GREY BRUCE Health SERVICES
Quality Health Care Right Here

Back to Balance

Backgrounder

Factors influencing Grey Bruce Health Services and shaping its journey back to balance

February 22, 2017

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Introduction

Grey Bruce Health Services (GBHS) is a cost-effective organization. Its unique multi-site operating model, supported by regional programs in areas such as addictions and mental health, diabetes, dialysis, oncology, stroke care, to name only a few, has long been cited by the Ministry of Health and Long-term Care and the Ontario Hospital Association as the epitome of a successful integrated rural healthcare system. Yet despite its acknowledged accomplishments, the organization is facing fiscal hardship and financial stress. Maintaining the status quo will exhaust GBHS' cash reserves within three to five years, leading to a diminishment of service availability and access to care. Now, therefore, is the time for bold decision-making, to leverage the current financial strength of the organization to retool for a sustainable future.

To remain relevant, GBHS must embrace change while exceeding ever-higher expectations for quality health outcomes. Staff and physicians must find innovative ways to use available resources more wisely and to add greater value to the patient experience. This requires clear, strategic, purposeful actions across the organization.

The GBHS Board of Directors approved a change agenda, entitled the Transformation ***Action***Plan, to guide the organization back to a sustainable financial footing by 2020. The plan offers a measured, evidence-based approach to transforming the organization over time through strategic investments in our people, new enabling technologies, leading business practices and aggressive process improvement efforts. Adopting a longer-term transformational strategy for the organization and allowing time for an intelligent corporate redesign, rather than a flurry of hastily planned program cuts, is not easy in the fast-paced health care sector where short-term results are expected and rewarded. Corporate tolerance for risk and the unblinking resolve of corporate leadership to stay the course are required.

The ***Action***Plan leverages the organization's available cash reserves over the next three years to:

- ✓ Invest in strategic change management capacity building initiatives
- ✓ Maximize revenue opportunities; and
- ✓ Reduce operating costs through process redesign efforts and targeted service adjustments

This Backgrounder explores the context within which GBHS operates, the drivers of change, the options available to the Board to address its fiscal challenges and the risks involved with those options compared to trying to maintain the status quo. It provides the reader with an understanding of the rationale behind the Transformation ***Action***Plan and the factors influencing the development of corrective action plans.

Setting the Context

Understanding the needs and expectations of the diverse communities it serves and the complex drivers of change within the healthcare system are essential in formulating strategies to sustain GBHS.

Canadian Health Care Trends

The Canadian population is growing, people are living longer and living with chronic disease longer, and the cost of new technologies escalates well ahead of the pace of inflation. Peoples' expectations of the health system are changing and driving dramatic changes in the definition and delivery of care. We now demand transparency in access to and information about our care, the quality of that care and our care experience. Patients and families are becoming true partners with care providers in the management of their health and care plans. They are demanding a healthcare system that can address all of their needs in an integrated fashion – not on an episodic or departmental basis, but on a continuum where lifelong health and overall wellness are priorities.

Once reliant almost solely on hospitals, health care in Canada is now focusing more on public health, health promotion, community-based care, primary care settings and home care. Medical advances have led to more outpatient procedures and a rise in the number of day surgeries. [1]

Governments and service providers must now demonstrate value for money spent. Laser-like focus is on innovation, quality, productivity and patient experience. It is now more about outcomes, not volumes and outputs. [2]

Ontario's Health System

The Ontario health system is a complex network of different organizations and service providers (see Figure 1). The **Ministry of Health and Long-Term Care** (MOHLTC) provides overall direction and leadership for the system.

