients in Complex Continuing Care (CCC) and Rehab actually did not meet the requirements for those beds and were in fact medical ALC patients. As a result of that analysis SAH started categorising those patients as medical ALC patients (beginning in 2008/09) which explains the dramatic shift shown above. On a comparable categorisation basis in 2006/07 there were a total of 20,917 ALC days and 22,673 ALC days in 2007/08. The increase in ALC in those years also creates a similar reduction in CCC and Rehab days.

The impact of ALC on an acute care hospital is complex and often counter intuitive. Since these patients in general have completed the acute part of their stay, one would expect that the costs of managing these patients would be less than a commensurate number of acute care patients and that in fact operating

cost should decline. All evidence shows that this rarely, if ever, happens if these patients are not geographically aggregated or are in overflow beds throughout the hospital.

ALC patients restrict the normal turnover of acute care beds (primarily acute medicine beds). A typical medical bed will turn over every 8 days meaning a new acute patient can come in every 8 days. The longer an ALC patient stays in the bed the fewer acute care patients can be accommodated so backups occur in the Emergency Department, which is virtually the only point of access for acute medical patients.

ALC patients also tend to be distributed throughout the institutions bed capacity (not geographically aggregated) and consequently staffing ratios/mix, which is geared to treating acute care patients cannot be changed to reflect patient care needs. Further, acute care clinicians are not necessarily trained or experienced in the type of care required for ALC patients which often leads to further deterioration in the ALC patient condition.

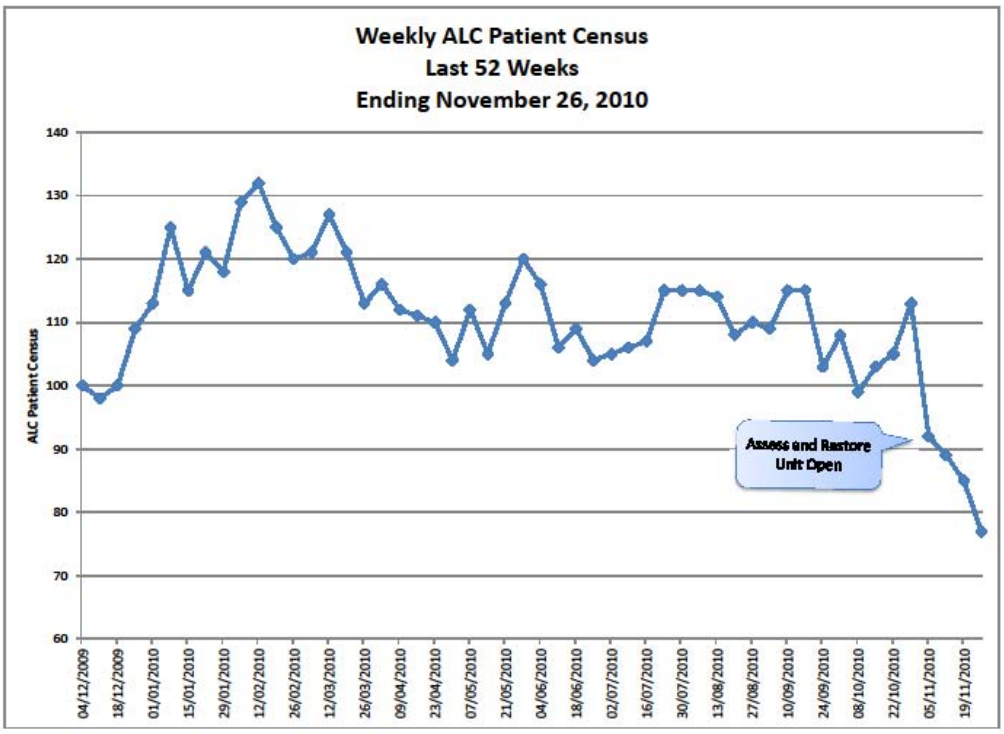
Extended stays in an acute care setting also increase the risk of exposure to nosocomial infections and other unintended hospital errors which can further extend lengths of stay and impact the ability to discharge these patients to appropriate settings. In essence ALC patients are placed at greater risk, increase the operational cost of the institution, reduce normal flow, and disguise or confuse the real demand for acute care beds.

It is our view that ALC has been a systemic issue in Algoma and Sault Ste. Marie for many years and certainly during the period under review. Our broad estimates are that at least 50% of the annual deficits that SAH has incurred can be attributed to the inefficiencies, process and flow problems that SAH has experienced because of ALC in the last 5 years. The impact on management, and front line staff of managing in, an almost constant, over capacity situation is considerable. As a minimum it drives sick and overtime for front line staff and becomes all-consuming for managers thus diverting them from other objectives.

As noted in the introduction to this report ALC was, for several years, a contentious issue between the NE LHIN and SAH with each contending that the problem belonged to the other. In the last 18 months a more positive and collaborative relationship has developed with new management and a spirit of willingness to solve the problems at each organisation.

The issue of system capacity, described earlier in this report, has been recognised and articulated and is agreed to by both parties. Furthermore, SAH has taken a more positive and proactive approach to ALC management by fully accepting that it needs to work with the NECCAC to reduce the accrual of ALC patients and to get medical patients home before they become ALC.

Numerous new processes and monitoring tools have been introduced including joint programs and staffing with the NECCAC as well as weekly reporting and monitoring by the SAH Senior Management Team since March 2010. Reductions in the number of ALC patients in hospital have occurred and can be correlated with improved management oversight and focus (e.g. June 2010 with the appointment of the COO) as well as the introduction of new strategies such as the Assess and Restore Unit in October 2010.



These initiatives have shown impressive results by reducing both the absolute number of ALC patients in SAH but, perhaps as importantly, slowing or reversing the number of patients that are becoming ALC. This reduction in the creation of ALC reflects the investment in Aging at Home, Home First as well as significantly improved process changes within SAH and between SAH and the NECCAC. Further investment and changes are planned. This issue will require sustained and relentless focus if it is not to slip back.

Having made the comments above, however, the number of ALC patients in SAH beds is still well above a level that is sustainable. At 70+ ALC patients, the hospital still faces significant inefficiencies due to over capacity. In the HIP, the hospital suggests that they reduce ALC patients to 15% of all beds. While this represents somewhat of a NE LHIN and Provincial target it still represents some

44 beds and therefore implies that there will be ALC patients throughout the new facility including on non-medical units.

In our view a more appropriate measure would be either an absolute target maximum number of ALC patients or the 15% should be based on the medical bed capacity (i.e. exclude surgery, maternal child etc.).

Recommendation # 6: The ALC target should be clarified between SAH and the NE LHIN and if necessary be redefined to ensure that the inefficiencies inherent in managing this type of patient population do not get built into the new facility.

Terms of Reference # 1

1. The peer reviewer will review the September 2010 Hospital Improvement Plan (HIP) and assess the feasibility of it resulting in a balanced budget for the Sault Area Hospital (the 'hospital') in a timeframe acceptable to the North East Local Health Integrated Network (NE LHIN).

The Peer Review Team spent considerable effort on reviewing the process for the development of the HIP. The HIP was developed in a very comprehensive and transparent manner. Finance provided an overview of the magnitude of the expected deficit to funding by March 2012, and assumptions regarding base funding to be received in that time. The entire management team was then challenged to review all elements of their operations in the context of the new building and determine what resources were going to be necessary to operate in the new facility. In this way, a "zero-base" budget was developed reflecting future needs. All suggestions were carefully reviewed by the line management team, and then a senior management group comprised of the COO, CFO, and VP Human Resources and members of their respective teams.

In parallel, the senior management team identified "corporate" opportunities for achieving savings including optimizing revenue sources, ALC initiatives, staffing-related initiatives (including sick and overtime usage), benchmarking, and overall cost performance.

Contingencies were provided to ensure that if there was slippage, the plan would still be achieved.

The group of COO, CFO, VP HR, and respective staffs realized that they would need to remain involved to ensure delivery was assured. Bi-weekly meetings are held to review progress on plans and guide the overall process.

In our view this was an effective process and the ongoing monitoring proposed by the management team and the oversight by the Board, if rigorously implemented, can yield success.

The HIP outlines a target level of savings to be achieved of $21.2 million, which is comprised of the total deficit from hospital operations from the 2009/10 audited financial statements of $12.4 million plus anticipated inflationary pressures to March 2012. The Peer Review Team reviewed the inflation assumptions, and is satisfied that the target level of revenue generating/savings to be achieved is reasonable and accurately reflects the quantum of effort that is required to be achieved.

The following summary provides a reconciliation of hospital operations from SAH audited 2009/2010 financial statements to SAH balanced budget in 2011/2012. This was extracted directly from the final HIP approved by the SAH Board in November 2010.

Update HIP Summary				
2009/10 Deficit from Hospital Operations				**12,395,944**
Projected inflationary impact:				8,777,465
Operational Changes Required to Achieve a Balanced Budget				**21,173,409**
Hospital Improvement Plan Summary				
Total Updated HIP Savings				**21,799,804**
Revenue enhancements				**3,291,618**
Additional Base Funding - not criteria based			2,553,669	
Patient, Recoveries and Other			545,949	
Pharmacy			192,000	
Human Resources/Health and Safety related changes				**2,233,912**
Sick time			1,200,000	
Overtime			700,000	
NEER surcharge			333,912	
Non-Clinical Service Changes				**2,815,000**
Changes to Management and Operational Support			1,051,061	
Reorganize resources associated with patient flow			668,000	
Housekeeping			586,000	
General Non-Clinical Service Changes - consulting, travel, management fees, supplies, computers			509,939	
Operating Efficiencies from New Hospital / Single Site				**3,248,487**
Clinical Service Changes				**12,210,787**
Programs/Services to operate within allocated funding			*1,416,243*	
Renal program		1,103,353		
Oncology Program		312,890		
Changes associated with 15% ALC and utilization management			*5,906,210*	
Operating Efficiencies			*3,131,045*	
Constant Care		977,547		
Surgical		200,000		
Critical Care		343,604		
Emergency		445,881		
Mental Health		224,000		
Mat Child		132,390		
Oncology		432,000		
Vascular access		50,000		
Nurse educators		200,000		
Telehealth		57,720		
General clinics		67,903		
No global funds for physician clinical services			*1,757,289*	
Top ups		318,289		
Hospitalists		1,439,000		
Contingencies				**(1,500,000)**
Ongoing labour adjustment cost contingency				**(500,000)**
One time transition costs				**$3.5 - $4 million**

The following table provides a high level overview of each initiative, and the status of each item:

HIP Initiative	HIP Plan	SAH Implementation Strategy	Peer Review Team Assessment
HIP #1: Base funding ($2.5M)	Assume .75% new global base funding in 2010/11 and 1.5% increase in 2011/12	Assumption approved by LHIN, however significant risk that there will be any base funding in 2011/12 across the province; Hospital performance in HBAM formula below average	Potential risk of $1.7 million short if provincial funding is not increased 1.5%
HIP #1: Patient Recoveries and Other ($.6M)	Focus on patient billing	New facility will allow for increase in preferred accommodation *(will implement at new site)*	Achievable
HIP #1: Pharmacy Recoveries ($.2M)	Initiative in the new Emergency Department	Pay for results funding received for pharmacist *(will implement at new site)*	Achievable
HIP #2: Sick Time ($1.2M)	Rigorous management of absenteeism; Improve scheduling practices; Improve health and safety; Reduce ALC	Sick call replacement approval by manager *(implemented)*; Process for vacation approval *(implemented);* Bi-weekly review by Senior Management *(implemented)*; Manager/HR focus on short-term absences *(implemented)*	Potential risk of not achieving. Good initiatives in place, but deeply engrained culture, and large change to be adopted.
HIP #3: Overtime ($700,000)	Rigorous management of pre-approved overtime; Adjusting workforce plans so mix of staff provides more flexibility; Improve scheduling practice; Closely monitoring overtime costs; Reduce ALC	Master schedules revised to achieve FT/PT and staff/patient ratios *(implemented)*; Overtime approval/documentation by manager *(implemented);* Bi-weekly review by Senior Management *(implemented)*	Potential risk of not achieving. Good initiatives in place, but deeply engrained culture, and large change to be adopted.
HIP #4: NEER surcharge ($.3 M)	Improvements in health and safety practices, monitoring through WSIB Workwell Audit criteria, Reduce ALC	Decreased frequency and severity of lost-time incidents, Robust Health and Safety culture *(implemented)*	Achievable
HIP #5: Changes to Management and Operational Staff ($1,051,061)	Reduce management and operational staff positions and restructure the management and support functions of the hospital, identified positions, additional positions being identified (total 22 positions)	Reduced management and operational staff positions identified (*will implement at new site)*	Achievable
HIP #6: Reorganize Resources related to Patient Flow ($668,000)	Reduce LOS and conservable days	Daily rounds (ICU, Medicine with hospitalist participation, Surgery) *(implemented)*; SAH and CCAC case managers on Medical Units/ED *(implemented)*, Clinical order sets and mobilization standards *(implemented);* Geriatric Emergency Nurse *(implemented),* 2nd Geriatric Nurse *(will implement at new site);* Review care delivery models *(will be undertaken at new site)*	Good initiatives in place. More can be done based on historic number of available conservable days.

HIP #7: Housekeeping ($.6M)	New facility, reduced ALC	Current cost structure far above benchmark in old facility *(will implement at new site)*	Achievable, but already near benchmark levels for support services overall.
HIP #8: General non-clinical service changes ($.5M)	Reduction in travel, consulting, management fees, supplies not required at new site; Facility insurance is now part of consortium costs	Expense reductions (*implemented);* Insurance *(will implement at new site)*	Achievable
HIP #9: Operating reductions from new hospital/single site ($3.2 M)	Elimination of duplicate sites and services, related transportation costs, and elimination of non-clinical services (e.g. print shop)	Hospital currently has off-site laundry, clinic facilities, and two hospital sites requiring significant transportation and duplicated infrastructure *(will implement at new site)*	Potential duplication with HIP #7 above. Stretch target, but achievable
HIP #10: Renal Dialysis Program ($1,103,353)	Discontinue use of global funds to supplement funding by Ontario Renal Network; installation of new equipment and reduce supply expenses	Full scope RPN *(implemented);* Reduced supply costs for haemodialysis *(in progress) ($300,000 from both initiatives)*	Relying on ministry new funding formula *($800,000 no validation received to date from MOHLTC*). This program has higher cost per visit compared to peers so alternative opportunities may exist.
HIP #11: Oncology Program ($312,890)	Discontinue use of global funds to support Algoma District Cancer Program	Reduce patient care coordinator, manager clinical trials, clerical *(will implement at new site)*	Achievable
HIP #12: ALC Rate 15% and Utilization Management ($5,906,210)	Reduction of ALC days and acute conservable days and reduce number of beds in operation by 72 beds on average	Annual operating costs for keeping 68 ALC beds at Plummer site is estimated at $6.6 million and capital costs of $0.42 million (preliminary estimates of operating/capital costs, more in-depth analysis is being conducted); Assess/Restore Unit *(implemented one-time funding for 26-beds until Mar 31, 2011; evaluation to be provided to LHIN with a request for on-going funding)*, Home First/Integrated Discharge Planning *(initiated, will fully implement at new site)*	Requires funding support from the LHIN. Peer Review Team recommends not taking patients to new site.
HIP #13: Constant Care ($977,547)	Reduce constant care in medical/surgical programs; Monitor staff safety and patient events	Revised hospital constant care policy; Revised ED policy for constant care *(implemented)*; Manager approval for constant care *(implemented);* Develop protocols (delirium, dementia) *(in progress)*	Stretch goal.
HIP #14: Surgical ($200,000)	Medical/surgical beds staffed like medical beds (full scope RPN)	Full scope RPN for 5 medical/surgical beds transferred to surgical unit *(implemented)*	Achievable
HIP #15: Critical Care ($343,604)	Implement appropriate staffing schedules and patterns; Reduce supply costs	Adjust ICU staff/patient assignment for Added Responsibility RN (telemetry beds being transferred to Acute Medical Unit) *(will be implemented at new site)*; Reduce supply costs	Given the footprint of the ICU in the new building, new PCOP funding has been recommended. Unlikely to achieve

		through standardization (*will implement at new site)*	expense reduction.
HIP #16: Emergency ($445,881)	Appropriate mix PT/FT; Utilization of pay for results funds to maximize flow	Fast Track changed to full scope RPN *(implemented)*; Staggered shift reduced RN *(implemented)*	Achievable.
HIP #17: Mental Health ($224,000)	Operate 30 beds within same level of funding	Operate 30 beds within same level of funding; Vacant position not filled *(implemented)*; Eliminate 0.5 ECT RN *(implemented)*; Reduced clerical support, costs in outpatient/off-site services *(will implement April 1st)*	Achievable
HIP #18: Maternal/Child ($132,390)	Not renewing MORE OB contract ($67,390) and have department absorb ($65,000)	Not renewing MOREOB contract *(will implement);* absorb remaining target through reduced costs across all programs *(will implement at new site)*	Achievable
HIP #19: Oncology Inpatient ($432,000)	Reduce staffing to be consistent with inpatient population	Reduce RN around the clock for 8 Oncology beds to be consistent with staffing for High Acuity Medical Unit *(will implement at new site)*	Achievable
HIP #20: Vascular Access ($50,000)	Tightening eligibility criteria	Reduce 0.5 FTE RN Chemo Suite and 0.5 FTE RN Medical Day Care *(will implement at new site)*	Achievable
HIP #21: Nurse Educators ($200,000)	Reduce Nurse Educators, implement new technologies	Reduce 4 Nurse Educators *(will be implemented in Sept, $400,000 annualized);* implement electronic solutions for education, tracking, occurrence reporting (*will implement in Sept)*	Achievable
HIP #22: Telehealth ($57,720)	Assign duties to primary nurses in Cancer Clinic	Reduce staffing, telehealth equipment will be in clinical areas and primary nurses assume role *(will implement at new site)*	Achievable
HIP #23: General Clinics/Clinical ($67,903)	Maximize revenue in Pacemaker Clinic ($15,777); Reduce expenditures in Medical Palliative Care ($24,903); and set satellite facilities budget increases commensurate with increase received in Small Hospital Funding ($27,223)	Pacemaker Clinic revenue increases *(will implement at new site)*; Medical Palliative Care will integrate into Medical Unit staffing model *(will implement at new site)*; Satellite facilities for Matthews and Thessalon aligned with funding *(implemented for 2011/12 budget)*	Achievable
HIP #24: Top-Ups $318,289	Discontinue locum top-ups from global funding	Advised Locums *(implemented)*	Stretch goal.
HIP #25: Hospitalists $1,439,000	Have program funded through alternate physician remuneration models, including enhanced MRP code funding, that would replace global funding	2011/12 budget will be held at 2010/11 actual costs ($800,000) *(this has been accounted for in contingency fund)*; New funding for growth $639,000 will be pursued through an AFP	Covered in contingency.

Our comments regarding the appropriateness and potential achievement of the specific elements of the above plan are set out below:

- We reviewed the anticipated inflationary increases and we conclude that appropriate assumptions have been made.

- (HIP #1) Additional base funding ($2.6 million) based on a .75% increase in 2010/11 and 1.5% increase in 2011/12. While the LHIN has apparently reviewed and agreed with the 2011/12 assumption ($1.7 million), the Peer Review Team cannot find any rational basis for this assumption. There has been no indication from the MOHLTC of base funding increases for the next fiscal year, and any discussions in the industry would suggest that there will likely be very limited base increases.

Recommendation # 7: SAH should review its assumption for MOHLTC funding increases and revise its plan to reflect a more conservative estimate of possible funding increase. Even if the MOHLTC/NE LHIN does provide funding at a higher level this will generate a funding "cushion" to deal with other eventualities.

- (HIP #2, #3, #4) Human Resource changes of $2.2 million are related to reductions of sick time, overtime and NEER (the Workplace Safety and Insurance Board's New Experimental Experience Rating) surcharges. These are aggressive targets.

  The plan includes revision of policies and processes, and development of practices for appropriate management and oversight. The elimination of the Central Staffing Office and moving towards eliminating the various Float Pools is shifting accountability to managers for replacement of sick time, approval of overtime, and approval of constant care. However, we suspect that there are deeply engrained cultural aspects that will be difficult to change immediately. The hospital is hiring staff as a means to achieve the plan – which we encourage and applaud – for example, managers have redone their master schedules and increased part-time staffing complement where appropriate. In addition, although the hospital was making progress on its overtime reduction plans through March 2010, overtime began to increase again in the earlier part of the current fiscal year, but with focused attention from the CEO, COO, CFO, and VP HR, has now experienced 3 months in a row of demonstrated improvement. Similarly, the hospital has seen a demonstrated improvement in sick time for the past 4 months in a row. This team realizes that much more work needs to be done before one could declare that these issues have been solved, but is committed and has appropriate tools in place to manage the situation.

- (HIP #5) Reduction of management and operational staff positions at the new site will achieve the target of $1.1 million; all requests for new hires are reviewed by the Senior Management Team and require CEO approval.

- (HIP #6) Reorganizing resources related to patient flow has a target of $0.7 million to be achieved through reduced length of stay (LOS) and conservable days. Initiatives that have been implemented include patient rounds, SAH and CCAC case managers, and mobilization standards. SAH has identified that at the new site, Home First/Integrated Discharge Planning will be fully implemented as well as a review of care delivery models will be undertaken. ALC aside, the hospital has had approximately 9,000 conservable days at the 75th percentile and 5,000 conservable days at the 50th percentile for the past several years. The ALC conservable days exceed 23,000, which has been a major distraction to any meaningful progress on these initiatives. Since ALC patients will not be moving to the new facility, an ideal opportunity is provided to address patient flow.

Recommendation # 8: SAH needs to implement additional strategies to address clinical utilization (reduce LOS, conservable days, and readmission rates) including a review of care delivery models and senior friendly initiatives. Specifically the hospital should review patients who stay longer than necessary due to inefficient clinical practice, turnaround times of diagnostic and therapeutic services, other hospital related delays in timely discharge and ensure it has the most efficient mix of RN and RPN and other healthcare workers.

- (HIP #7) Housekeeping reduction of $0.6 million. The rationale for this decrease is based on the fact that there are inherent extra costs in the cleaning of two very old buildings. However, a comparison to the HIT tool would suggest that the hospital is already amongst best practice providers in all areas of support services. This specific initiative may be possible, but the hospital should be cautious that they have not double-counted the opportunity between existing operations and HIP #9 below. The post construction operating plan (PCOP) allows for an increase for the extra square footage of the new facility based on the current cost structure. Management is confident that this is not double counted and that the saving here and at #9 will be achieved.

- (HIP #8) General non-clinical service changes. This item includes reducing travel, conferences, management fees and computer purchases. These represent prudent changes particularly with the move to the new facility, asset refresh, and the need to focus on operational efficiencies in the short term. However, we would note that this is not sustainable in the long run and will need to be addressed in future years.