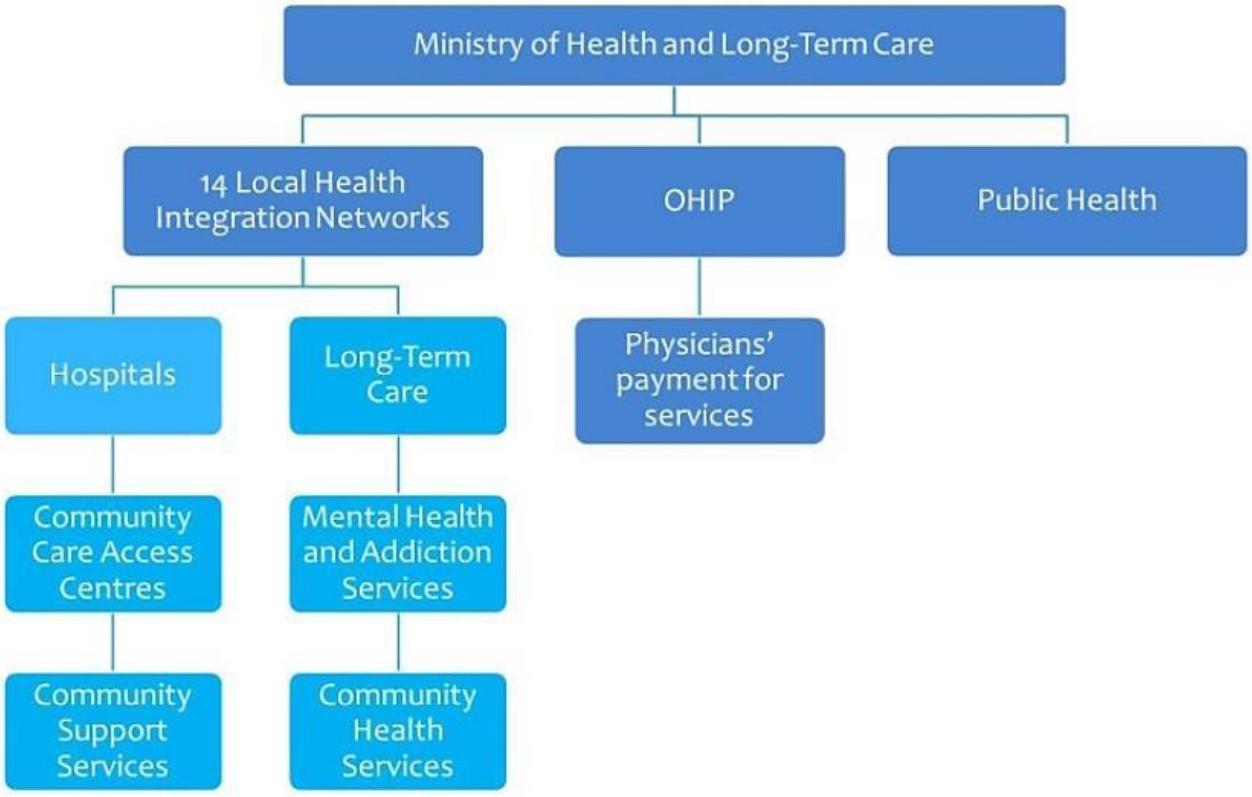
Local Health Integration Networks (LHINs) plan, engage and make decisions at a regional and local level to improve the functioning of the system. They also allocate and monitor funds to hospitals and other service providers. LHINs do not have responsibility for physicians, Public Health Units, ambulance services, or provincial networks (e.g., Cancer Care Ontario). Please note that as of May 1, 2017 the 14 CCACs will merge with their respective LHIN organizations.

[1] Excerpt from on line Health Canada reference, Canada's Health Care System, www.hc-sc.gc.ca

[2] 2015 Health Care Outlook Canada, Deloitte, Lisa Purdy

A Board of Directors governs each health care service provider. The Board is responsible for strategic planning; quality of care; financial oversight; management performance; evaluation and board effectiveness. GBHS is a public hospital and operates under the provisions of the Public Hospitals Act. The Act and many other pieces of legislation/regulations prescribe what a hospital organization like GBHS can and cannot do.

Figure 1: Structure of Ontario Health Care System



Source: Ministry of Health and Long-term Care Website

Pressures on the Ontario Health System

The Ontario health system is facing unprecedented demographic and fiscal challenges. Ontario's population has grown at an annual rate of approximately 1 per cent per year over the past decade. This equates to an additional 140,000 people each year (the population of Guelph or Barrie).[3] At the same time, the population is aging, with increasingly complex health needs.

Over the next 25 years, the population of Ontario seniors will double from two million to four million and make up 25 per cent of the total population. According to the Canadian Institute for Health Information, nearly three-quarters of Canadians over the age of 65 have at least one chronic health condition, and Statistics Canada estimates that one-third of Canadians over the age of 65

[3] Canadian Census 2016, Statistics Canada

have a disability. People are living longer and living with chronic disease longer. The cost of care for a senior is, on average, three times higher than for other age groups.