- (HIP #9) Operating efficiencies from new hospital/single site ($3.2 million). The hospital operated two hospital sites plus Riverview Centre and an external laundry facility. These savings will be achieved by amalgamating all operations on one site, primarily through removing duplications of services, supervisory effort and transportation costs between sites. The initiative also includes additional preferred

accommodation revenue ($150,000) and the closure of the Print Shop ($250,000). The single largest element is a reduction in maintenance costs ($1.2 million) due to the differences in the new facility versus the current old facilities. This item appears to be a stretch target, but should be achievable.

- (HIP #10) Specially funded programs to operate within current funding envelope. The Renal Dialysis Program ($1.1 million) currently operates in excess of the funded levels. The Renal Program has developed specific targets to achieve $.3 million of savings, but is waiting for an anticipated funding formula change from the Ontario Renal Network to increase funding by $.8 million to achieve the full target. No contingency plans are in place if the funding formula change does not occur. An analysis through the Hospital Indicator Tool (HIT) and the hospital's benchmarking data would suggest that there is significant opportunity for improvement in operations of the Renal Program at SAH. HIT would suggest that there are more visits and a higher cost per visit than peer hospitals.

Recommendation # 9: The Renal Program's anticipated MOHLTC funding of $0.8 million requires a contingency plan should this funding not be realized. The program should be reviewed in detail to determine if there are further opportunities to improve cost and volume performance.

- (HIP #11) The Oncology Program budget has been aligned with funding received from all sources to support the Algoma District Cancer Program for $0.3 million of savings. This will be achieved at the new site through reducing positions.

- (HIP #12) 15% ALC target ($5.9 million). This is essentially new revenue that the LHIN must find to support 68 beds in an alternative location. We strongly agree that the majority of ALC patients should not be transferred to the new SAH facility. *If that were to happen SAH would have virtually no opportunity to get the new facility operating in an appropriate and efficient manner. In fact, the new facility may not even have sufficient space to accommodate the number of ALC patients currently in SAH*. In January 2011, there were on average 80+ ALC patients and on average 23 patients in short stay complex continuing care (Assess and Restore Unit). In the new hospital, there will be capacity for 35-37 overflow beds and a 26-bed Assess and Restore Unit (TCU). Several alternatives have been examined by the community and one was identified as a viable alternative, however, during the course of the peer review it was identified by the NE LHIN, SAH and third parties that this alternative was no longer viable. It seems that the only option that remains is to cohort the ALC population at the Plummer site and that SAH be funded to continue to provide care to this patient population until permanent new physical capacity becomes available. Keeping 68 ALC beds at the Plummer site is estimated, by SAH, to have an annual cost of approximately $7

million operating costs and $0.42 capital costs. These are preliminary estimates and more in-depth operating/capital cost analysis is being conducted. The Peer Review Team has not had the opportunity to review this other than as high level estimates.

Once adequate additional physical capacity is available the old sites should be decommissioned and alternative uses sought. As a result, additional temporary funding will be required to ensure that the hospital has a chance of success in its new location. The hospital has for many months been planning under two scenarios: the first being to move all ALC patients to the new site; and the second to accommodate them on the Complex Continuing Care unit at the Plummer site. The hospital decided in late December that it would only plan for the ALC population staying at the Plummer site and has taken the uncertainty away from the move planning by declaring this. Thus all move planning is based on not moving the non-ALC population. We fully concur with this approach as moving the ALC population jeopardises the hospital's chance of financial turnaround and in our view would result in all the existing inefficiencies being ingrained into the new facility.

Recommendation # 10: The 68 ALC beds should remain at the Plummer site in the short to medium term. The NE LHIN should continue to work quickly with the MOHLTC to identify the source and feasibility of funding for these beds. (RECOMMENDATION UPDATE: The NE LHIN has been working on a strategy to retain space at the Plummer site on a short term basis and to develop additional long-term care capacity on a permanent basis. On February 15, 2011, the MOHLTC provided $6.6 million in additional annual funding to support this strategy.)

- (HIP #13) To achieve a reduction in constant care of $1 million in medical and surgical programs, the hospital policy was revised, as well as the policy for constant care in the Emergency Department. Constant care is linked to overcapacity, as overflow beds do not lend themselves to efficient bed configurations and geographically locating similar types of patients requiring close monitoring for patient safety.

- (HIP #14 to # 23) Each clinical area has a HIP target and plan which has been implemented or will be implemented at the new hospital. This reduction of $2.2 million will be achieved in surgery, critical care, emergency, mental health, maternal child, inpatient oncology, vascular access, nurse educators, Telehealth, and general clinics/clinical. Some of the strategies include reducing positions, changing staff/patient ratios, changing staff skill mix, and reducing supply costs.

  To improve continuity of care and transfer between care providers, the new hospital is changing to a closed ICU model (with dedicated Intensivists). Internal Medicine managed the ICU who as of March 7,

2011 would no longer provide coverage. The hospital has been working on an interim plan (locum day coverage, night coverage by General Internal Medicine, Intensivist recruitment). At present, 50% of Internal Medicine on-call coverage is provided by Locums.

Recommendation # 11: A transition plan needs to be developed for physician integration to the new site; physician coverage for the closed ICU is a priority. This must be complete by March 6, 2011. (RECOMMENDATION UPDATE: Although an interim strategy was implemented, a longer-term plan is required.)

- (HIP #24 and #25) No global funds for physician clinical services ($1.8 million). What the hospital is proposing here is that it will stop funding physician services through its global budget. While this is admirable and a goal of the MOHLTC, there is a high risk that this initiative will not be achieved given SAH's inability to attract an appropriate cadre of specialist and subspecialist physicians. Locums have been advised that top-ups will not be provided ($.3 million); there is a provision in the contingency fund for exceptional circumstances. At the new hospital, hospitalists manage patients on a moderate acuity medical unit, a complex care unit with nurse practitioner support, and a rehab unit. Furthermore, withdrawing financial support for the hospitalist program at this time without an alternative plan for managing in-patients will be problematic. At a time when the hospital wants to make significant other changes including utilization improvements, it will be critical that there is an adequate complement of physicians and supporting resources at the Hospital. To achieve this goal, several years of transition may be required as well as new Provincial incentives or funding schemes that incent physicians to provide in-patient hospital care.

Recommendation #12: SAH needs to find other savings opportunities or utilise its contingency in the HIP as its ability to stop this payment stream is very limited until funding models for Hospitalists and Internal Medicine are amended to provide appropriate incentives to providing in-patient hospital care. SAH should continue to work with other hospitals and its association to advocate for revision to funding arrangements.

The HIP is designed to save $21.8 million by March 2012 based on a total estimated requirement of $21.2 million comprised of the $12.4 million deficit reported at March 2010 plus anticipated inflationary increases over the subsequent 2 years of $8.8 million.

Our general comments on the 2010 HIP are that it is an excellent starting point from which SAH can build a more aggressive turnaround plan that will lead it to success. Our view is that this can be achieved without any significant service reduction. This does not mean that the service profile should not change, but rather that SAH is operating in a zero-sum change environment. Consequently services that are needed by the community will need to be implemented only when appropriate funding is in place. Furthermore, where there is need for

expansion of certain existing services (e.g., ENT surgery) these need to be accommodated by the elimination of other procedures that have limited efficacy for the community.

As a result of the observations above, it is important that the hospital develop further initiatives for efficiency, waste reduction, and revenue generation beyond what has been done to date. All hospitals are facing significant challenges in the coming years, but SAH is starting from behind, and must make up ground. If the Peer Review Team is correct, and there are some overly optimistic assumptions, or if there is slippage in any of the initiatives, or even just to get a head-start on future years, it would be prudent to have some additional initiatives for consideration in the very near future.

The hospital's benchmarking opportunities may provide some clues. While one should always be careful with benchmarking, there are apparently some significant opportunities that might provide direction for a team to review and consider if operations can be improved. As is common in many healthcare institutions, people often try to "*trash the data"* or find why they cannot achieve a benchmark. SAH should be prepared for this reaction, and should insist that effort and energy should be devoted to how to do something rather than on why they can't. The mantra and attitude going forward must reflect a "just do it" culture. While the Peer Review Team has not done an in-depth study, the hospital's benchmarking would offer opportunities for a more in-depth analysis.

Recommendation # 13: SAH must achieve a balanced position in 2011/12. This is non-negotiable, and is required to rebuild credibility with the NE LHIN and the MOHLTC, in addition to rebuilding financial health.

Recommendation # 14: SAH Board of Directors should define a policy that specifies that any new services or programs should not be introduced without appropriate funding being in place and that expansion of existing services can only be provided within existing resources or through new funding.

Recommendation # 15: SAH should develop a further list of initiatives as either a mitigating strategy or to commence the process of balancing for future years.

Recommendation # 16: SAH should continue to work with the NE LHIN to identify strategies to address one time costs ($3.5 million) associated with the HIP implementation. If the NE LHIN is not able to support the hospital, further cost reduction changes will be required by SAH to achieve the overall balanced target by March 2012.

Terms of Reference # 2

2. The peer reviewer, with oversight of the NE LHIN, will work with the hospital to develop an implementation plan for the HIP.

Based on our preliminary analysis above it is clear that the HIP will not address the depth of issues facing SAH. From an operational perspective more needs to be done to drive down the operating costs. Much of this has been articulated above, however here are further high-level observations.

Post Construction Operating Plan Funding

While the focus of the Peer Review team is not on the Post Construction Operating Plan (PCOP) funding, it is clear that the traditional introduction of this funding model will cause significant issues for the hospital. Substantial changes will need to be made to the model to ensure that appropriate funding is provided for the changes in operations arising from this greenfield facility. The traditional PCOP model provides funding for new volume of activity and an extrapolation of building support costs from the previous facility operations. This new greenfield hospital has only a relatively small amount of outpatient activity growth but roughly 50% more space than current operations.

There may be other elements requiring negotiation, but the following significant elements have been observed which must be addressed:

- Emergency Department – the functional program and the resulting facility footprint are much larger and designed in an entirely different configuration than operations at the General site. Despite no anticipated growth in volumes, the cost of operations will be substantially higher. The "pod" design and larger space will require more nursing staff to ensure an appropriate safe care environment. In addition, the design incorporates a Clinical Decision Unit which can be very effective in managing patients throughout the organization. It is estimated that staffing the larger space and CDU would add approximately $1.4 million to the cost of operations**.**
- Critical Care – this unit has also been designed much differently than operations at the General site. The new facility provides for 12 ICU and 2 overflow beds. Operations at the General site included 6 critical care ventilated and 6 non-ventilated beds. The hospital is likely to see substantial pressure to operate all 14 beds, and will have to be very diligent to maintain just 12 beds. Two incremental ICU beds would typically cost $800,000-$1,000,000. All of the new rooms would allow 1:2 nurse to patient ratios, but nothing higher due to the configuration. The current ratio for staffing the non-vented beds is approximately 1:3 (depending on patient acuity), and therefore, approximately a $300,000 annual difference in staffing alone.
- Operating Rooms – the functional program and the resulting facility design have increased the number of operating rooms from 4 to 5 which the Peer Review team estimates would add approximately $1 million to the cost of operations.
- Facility costs – the current PCOP model uses a linear extrapolation of current utility and building support costs to the new facility. However, the

new fire code, electrical, building and air handling standards are substantially different than in the old facilities. An engineering study would need to be completed to understand the total implications.

- The Transitional Care Unit (26 beds) will not be opened unless there is continued funding from the NE LHIN; SAH is conducting an evaluation of the Assess and Restore Unit pilot and request for on-going funding.
- Radiation therapy – the PCOP needs to address that there are no start-up funds (approximately $800,000). It is understood by the Peer Review Team that other hospitals receive $300,000 per radiation bunker for commissioning which would assist with offsetting these transition costs. It appears that calibration funding of $325,000 has been provided through the PCOP.

Recommendation # 17: PCOP development and negotiation for a greenfield facility is a complex issue. SAH should seek expert support on the development and negotiation of its PCOP application.

Terms of Reference #3

3. The peer reviewer will assess the readiness and capacity of the hospitals management team to implement the HIP and account for its results.

There have been substantial changes in both the senior and middle management teams in the last 5 years and in particular in the last 30 months. In our view the changes in the last 24 months have resulted in a strengthening of the Senior Management Team.

A new CFO was appointed October 29, 2007 and subsequently left in May 2009 The incumbent CFO was appointed October 26, 2009. The hospital has also had massive turnover in key financial management positions with 9 different Directors or Managers of Finance over an 8 year period.

The CFO has extensive experience in the MUSH sector and with financially troubled organizations. The focus of his work has been on the 2011/12 operating year. All budgets have essentially been zero-based, where each manager was asked and extensively challenged to provide a budget that would reflect operations in the new facility. The focus was not on the new facility per se, and may be a subtlety, but due to the timing of the move to the new facility, provides the opportunity to totally rethink operations in the new setting where adjacencies and other operating elements will be substantially different than the current two hospital site model.

The CFO created a process for monitoring progress against all initiatives, and with the VP Human Resources and the COO has rolled up their sleeves to review and monitor each element of the plan in exhaustive detail. While this would not

normally be the role of these senior staff, they believe that the magnitude of the effort and the need for continuous monitoring will require this level of oversight for the foreseeable future. The Peer Review Team applauds this initiative.

The CFO has also had to totally rebuild his team of Finance and IT professionals. A new Director of Finance, some new analysts, and a new Chief Information Officer are now in place and providing support to the balanced budget and new hospital transition processes.

The VP Human Resources is a new position since August 2009. Previously, there was no Vice-President position, and the Human Resources function was shared with Group Health Centre. The VP of Human Resources has been rebuilding the Human Resources and Organisational Development Portfolio to better support SAH.

Staff resources are now assigned to programs to develop knowledge of the program group, the respective collective agreements, and provide HR advice to the programs. The organization is starting to build a more appropriate knowledge and approach to the collective agreements. One previous cost reduction tool used by the organisation was a hiring freeze; however, it was taken to an extreme, so there were no replacements or any recruiting at all. The organisation did not understand the operational implications of not replacing retirements, leaves, or other people leaving the organization. These processes had a significant negative impact on overtime and sick time.

The organization is now recruiting in selected areas, and reviewing “holes” in the schedules to ensure that there is an appropriate staff complement – including a review of full-time and part-time staff – to get the work done on regular rather than premium time.

There has been an analysis of sick patterns, and a full review of policies and procedures for managing sick and overtime. Manager expectations for managing sick and overtime have been clarified, and with the HR advisors, teams are better prepared to deal with sick and overtime requests and day to day management. With the assistance of HR, teams are now looking at staff mix and roles. There is much more work to be done but some success is occurring as last four months demonstrates a 26% reduction in sick time from the previous four months of this fiscal year.

A Chief Operating Officer (COO), the lead person for all clinical programs was appointed May, 2008 and then left in June 2010. The incumbent was promoted to the acting position in June 2010 and permanently appointed in October 2010.

The new COO has a comprehensive working knowledge of all the clinical programs/services and, in particular what needs to be achieved. As executive lead for over half of the HIP strategies, the COO’s depth and clarity about

required actions and her leadership style of accountability and collaboration is well respected.

As noted previously, the CEO has held the position for approximately 4 years. During this time the CEO has introduced a new accountability model for the organisation and managers and has started the implementation of the Hardwiring Excellence program to align corporate and management goals and accountabilities. The new strategic plan emphasises this model, identifies the need for process improvement methodology and has the support of the Board.

While there is clear senior leadership support for this program it is apparent that the organisation has not yet fully embraced the model. This is not atypical given the stage of introduction. This is a process of cultural change which takes time and relentless focus. A strategy has been developed to reinforce manager accountability, however with the move to the new site the challenge has been competing priorities. From the Peer Review Teams own experience programs such as this take considerable time and effort and constant monitoring to achieve sustainable culture change.

We commend the organisation for its efforts so far and encourage SAH to aggressively continue the role out and implement sustainable change at the new site.

As noted above SAH does not yet have a continuous quality improvement methodology which would allow it to engage frontline staff and drive the quality agenda broadly. It has been identified as a strategic imperative. There are several methodologies available and one in particular, Lean, is gaining favour in the industry. We caution that on the introduction of such a tool set, that it not be positioned as a cost reduction methodology. The drastic cost reduction process should be kept separate and a toolset such as Lean used as a safety net to reengineer processes to the new cost structure realities as well as ongoing quality and process improvement.

Recommendation # 18: SAH should continue with the implementation of Hardwiring Excellence and should introduce a continuous quality improvement program such as Lean. This should be done by June 30, 2011 so that the program can support the redesign of processes in the new facility as well as dealing with required process changes to deal with the resource reductions implemented as part of the restructuring plan.

One of the key responsibilities of a CEO is recruiting a team to help lead the organisation. This is a difficult and challenging responsibility that requires finding the right skills and personalities that will blend and function as a high performing team. Frank and open discussions with the CEO elicited comments that he felt he had made mistakes in hiring in the past and that some of the choices had set the organisation back in terms of its ability to turn the organisation around. We appreciated and respect the CEO's candour on this matter. We also recognise

that this is not an unusual occurrence in any organisation, building high performing teams is part art, science and gut feel and very few get it right the first time.

Another pivotal role for the CEO is describing a clear and succinct vision for the organisation and then constantly communicating and reinforcing that vision. SAH has articulated a vision and the CEO together with the Board Chair have been making many external presentations. The CEO and his team have been making similar internal communications. We received feedback from some quarters questioning whether SAH has accepted full responsibility for resolving its own problems or at least taking the lead on resolution of those problems where they transcend the organisation's boundaries. Our review of the documented messaging in presentations does not support this view, however, it apparently exists. The need for continuous, consistent communication is highlighted by these perceptions.

The vagaries of historic funding of hospitals are rampant in the Ontario healthcare system. There are currently few if any meaningful and objective ways of comparing funding levels between populations and individual hospital providers. It is critically important that this issue does not cloud any communications internally or externally and certainly reliance should not be placed on resolution of any perceived gaps in the short term.

The Peer Review Team has had the opportunity to spend time over the last few weeks with all members of the Senior Management Team as individuals and as a group. We have collectively concluded that this relatively new team is coming to grips with the huge challenges they face. There appears to be both a plan and a willingness to tackle the issues. There appears to be strong Board support for this approach. What remains to be seen is whether the team has the toughness to do what has to be done in this incredibly difficult situation.

Recommendation # 19: We recommend that the existing Senior Management Team be given a clear mandate to fix the financial issues and realise a financial breakeven for the year ending March 31, 2012, that they be held strictly accountable by the SAH Board. Further, they be required to have delivered a multi-year plan to achieve a sustainable surplus by December 31, 2011.

Terms of Reference # 4

4. The peer reviewer will assess the readiness and capacity of the hospitals management team to successfully implement the move to the new facility.

The Sault Area Hospital project involves the consolidation of the Plummer and General sites of the Sault Area Hospital onto a greenfield site. The project resulted in the construction of a new three-story facility in excess of 580,000

square feet. The new hospital is located at Great Northern Road and Third Line on approximately 53 acres of land. The new building will accommodate 291 acute care, rehabilitation, mental health and complex continuing care beds, support services and outpatient programs and the introduction of a radiation treatment bunker as a satellite to the North East Regional Oncology Program. The following summarizes major milestones for the SAH new-build:

- Selection of preferred proponent - June 2007
- Financial and commercial Close - Aug. 15, 2007
- Ground-breaking - Aug. 23, 2007
- Occupancy permits - Aug. 19, 2010
- Substantial completion - Oct. 13, 2010
- Orientation and training - Oct. 15, 2010 – Mar. 4, 2011
- Public open house - Feb. 2011
- Patient move - Mar. 6, 2011

At the time of writing this report, the Team assessed the status in the following key areas in order to determine the operational readiness and capacity to move into the new facility:

- Physical facility;
- Furniture, fixtures and equipment;
- Physical relocation strategy;
- Technology;
- New facility orientation;
- Communications; and
- Financial.

Physical Facility

On Oct. 13, 2010 SAH reached Substantial completion of the Project (on time and on budget), at which time the facility was handed over to the hospital to begin its transition planning leading up to occupancy. Some key features of the new SAH include:

Facilities & Services	Service level /% increase
Square footage	Approximately 583,000 20% larger than two existing sites combined
Expanded emergency department	Doubling in size from existing facilities
Additional private rooms	50% in medical/surgical units 45% overall in inpatient units

The building systems are installed and commissioned and maintenance employees have been transitioned and have received the majority of training.

Training on the remaining systems scheduled for January 2011 included: laundry; food services; walk-in refrigerators and freezers; RO water system; and patient wandering and infant security system.

Hospital Infrastructure Partners will maintain the hospital for 30 years (2010 – 2040) and be responsible for the building maintenance, repair and lifecycle replacement during that period. Lifecycle maintenance represents the total cost of replacing, refurbishing and refreshing building structure and systems over their useful life. Lifecycle Costs will involve the replacement of the facility's base building elements that have exceeded their useful life (e.g., floor finishes and certain mechanical and electrical components) and will be returned in a state acceptable to the hospital at the end of the agreement. Performance Monitoring Reports are being submitted on a monthly basis; these reports are structured as a scorecard for a variety of facility condition targets and speak to the readiness of the facility to be occupied, not to mention as a measure of the output specifications for the maintain component of the AFP model.

The project has not reached Total Completion and the hospital continues to work on the Transition and Occupancy Plan and occupied the building on March 6, 2011, which is one month ahead of the original contract date.

Furniture, Furnishings & Equipment (FF&E)

The SAH total equipment budget is $27M which is made up of $21.7M for FF&E and $5.2M allowance for minor, non-depreciable equipment. FF&E is structured in two streams – the first is classified as fixed equipment; the second as functional equipment. Fixed equipment represent large pieces of equipment that are integrated or built-in to the facility infrastructure – these include large pieces of diagnostic imaging equipment, sterilizers, commercial washers and dryers, medical gas towers, surgical lights, etc. As of Dec. 22, 2010 these types of equipment have either been installed or, as in the case of the commercial washers and dryers, are on-site being installed.

FF&E included in the functional stream represents all other requirements including roll-in equipment, office furnishings, etc. The procurement of this equipment, fixtures and furnishings is well underway with the majority of purchase orders issued and equipment received and/or in various stages of delivery. Delivery of FF&E has been staggered over 5 months beginning in October 2010 and concluding by February 2011.

The only minor item of concern is the digital mammography machine which, at this time, will likely not be ready for installation by March 6, 2011. This equipment is currently waiting licensing from Health Canada. To mitigate this risk the vendor has agreed to relocate the existing mammography unit to the new hospital at the vendor's expense. There is a robust procurement plan and tracking system in place that is well managed.

Physical Relocation

SAH has retained Health Care Relocations(HCR) to assist with the management, planning, coordination and actual physical relocation of the facility. HCR is well known and has a proven track record for successfully accomplishing health facility moves. Combined with a dedicated team at SAH the outcome has been a comprehensive and detailed strategy and plan for executing the move. A New Hospital Move Coordination Team and New Hospital Occupancy Steering Committee have been established to provide leadership and assistance with the planned relocation as well as to address any concerns and/or issues that may arise. Responsibilities and accountabilities have been established in departmental protocols for moving day (including designated moving teams) and the final move sequence plan and move schedule has been developed, and has been well communicated. In essence, the move will take place over a 3 week period culminating with the patient move on March 6, 2011. To facilitate the move, both Service Level Reduction and Post Move Recovery plans have been developed. The Service Level Reduction plan includes reducing patient census on the day of the move from 291 to 211 and includes service curtailment (e.g. emergency department, operating rooms) at 05:59 hours at the old facilities, and cut over to the new hospital at 06:00 hours. Discussions with walk-in clinics have been undertaken and two (2) clinics have agreed to open on the weekend of the move to relieve some of the pressures on the emergency department. At this time (January 24th 2011) the largest ambulatory care provider, Group Health Centre, has not agreed to provide this kind of support. The Post Move Recovery plan is based on a 15-day ramp-up for services to resume to 100% capacity. Although the hospital team identifies the potential cancellation of procedures should unforeseen operational challenges arise, the 15-day window is aggressive from the point of view of staff being comfortable with new technologies, new processes, etc. SAH should not underestimate the challenge of moving into and occupying a new building with the new technologies that have been introduced.

Both internal (within the buildings) and external (to the new hospital) move transfer routes have been identified and a “mock” patient move undertaken including the participation of local EMS services. The mock exercise resulted in adjustments to patient and equipment flow to keep these activities separate and a back-up moving route has been identified and mapped.

Activities seem to be on track and, although still implementing, the teams seem to be aware of potential risks and have developed strategies to address them. The "90 day no-fly zone" (where no new initiatives are taken on and/or where critical elements should previously have been completed) is an important element, however, strict adherence to this protocol will be a challenge.

Some units are still developing the details of their transition plans so not all is fully complete - which could create issues - but the processes, support and oversight are there to manage it. SAH needs to lock down on what to do with the

ALC. The current move strategy was developed on the assumption that all patients would be moved into the new hospital; ALC along with supporting equipment, staffing, etc., is planned to be moved prior to Feb. 21, 2011.

Detailed planning has been done to keep the ALC patients in the existing space and the decision has been taken by SAH leadership. Apparently the "Move Consultants" had not been informed of this as of Jan. 13th. It appears that there are some communication issues on the team and Senior Management is in the process of resolving this communication issue.

The Functional Program identified the following bed breakdown.

Beds	2008/09
Maternal -child	21
Medical/surgical/oncology	155
Critical care/stepdown	14
Rehabilitation	26
Mental Health	25
Complex Continuing Care	50
ALC	-
Total	289
	2009/10
Paediatric Mental Health	2

The NE LHIN has endorsed the addition of 7 mental health beds to the hospital and no further ministry approvals are required to expand the services. The addition of 7 beds to the approved Mental Health Functional Program will be accommodated by repurposing six (6) bedrooms from the Level 1 Medical Unit for use by the Mental Health Program. There will be additional renovations and costs, which are proposed by SAH to be funded through the HIRF allowance for 2010/11; although HIRF funding does not typically apply to this type of project. The SAH will be expected to incorporate these beds in the existing bed complement of the approved beds for the new hospital and to fund the 7 beds within its existing operating allocation. The mental health bed capital submission for this change to the approved Functional Program has been reviewed and approved by HCIB. HCIB has indicated that, in respect of the capital retrofits that are required, it is the ministry's expectation that it will be in compliance with the appropriate legislation such as the Public Hospitals Act, and with the policy and process set out in the Capital Planning Manual and including applicable procurement policies. As such, the ministry requires that an FEC be submitted for review before the ministry can approve the project to proceed. Although SAH is planning on proceeding with the planned change and HCIB is aware of the hospital's wish to complete the necessary renovation no ministry approval has been issued. The renovation of the additional beds is likely to impact SAH's ability to occupy the additional beds at the time of the move.

Recommendation # 20: SAH should consider extending the duration of the Post Move Recovery Plan period to ensure a smooth transition and "shake down" of operating processes in the new facility.

Recommendation # 21: Transition Plans need to be finalized ASAP. In particular, physician training requires more focused attention and must be complete by the end of February 2011. (RECOMMENDATION UPDATE: Transition plans were completed prior to the move.)

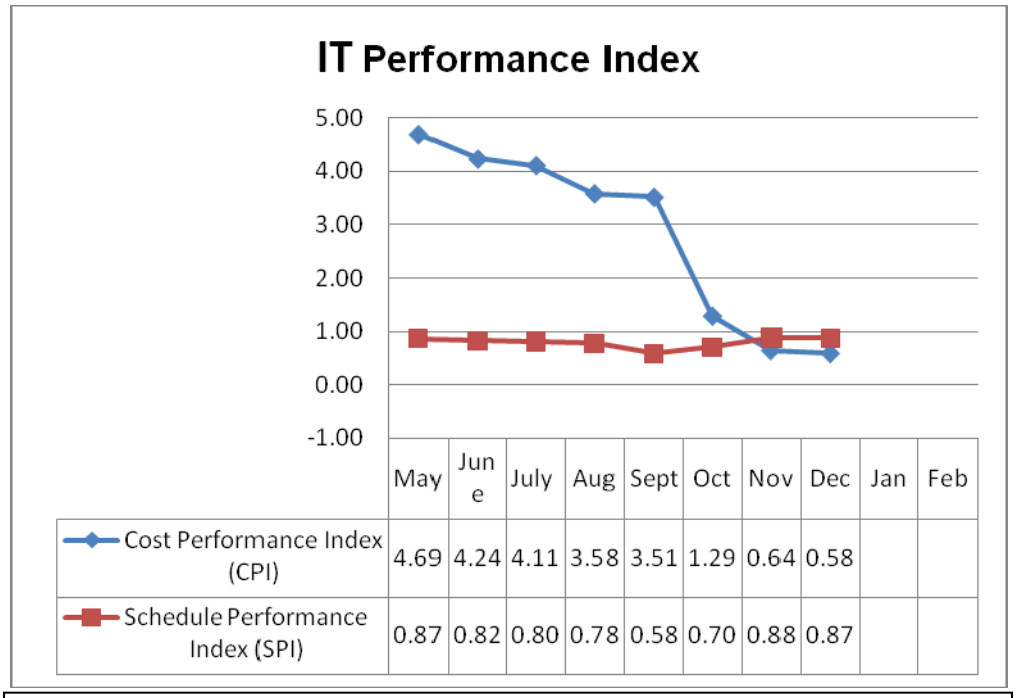
Recommendation # 22: ALC patients must remain at the existing site. (We fully support the SAH's decision in this regard.) The impact on the relocation plan, the logistics of supporting this patient population and a plan of action needs to be broadly communicated to all relevant parties. (In late December 2010, SAH decided that it would only plan for the ALC population staying at the Plummer site.)

Recommendation # 23: SAH continue discussions with the MOHLTC Capital Branch to resolve funding issues, approvals and expectations for the mental health capital retrofit.

Technology

Information Technology & Services

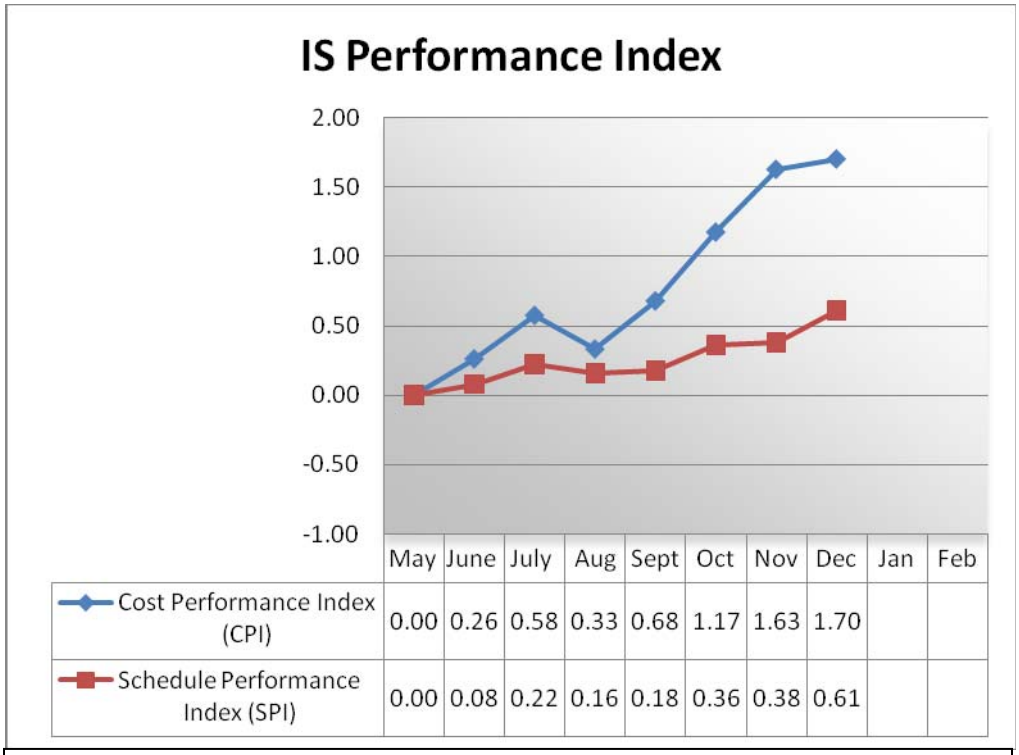
The technology and infrastructure plan is tracked under two categories: IS Tasks; and IT Tasks. The IT tasks are predominantly network infrastructure, telecom, computer hardware, and software related tasks. The IS tasks are mainly Meditech rebuilds and Meditech interface related tasks as well as application related tasks. IT and IS got off to a slow start and, despite having made up ground in the fall 2010, continues to track marginally behind schedule as evidenced by the Schedule Performance Index (SPI).



	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Cost Performance Index (CPI)	4.69	4.24	4.11	3.58	3.51	1.29	0.64	0.58		
Schedule Performance Index (SPI)	0.87	0.82	0.80	0.78	0.58	0.70	0.88	0.87		

- Ideally the Cost Performance Index should be tracking at 1. Tracking below 1 indicates that expenditures have increased. The purchasing budget constraints of August and September were substantially released in October, November and December such that the project was not spending money fast enough and has now begun to catch up on spending.
- Ideally the Scheduled Performance Index should be tracking at 1. Tracking below 1 indicates that the project is still behind schedule.

Source: SAH



	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Cost Performance Index (CPI)	0.00	0.26	0.58	0.33	0.68	1.17	1.63	1.70		
Schedule Performance Index (SPI)	0.00	0.08	0.22	0.16	0.18	0.36	0.38	0.61		

- The SPI trends reflect the condition that the Meditech rebuilds have continuously been behind schedule. However SPI is trending upwards significantly with the completion of the rebuilds and first round of testing.

Source: SAH

At this stage of the project the greatest concern is the lack of schedule float in the implementation schedule – in other words there is little or no room for delays; there will also be a point of "no return" when adding resources to mitigate won't be effective. If the hospital gets to this point there should be a back-up plan that assesses what new IT/IS changes can be done post move. Alternatively, the Hospital may wish to bring on the additional resources now thereby creating some buffer for unforeseeable items and recovering some of the schedule slippage. To SAH's credit, the CIO has implemented a "no-fly zone" for a one (1) year period commencing in June 2010 – basically, no additional projects, changes to systems/software, etc., will be undertaken during this period unless related to the new hospital move and/or mandated by the LHIN or Ministry. This has assisted in mitigating the potential to create additional pressures on the schedule, however SAH needs to remain focused on the IT/IS component. Several critical tasks with multiple dependencies are currently being tracked – these need to be completed in January 2011 in order to not increase the risk to the project.

Recommendation # 24: SAH should consider bringing on additional IT resources now in order to recover some of the schedule slippage and create some buffer for potential unforeseeable items. This will have to be found within existing funding.

New Facility Orientation

Facility orientation is scheduled from October 15, 2010 through to March 19, 2011, within the Post Move recovery period. The new hospital project team conducted tours for staff, physicians and volunteers to acquaint them with the new building, its surroundings and systems. Orientation was structured in both classroom settings as well as in home units. The agenda for the classroom typically covered:

- General facility orientation
- Life cycle maintenance service
- Hospital design
- Expectations concerning
    - Pneumatic tube
    - Medication management
    - Codes
    - Infection control
- Service delivery models
    - Laundry
    - Food services
    - Logistics
    - Housekeeping
- Technology
- Managing change
- Visit to home unit

Clinical orientation occurred between October and December 2010 and non-clinical orientation is scheduled to run between Jan. 17, 2011 and Feb. 18, 2011. In addition, an online training module is available to staff. During the course of our review one of our team members had an opportunity to observe the surgical department clinical unit-specific orientation. This type of staff engagement allowed for a number of questions to be asked as well as provided an opportunity for staff to reconsider both patient and workflow changes from present as well as the impact of new technologies. The challenge will be in the follow-up, however, we observed a commitment to getting questions resolved and addressing concerns that were not anticipated – this included managing flow within the abundance of space now available in the new facility.

An area of concern is the participation of physicians in the orientation to the new facility. There should be ample time to accommodate this but it needs to be scheduled. There are a number of new systems and processes that will take some getting used to.

Recommendation # 25: A detailed physician training/orientation program should be completed prior to occupancy. In particular, the changes in technology need to be an area of emphasis. (RECOMMENDATION UPDATE: Completed in advance of the move.)

Communications

The New Hospital Move Communications Plan is comprehensive in its scope and targets numerous stakeholders, both internal and external. Its purpose is to support the safe transition to the new hospital. Timelines, tactics and messaging have been appropriately identified.

Financial

The hospital has employed a zero-based budgeting approach for the new facility – which is ideal and appropriate given the new surroundings and very different configuration of the hospital services. Essentially, each manager was requested to develop a budget for their new unit/department/function in the new facility. Corporate goals were developed to deal with interactions between departments and functions. Plans were reviewed in great detail by a group comprised of the Chief Operating Officer, VP Finance and VP HR and key staff from these portfolios to ensure rigour and consistency in the budget development process. In this way, the hospital has determined the needs for the new facility vs. the wants, and has also eliminated issues that can arise in budgeting when incremental change to an existing budget is contemplated. In addition, this group continues to meet bi-weekly to review progress towards the plans so that there is a very effective monitoring of the transition to the new facility from a budget and cost management perspective.

As noted previously, the PCOP is an additional concern. The traditional funding model does not always work particularly well for a greenfield site. This project also includes the new Radiation Oncology program, and transition funding is not available through CCO normal funding processes.

Recommendation # 26: The MOHLTC should consider advancing PCOP start-up funding to assist SAH with one-time costs related to occupancy, e.g. staff training, etc. which we understand is consistent with the normal PCOP process. (RECOMMENDATION UPDATE: On February 15, 2011, the MOHLTC provided SAH with $11.2 million in PCOP funding to support transition to the new hospital.)

Recommendation # 27: The hospital, NE LHIN and MOHLTC should commence negotiation of the PCOP in earnest immediately. There are several substantial issues which must be addressed as noted in this report, and since they are different than the traditional model, immediate focus is required to resolve this.

Terms of Reference #5

5. The peer reviewer will review the relationship between the hospital and its stakeholders including the LHIN, physicians in the hospital and community, and other hospitals in the community.

SAH operates somewhat in a fish bowl because of its geographic isolation. It literally is “the only hospital game in town”.

As noted elsewhere in this report the relations between SAH and the NE LHIN appear to have improved over the last 12 months although concerns still exist around the ongoing deficits.

The relationship with Group Health Centre (GHC) has been strained for many years. New leadership has been appointed at the physician group and hope has been expressed on both sides that a more open and effective relationship can be built going forward.

In the past there has been little commonality of purpose or joint programming and planning for the community between GHC and SAH. In part, this is attributable to Group Health Centre not operating under a common accountability structure with SAH as well as frictions between the hospital and community based medical staff. There is also a lack of alignment of incentives that also impacts the relationship.

Of note is that the NE LHIN has no jurisdiction whatsoever over any of the operations of Group Health Centre despite it being the second largest supplier of health services in the Algoma region after SAH. Relationships between Group Health Centre and the SAH have and continue to be strained. Much of this friction arises from SAH’s view that GHC does not effectively prevent demand on the hospital (in fact contributes to it), that its physicians (particularly GPs) do not adequately support inpatient care at the hospital. In turn the physician groups, particularly the GPs resent having to work in the SAH unlike their colleagues in southern Ontario who have effectively withdrawn from hospital practice.

One thing that GHC is committed by contract to provide to SAH is GP coverage for the in-hospital care of GP-rostered patients. This is a model that is consistent across the north including all new Family Health Teams. It is also a clear source of friction as the GP’s would prefer not to have this responsibility. There is also conflict between the Emergency Department physicians and the GPs with each feeling that the other “dumps” patients on them.

There is clearly a lack of alignment for the benefit of the patients and Sault Ste. Marie Community between GHC and SAH. Clearly the modus operandi of Group Health Centre does impact the hospital. For instance Group Health Centre operates a same day appointment clinic from 9 a.m. to 8 p.m., however, this has evolved to be effectively a by-appointment only service and any and all urgent care or demand is sent to the Emergency Department of SAH. In the opposite direction, GHC physicians report patients being told they should be seeing their GP or a walk-in clinic. Clearly this is not good for patients. There are numerous other examples of this lack of alignment, which appears to be driven by physician

desires to practice in a manner that is most beneficial to them personally rather than the community.

Recommendation # 28: The MOHLTC should revaluate the accountability structure of Group Health Centre (GHC) and consider allocation of at least the non-physician component of funding through the NE LHIN. Furthermore, GHC should be brought under the NE LHIN accountability model and should develop periodic service accountability agreements with the NE LHIN.

Recommendation # 29: SAH and GHC should set up a joint structure at the leadership level including board, physician and administrative leaders as a forum for collaborative discussions and issues management between the organisations.

Recommendation # 30: SAH and GHC should create a joint planning structure to deal with programmatic changes at each organisation to more effectively plan for the future and serving their mutual community.

SAH has developed long term relationships with the Hôpital régional de Sudbury Regional Hospital. SAH refers patients to the Sudbury Regional Hospital for tertiary services, this is dependent on the hospital's capacity to receive referrals (patient would be referred to another tertiary hospital); patients are repatriated as SAH bed availability allows. SAH refers patients for interventional cardiology, cardiac surgery, and neurosurgery. For thoracic surgery, as SAH is not a designated Cancer Care Ontario Level 1 facility, a service agreement is being developed with Sudbury Regional Hospital. Once radiation therapy is offered at SAH, Sudbury Regional Hospital will take only patients requiring more complex radiation therapy, SAH will do most oncology surgery with the exception of thoracic now that an ENT surgeon and a urologist has been recruited and a second urologist is coming in the fall. Mental Health patients requiring ECT are referred to Sudbury Regional Hospital; SAH is the schedule 1 facility for the Algoma District and receives mental health referrals from outlying areas.

Medical Leadership

Prior to 2007 relations between medical leadership and administration were very strained. Relations between the COS and the CEO appear to be strong and the COS sits as part of the current Senior Management Team of the organisation.

The Chief Of Staff position was filled from July-Oct 2006 on a shared basis by five physicians. The new COS became interim in 2006 then permanent in 2007.

The VP Medical Affairs position was created in 2008 and the incumbent sits as part of the senior management team and the MAC.

As noted previously in this report, there have also been changes in the medical staff leadership, these changes do not represent unusual turnover as there has clearly been stability in medical leadership since 2006.

Our interviews with medical leaders and a small number of frontline physicians give us concern that the medical leadership and medical staff may not be on the same page as hospital management and the Board. The following comments do not apply to all medical staff leaders as there are a small number that seem to have “got it” and they are a nucleus on which to build communication and support.

We would characterise the perspective of many the medical staff and leaders as rather limited. There does not appear to be any real acceptance of either the economic realities faced by the province nor the dire financial situation of the hospital. They know the hospital is in financial difficulty but appear to believe it is someone else’s problem, that their area is not the problem and should not be impacted. In general, they exhibit a perspective and approach that is not empathetic to the major changes that are required.

We have been informed by leaders at the Board, management and some medical leaders that, in their experience, the medical staff and leaders have come a long way in the last 3 or 4 years.

Community

We have not conducted any focus groups or analysis of community relations. We aware that the Board Chair and CEO have been spending considerable effort talking to the community and the few community leaders we have interviewed acknowledge this and indicate that the community has heard clearly that SAH has a significant financial problem that needs to be fixed locally and that a huge driver of this has been ALC patients driving over capacity in the acute care hospital.

Summary and Conclusions

We recognize that SAH faces challenges that are different to most other hospitals.

- Isolation from other major urban centres (at least 3.5 hours by road) and other health care system supports means higher utilization of hospital resources.
- Isolation means that the size of some programs is suboptimal from an economy of scale perspective but necessary from a community point of view.
- It has historically operated on two very old and very inefficient sites.

However, the imperative for financial health is no different than any other hospital.

In our view, the lack of post-acute accommodation capacity has been a fundamental driver of the deficit at SAH. This could easily represent 50% of the annual deficit for the last 5 years and 50% of the accumulated working capital deficit.

Once the post-acute capacity issue is resolved then SAH can balance its budget without any significant service reductions. To be clear, if the approximately 70 ALC patients are funded to remain at the Plummer Site or are moved to another community setting (no apparent capacity at the moment) then the remaining deficit can be eliminated without service reductions.

The Peer Review Team strongly recommended that the ALC patients not be moved to the new facility as, in our view, all of the existing inefficiencies would be locked into the new facility with very little likelihood of SAH being able to fix them. The NE LHIN had been working on a strategy to retain space at the Plummer site on a short-term basis and to develop additional long-term care capacity on a permanent basis; on February 15, 2011 the MOHLTC announced $6.6 million in additional annual funding to support this strategy.

The 2010 HIP has many achievable targets and initiatives but more needs to be done and a multiyear financial restructuring strategy needs to be developed and implemented quickly. High level benchmarking data by the hospital indicate that the opportunity for further cost reduction does exist and that there is scope to achieve at least modest surpluses in the future.

The Board, Senior Management Team and some of the Medical Leadership are on the same page and recognise the need and the urgency for decisive action. They understand that others cannot solve these problems for SAH. The first step to building credibility with the MOHLTC and the NE LHIN is to balance operations.

Future incremental funding is likely to be distributed through the HBAM formula as well as other performance based funding initiatives. Cost performance is an important aspect of that formula. *Balancing the books* will improve performance in the formulae and will therefore assist in future years.

The new facility offers opportunity and risk. The opportunity is that it can be regarded as a new start, that it provides a platform for sustained process and cultural change and the ability to operate effectively and in a financially responsible manner. The risk is that operational “shakedown” deflects focus from balancing the books in an urgent manner.

SAH has undertaken extensive planning for the move, the plans are documented, they are in the process of being implemented and risk mitigation plans are in place or are being developed. In our view SAH is well prepared for the move.

The PCOP process is not geared to dealing with greenfield sites so much negotiation will be required in this regard. The existing PCOP is not adequate to fund normal operations at the new facility. On February 15, 2011, the MOHLTC provided SAH with $11.2 million in PCOP funding to support transition to the new hospital. SAH should continue to work constructively with the NE LHIN and MOHLTC to ensure an appropriate funding level for the new hospital under the PCOP.

Relationships with physicians are a key to success and pose some ongoing risk to the organization as some of the Medical Leadership has not accepted that they have to be part of the solution and that they cannot expect others to be affected but not them. Further, relations between the major community service provider and SAH are not positive. In part this reflects lack of alignment of incentives, but also inadequate governance, and accountability structures.

We believe the leadership, management and governance talent and capacity exists at SAH to resolve the financial situation and, that this needs to be done urgently.

Appendix A

Bios

Rik GANDERTON

Rik Ganderton is the President and Chief Executive Officer of the Rouge Valley Health system, a multi-site community hospital system in the east GTA. He is a Chartered Accountant by training. He spent more than 25 years as a consultant to the healthcare industry specialising in strategic and operational performance improvement. He was formerly the National Healthcare Partner with PricewatehouseCoopers and subsequently with IBM Business Consulting. He has had extensive experience restructuring hospitals and other organisations to provide improved operational and financial performance. He has been the CEO at Rouge Valley since 2007. He has lead the operational and cultural transformation of that organisation from one of the lowest performing hospitals in the province with a history of significant financial deficits and operational problems to one that is now delivering high volumes of quality care in a timely manner and generating sustainable operating surpluses.

BRIAN EDMONDS

Brian Edmonds is a private management consultant working primarily in the role of Interim Chief Financial Officer, and offering strategic consulting advice to a variety of teaching and community, private and public health service providers as these organizations look for performance improvement opportunities. He has also acted as a member of a team advising an Ontario Ministry of Health Supervisor on the operations of a major community Hospital. Earlier in his career Brian was the Vice President, Finance of the Trillium Health Centre, and worked with a variety of Ontario Ministry of Health and Joint Policy and Planning Committees. Prior to working at Trillium, Brian played a key role in the financial turnaround of St. Michael's Hospital, a world-renowned Teaching Hospital. Brian has over 10 years of experience in the private sector including Quebecor, Bell Canada Enterprises, and The Sports Network where he worked in Corporate Finance and Accounting functions developing long range financial plans and business cases for major acquisitions. Brian has served as a Board member of several not-for-profits, including experience as Chair of the Finance Committee of the Board.

RICK GOWRIE

Rick Gowrie is a senior, client focused, Health Care Executive with 18+ years of progressive and specific experience in health facilities planning, hospital line management, facilities construction and renovations, strategic planning, and project implementation and management. Currently, the Vice-President of Capital Redevelopment, Facilities and Support Services at Rouge Valley Health

System, Rick provide leadership and accountability for this portfolio including defining portfolio strategic direction and building collaborative relationships between support services and various stakeholders.

PATRICIA PETRYSHEN

Patricia Petryshen is a healthcare consultant with senior leadership experience in large healthcare organizations and in government. Some of her past positions include: Vice President, Quality and Health Services Performance, and Executive Vice President, Acute Programs (Fraser Health Authority); Assistant Deputy Minister, Performance Management and Improvement Division, Ministry of Health Services (Government of British Columbia); and Executive Vice President, Programs, Hospital Relations, and Chief Nursing Officer (St. Michael's Hospital). Patricia has held academic appointments at several universities, conducted research, and has been appointed to national and provincial councils, boards, and foundations.

Appendix B

Peer Review Interview Listing

1. Introductory meeting with Senior Management Team as a whole.
2. Kelli-Ann Lemieux, Director, Clinical Support Services (Chief Allied Health Professional)
3. Mario Paluzzi, Director, Communications & Public Affairs
4. Brenda Lynn, Director, Oncology & Renal Programs
5. Dr. Al McLean, Chief of Staff
6. Katherine Hewitt, Director, Emergency, Critical Care & Access
7. Elaine Pitcher, Board Chair
8. Max Liedke, VP/Chief Financial Officer
9. David Orazietti, MPP
10. Cheryl Pavoni, Executive Director, Foundation
11. Marie Paluzzi, VP/Chief Operating Officer
12. Ron Gagnon, President & CEO
13. Johanne Messier-Mann, Director, Maternal Child & Medical Programs (CNO)
14. Jamie Melville, 1st Vice Chair, Board of Directors
15. Harry Koskenoja, Director, New Hospital Development
16. Joanne Dumanski, Board Member (Chair, Quality & Service Committee)
17. Jeff Weeks, Director, Information, Communications & Technology Services (CIO)
18. Peter Vaudry, Acting Chair, NE LHIN
19. Richard Joly, Chief Executive Officer, NE Community Care Access Centre (Conference Call)
20. Jane Sippell, Director, Mental Health & Addiction Programs
21. Ila Watson, VP Human Resources
22. Dr. Malcolm Brigden, Vice President, Medical Staff Association; Medical Director of Oncology
23. Dr. Emmalee Marshall, VP Medical Affairs
24. Terry Tilleczek, Senior Director, ED/ALC NE LHIN (conference call)
25. Dr. Heather O'Brien, President, Medical Staff; Chief of Anaesthesia; Interim Medical Director of Critical Care
26. Denis Turcotte, Consultant
27. Lori Bertrand, Director, Surgical Program
28. Lorne Carter, Board Member (Treasurer)
29. Dr. Kirk Zufelt, Chief of Paediatrics
30. Dr. Silvana Spadafora, Medical Oncologist
31. Greg Punch, Interim CEO, Group Health Centre
32. Dr. Robert Maloney, Chief, Hospitalist Program
33. Anthony Marrato, Board Member (Chair, Governance Committee)
34. Dr. Michael Nanne, Board Member
35. Dr. Marilyn Leahy, Chief of Family Medicine
36. Philip Virene, Board Member (Chair, New Hospital Planning Committee)

37. Dr. Donald MacIntosh, Medical Director, Emergency Program
38. Louise Paquette, CEO, NE LHIN
39. Martha Auchinleck, Senior Director, Performance & Decision Support, NE LHIN
40. Dr. David Fera, President, Algoma District Medical Group
41. Dr. Joe Reich, Medical Director, Surgical Program
42. Colleen Tew, Vice-President Integrated Healthcare Solutions, Health Care Relocations (conference call)
43. Dr. Lino Pistor, Medical Director of Mental Health Program
44. Dr. Greg Berg, Medical Director of Medical Program
45. Robin Joanisse, Manager, Emergency & Satellites
46. Mary Runde, Manager, Critical Care
47. Gisele Anderson, Manager, Maternal/Child
48. Mindy Lindstedt, Manager, Medical Unit/General Float Pool
49. Toni MacLeod, Operational Manager, Assess and Restore
50. Susan Hamel-LaFord, Manager, Care Unit, TCU
51. Cynthia Johnston, Manager, Medical Unit/Cath Lab
52. Dr. David Berry, Medical Director of Renal Program
53. Dr. David Walde, Community based Oncologist
54. Mark Lewis, New Hospital Training and Orientation Coordinator
55. Andrea Moraca, Project Manager, New Hospital
56. Giancarlo D'Ettorre, Financial Analyst
57. Joe D'Angelo, Manager Diagnostic Imaging (E-Mail)
58. Julie DeSimone, Move Coordinator, New Hospital Project Team
59. Vas Georgiou, Vice-President, Infrastructure Ontario (E-Mail)
60. Nathalie Danjoux Senior Consultant, Health Capital Investment Branch Health System Information Management and Investment Division Ministry of Health and Long-Term Care

Appendix C

Recommendations in numerical order

Recommendation # 1: The Board should consider what leadership triad offers the greatest chance of success to lead SAH through the next 12 to 24 months.

Recommendation # 2: The NE LHIN should develop a Post Acute Care Capacity plan by April 30, 2011 and submit it to the MOHLTC. The plan should consider whether the 256 beds that will be vacated in 2012, through the replacement program, offer an opportunity to catch up on the significant post-acute accommodation shortages that are driving the ALC issue at SAH. (RECOMMENDATION UPDATE – The NE LHIN has been working on a strategy to retain space at the Plummer site on a short term basis and to develop additional long-term care capacity on a permanent basis. On February 15, 2011, the MOHLTC provided $6.6 million in additional annual funding to support this strategy.)

Recommendation # 3: The NE LHIN should enhance the current structure that includes the major health providers in Sault Ste. Marie including SAH, Group Health Centre, Family Health Teams, the North East Community Care Access Centre, Long Term Care Representatives, other community providers and the municipality. This group should develop a community health plan that allows SAH to focus on its core role of acute care services and that ensures other providers make available the appropriate services, in appropriate locations and at appropriate times to ensure SAH is not the "default" provider. This should be completed by March 31, 2012 and implemented as soon as possible thereafter.

Recommendation # 4: When SAH has achieved a balanced operating position, SAH and the NE LHIN should re-examine the scope of service provided at these satellite facilities (Thessalon and Matthews Memorial).

Recommendation # 5: SAH should develop operating plans that create surpluses in future years to rebuild working capital and pay off debt and to allow it to have sustainable operations going forward. We do not recommend any special treatment for SAH to support the working capital position beyond what the NE LHIN is doing today through cash advances and what the MOHLTC may develop as a potential provincial-wide working capital solution.

Recommendation # 6: The ALC target should be clarified between SAH and the NE LHIN and if necessary be redefined to ensure that the inefficiencies inherent in managing this type of patient population do not get built into the new facility.

Recommendation # 7: SAH should review its assumption for MOHLTC funding increases and revise its plan to reflect a more conservative estimate of possible funding increase. Even if the MOHLTC/NE LHIN does provide funding at a higher level this will generate a funding "cushion" to deal with other eventualities.

Recommendation # 8: SAH needs to implement additional strategies to address clinical utilization (reduce LOS, conservable days, and readmission rates)

including a review of care delivery models and senior friendly initiatives. Specifically the hospital should review patients who stay longer than necessary due to inefficient clinical practice, turnaround times of diagnostic and therapeutic services, other hospital related delays in timely discharge and ensure it has the most efficient mix of RN and PRN and other healthcare workers.

Recommendation # 9: The Renal Program's anticipated MOHLTC funding of $0.8 million requires a contingency plan should this funding not be realized. The program should be reviewed in detail to determine if there are further opportunities to improve cost and volume performance.

Recommendation # 10: The 68 ALC beds should remain at the Plummer site in the short to medium term. The NE LHIN should continue to work quickly with the MOHLTC to identify the source and feasibility of funding for these beds. (RECOMMENDATION UPDATE: The NE LHIN has been working on a strategy to retain space at the Plummer site on a short term basis and to develop additional long-term care capacity on a permanent basis. On February 15, 2011, the MOHLTC provided $6.6 million in additional annual funding to support this strategy.)

Recommendation # 11: A transition plan needs to be developed for physician integration to the new site; physician coverage for the closed ICU is a priority. This must be complete by March 6, 2011. (RECOMMENDATION UPDATE: Although an interim strategy was implemented, a longer-term plan is required.)

Recommendation #12: SAH needs to find other savings opportunities or utilise its contingency in the HIP as its ability to stop this payment stream is very limited until funding models for Hospitalists and Internal Medicine are amended to provide appropriate incentives to providing in-patient hospital care. SAH should continue to work with other hospitals and its association to advocate for revision to funding arrangements.

Recommendation # 13: SAH must achieve a balanced position in 2011/12. This is non-negotiable, and is required to rebuild credibility with the NE LHIN and the MOHLTC, in addition to rebuilding financial health.

Recommendation # 14: SAH Board of Directors should define a policy that specifies that any new services or programs should not be introduced without appropriate funding being in place and that expansion of existing services can only be provided within existing resources or through new funding.

Recommendation # 15: SAH should develop a further list of initiatives as either a mitigating strategy or to commence the process of balancing for future years.

Recommendation # 16: SAH should continue to work with the NE LHIN to identify strategies to address one-time costs ($3.5 million) associated with the HIP implementation. If the NE LHIN is not able to support the hospital, further cost reduction changes will be required by SAH to achieve the overall balanced target by March 2012.

Recommendation # 17: PCOP development and negotiation for a greenfield facility is a complex issue. SAH should seek expert support on the development and negotiation of its PCOP application.

Recommendation # 18: SAH should continue with the implementation of Hardwiring Excellence and should introduce a continuous quality improvement program such as Lean. This should be done by June 30, 2011 so that the program can support the redesign of processes in the new facility as well as dealing with required process changes to deal with the resource reductions implemented as part of the restructuring plan.

Recommendation # 19: We recommend that the existing Senior Management Team be given a clear mandate to fix the financial issues and realise a financial breakeven for the year ending March 31, 2012, that they be held strictly accountable by the SAH Board. Further, they be required to have delivered a multi-year plan to achieve a sustainable surplus by December 31, 2011.

Recommendation # 20: SAH should consider extending the duration of the Post Move Recovery Plan period to ensure a smooth transition and "shake down" of operating processes in the new facility.

Recommendation # 21: Transition Plans need to be finalized ASAP. In particular, physician training requires more focused attention and must be complete by the end of February 2011. (RECOMMENDATION UPDATE: Transition plans were completed prior to the move.)

Recommendation # 22: ALC patients must remain at the existing site. (We fully support the SAH's decision in this regard.) The impact on the relocation plan, the logistics of supporting this patient population and a plan of action needs to be broadly communicated to all relevant parties. (In late December 2010, SAH decided that it would only plan for the ALC population staying at the Plummer site.)

Recommendation # 23: SAH continue discussions with the MOHLTC Capital Branch to resolve funding issues, approvals and expectations for the mental health capital retrofit.

Recommendation # 24: SAH should consider bringing on additional IT resources now in order to recover some of the schedule slippage and create some buffer for potential unforeseeable items. This will have to be found within existing funding.

Recommendation # 25: A detailed physician training/orientation program should be completed prior to occupancy. In particular, the changes in technology need to be an area of emphasis. (RECOMMENDATION UPDATE: Completed in advance of the move.)

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Recommendation # 27: The hospital, NE LHIN and MOHLTC should commence negotiation of the PCOP in earnest immediately. There are several substantial issues which must be addressed as noted in this report, and since they are different than the traditional model, immediate focus is required to resolve this.

Recommendation # 28: The MOHLTC should revaluate the accountability structure of Group Health Centre (GHC) and consider allocation of at least the non-physician component of funding through the NE LHIN. Furthermore, GHC should be brought under the NE LHIN accountability model and should develop periodic service accountability agreements with the NE LHIN.

Recommendation # 29: SAH and GHC should set up a joint structure at the leadership level including board, physician and administrative leaders as a forum for collaborative discussions and issues management between the organisations.

Recommendation # 30: SAH and GHC should create a joint planning structure to deal with programmatic changes at each organisation to more effectively plan for the future and serving their mutual community.

Appendix D

Recommendations by Theme

The report makes 30 recommendations which focus on:

- Governance, accountability;
- Post acute care capacity, community health plan, ALC beds;
- Clinical utilization, scope of satellite facilities;
- Physician integration plans for new site, funding arrangements for Hospitalists and Internal Medicine;
- Requirement for a balanced budget, operating plans that create multiyear surpluses, contingency plans;
- Transition funding, PCOP development/negotiation;
- Transition plans and physician orientation, post move recovery plan, IT schedule, mental health capital retrofit;
- Group Health Centre.

For each of the above themes, the related recommendations are as follows:

- Governance, accountability

Recommendation # 1: The Board should consider what leadership triad offers the greatest chance of success to lead SAH through the next 12 to 24 months.

Recommendation # 18: SAH should continue with the implementation of Hardwiring Excellence and should introduce a continuous quality improvement program such as Lean. This should be done by June 30, 2011 so that the program can support the redesign of processes in the new facility as well as dealing with required process changes to deal with the resource reductions implemented as part of the restructuring plan.

- Post acute care capacity, community health plan, ALC beds

Recommendation # 2: The NE LHIN should develop a Post Acute Care Capacity plan by April 30, 2011 and submit it to the MOHLTC. The plan should consider whether the 256 beds that will be vacated in 2012, through the replacement program, offer an opportunity to catch up on the significant post-acute accommodation shortages that are driving the ALC issue at SAH. (RECOMMENDATION UPDATE – The NE LHIN has been working on a strategy to retain space at the Plummer site on a short term basis and to develop additional long-term care capacity on a permanent basis. On February 15, 2011, the MOHLTC provided $6.6 million in additional annual funding to support this strategy.)

Recommendation #3: The NE LHIN should enhance the current structure that includes the major health providers in Sault Ste. Marie including SAH, Group Health Centre, Family Health Teams, the North East Community Care Access

Centre, Long Term Care Representatives, other community providers and the municipality. This group should develop a community health plan that allows SAH to focus on its core role of acute care services and that ensures other providers make available the appropriate services, in appropriate locations and at appropriate times to ensure SAH is not the "default" provider. This should be completed by March 31, 2012 and implemented as soon as possible thereafter.

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Recommendation # 22: ALC patients must remain at the existing site. (We fully support the SAH's decision in this regard.) The impact on the relocation plan, the logistics of supporting this patient population and a plan of action needs to be broadly communicated to all relevant parties. (In late December 2010, SAH decided that it would only plan for the ALC population staying at the Plummer site.)

Recommendation # 6: The ALC target should be clarified between SAH and the NE LHIN and if necessary be redefined to ensure that the inefficiencies inherent in managing this type of patient population do not get built into the new facility.

- Clinical utilization, scope of satellite facilities

Recommendation # 8: SAH needs to implement additional strategies to address clinical utilization (reduce LOS, conservable days, and readmission rates) including a review of care delivery models and senior friendly initiatives. Specifically the hospital should review patients who stay longer than necessary due to inefficient clinical practice, turnaround times of diagnostic and therapeutic services, other hospital related delays in timely discharge and ensure it has the most efficient mix of RN and PRN and other healthcare workers.

Recommendation # 4: When SAH has achieved a balanced operating position, SAH and the NE LHIN should re-examine the scope of service provided at these satellite facilities (Thessalon and Matthews Memorial).

- Physician integration plans for new site, funding arrangements for Hospitalists and Internal Medicine

Recommendation # 11: A transition plan needs to be developed for physician integration to the new site; physician coverage for the closed ICU is a priority. This must be complete by March 6, 2011. (RECOMMENDATION UPDATE: Although an interim strategy was implemented, a longer-term plan is required.)

Recommendation #12: SAH needs to find other savings opportunities or utilise its contingency in the HIP as its ability to stop this payment stream is very limited until funding models for Hospitalists and Internal Medicine are amended to provide appropriate incentives to providing in-patient hospital care. SAH should continue to work with other hospitals and its association to advocate for revision to funding arrangements.

- Requirement for a balanced budget, operating plans that create multiyear surpluses, contingency plans

Recommendation # 13: SAH must achieve a balanced position in 2011/12. This is non-negotiable, and is required to rebuild credibility with the NE LHIN and the MOHLTC, in addition to rebuilding financial health.

Recommendation # 19: We recommend that the existing Senior Management Team be given a clear mandate to fix the financial issues and realise a financial breakeven for the year ending March 31, 2012, that they be held strictly accountable by the SAH Board. Further, they be required to have delivered a multi-year plan to achieve a sustainable surplus by December 31, 2011.

Recommendation # 5: SAH should develop operating plans that create surpluses in future years to rebuild working capital and pay off debt and to allow it to have sustainable operations going forward. We do not recommend any special treatment for SAH to support the working capital position beyond what the NE LHIN is doing today through cash advances and what the MOHLTC may develop as a potential provincial-wide working capital solution.

Recommendation # 14: SAH Board of Directors should define a policy that specifies that any new services or programs should not be introduced without appropriate funding being in place and that expansion of existing services can only be provided within existing resources or through new funding.

Recommendation # 15: SAH should develop a further list of initiatives as either a mitigating strategy or to commence the process of balancing for future years.

Recommendation # 7: SAH should review its assumption for MOHLTC funding increases and revise its plan to reflect a more conservative estimate of possible funding increase. Even if the MOHLTC/NE LHIN does provide funding at a higher level this will generate a funding "cushion" to deal with other eventualities.

Recommendation # 9: The Renal Program's anticipated MOHLTC funding of $0.8 million requires a contingency plan should this funding not be realized. The program should be reviewed in detail to determine if there are further opportunities to improve cost and volume performance.

- Transition funding, PCOP development/negotiation

Recommendation # 16: SAH should continue to work with the NE LHIN to identify strategies to address one-time costs ($3.5 million) associated with the HIP implementation. If the NE LHIN is not able to support the hospital, further cost

reduction changes will be required by SAH to achieve the overall balanced target by March 2012.

Recommendation # 17: PCOP development and negotiation for a greenfield facility is a complex issue. SAH should seek expert support on the development and negotiation of its PCOP application.

Recommendation # 26: The MOHLTC should consider advancing PCOP start-up funding to assist SAH with one-time costs related to occupancy, e.g. staff training, etc. which we understand is consistent with the normal PCOP process. (RECOMMENDATION UPDATE: On February 15, 2011, the MOHLTC provided SAH with $11.2 million in PCOP funding to support transition to the new hospital.)

Recommendation # 27: The hospital, NE LHIN and MOHLTC should commence negotiation of the PCOP in earnest immediately. There are several substantial issues which must be addressed as noted in this report, and since they are different than the traditional model, immediate focus is required to resolve this.

- Transition plans and physician orientation, post move recovery plan, IT schedule, mental health capital retrofit

Recommendation # 21: Transition Plans need to be finalized ASAP. In particular, physician training requires more focused attention and must be complete by the end of February 2011. (RECOMMENDATION UPDATE: Transition plans were completed prior to the move.)

Recommendation # 25: A detailed physician training/orientation program should be completed prior to occupancy. In particular, the changes in technology need to be an area of emphasis. (RECOMMENDATION UPDATE: Completed in advance of the move.)

Recommendation # 20: SAH should consider extending the duration of the Post Move Recovery Plan period to ensure a smooth transition and "shake down" of operating processes in the new facility.

Recommendation # 24: SAH should consider bringing on additional IT resources now in order to recover some of the schedule slippage and create some buffer for potential unforeseeable items. This will have to be found within existing funding.

Recommendation # 23: SAH continue discussions with the MOHLTC Capital Branch to resolve funding issues, approvals and expectations for the mental health capital retrofit.

- Group Health Centre

Recommendation # 28: The MOHLTC should revaluate the accountability structure of Group Health Centre (GHC) and consider allocation of at least the non-physician component of funding through the NE LHIN. Furthermore, GHC should be brought under the NE LHIN accountability model and should develop periodic service accountability agreements with the NE LHIN.

Recommendation # 29: SAH and GHC should set up a joint structure at the leadership level including board, physician and administrative leaders as a forum for collaborative discussions and issues management between the organisations.

Recommendation # 30: SAH and GHC should create a joint planning structure to deal with programmatic changes at each organisation to more effectively plan for the future and serving their mutual community.