In 2016, health care consumes about 43 cents of every dollar spent on provincial programs and if left unchecked would be on pace to consume upwards of 70 per cent of the provincial budget within ten years. The Province is running significant annual budget deficits, adding to an accumulated debt of $300 billion, as of July 2016[4]. The Government has signaled very strongly its intent to reduce the growth of health spending as part of its strategy to eliminate its deficit and shrink the debt.

The government has limited annual growth in the health sector over the past few years to about two per cent, largely through cutting payments to doctors and freezing hospitals' base operating funding - though in the fall economic update it added $140 million in new hospital base funding (of which GBHS received $619,000).

Provincial Health Policy

There is a palpable sense of urgency across the health system as the Province strives to constrain costs and provide *"the right care, at the right time, in the right place."*[5] The Provincial Government is moving deliberately, through its ***Action***Plan for Health Care, to refocus the health care system on:

- Population health & prevention of illness, not healthcare or hospitals
- Outpatient services rather than inpatient stays
- Good value for money invested, and being accountable to the public
- Evidence-based
- Creating a seamless continuum of care and collaboration across levels and sectors
- Making superior quality consistent and predictable

Limiting available resources requires careful and often tough choices between health priorities. The Province's ***Action***Plan aims to ensure that patients receive timely access to the most appropriate care in the most appropriate care setting. The Plan calls for getting the greatest value for patients from the system and allowing evidence to inform resource allocation decisions. "If there is evidence to support a new procedure or test, we will fund it. If the evidence is not there, funding will not be available".[6] This is a profound policy shift, which has rocked the hospital sector. While still important, hospital-based care no longer is the primary driving force of health policy and funding decisions.

[4] Canadian Taxpayers Association

[5] Ontario Action Plan for Healthcare, 2012

[6] Ontario Action Plan for Health Care, 2012

The Changing Nature of Hospital Care

The primary purpose of a community hospital is to provide good medical care; to care and to cure. While that fundamental purpose may not change, the means by which hospitals provide care is changing, and at an accelerated pace due to innovations in science and applied technology combined with vice-like budget pressures.

In the 1970's, for example, it was common for a patient with a hernia to spend up to five days in hospital after an operation. Today, physicians perform that surgery on an outpatient basis. It once was common for a woman to spend 10 days in the hospital after giving birth, rather than today's more-standard 24-hour turnaround.

The number of inpatient hospital beds, once the accepted measure of a hospital's relative importance, level of medical sophistication and perceived community value, has been replaced by measures of the patient experience (including quality and satisfaction), improvement in the health of populations, and reduction in the per capital cost of health care. In 1970, for example, there were 7.0 hospital beds per 1,000 people in Canada. By 2005, the nation-wide ratio had dropped to 3.4[7].

Between 1990 and 2014, Ontario lost over 18,000 hospital beds.[8] That number has continued to climb as hospital after hospital has shed inpatient beds in response to changing medical care and budget pressures. Ontario now has a bed/1,000 population ratio of 2.3, compared to the average for all other provinces of 3.5.[9]

Grey Bruce has not escaped this transformation of the community hospital. Designed to accommodate just over 900 in patients, the existing hospitals in the two counties now have an inpatient bed count of just over 400; a decline of 56% since the late 1980s. Every hospital in the region has experienced bed closures, as Figure 2 shows.

Figure 2: Hospital Inpatient Beds (all types) in Grey Bruce

Hospital Site	Bed Design Capacity	Funded Beds in 2016
Lion's Head	10	4
Markdale	55	14
Meaford	68	15
Owen Sound	417	186
Southampton	28	16
Hanover	80	28

[7] Statistics Canada
[8] Ontario Health Coalition
[9] Statistics Canada

Wiarton	33	22
Walkerton	122	62
Chesley	22	22
Durham	35	10
Kincardine	68	36
Total	938	415

Source: Review of hospital histories and websites

GBHS Activity Levels

The shift away from inpatient services is evident upon review of activity levels at GBHS over the past ten years. In that time, the volume of inpatient activity declined slightly overall while the volume of outpatient activity has grown dramatically (See Figure 3):

- Inpatient volumes declined 4% overall and the number of patient days declined dropped 8%, while the average length of stay for acute care patients remained essentially unchanged at about 5.5 days.

- The number of births at Owen Sound increased over the decade by about 6%. The number peeked at 850 a few years ago

- Surgical volumes have increased only slightly

- The inpatient occupancy rate at Owen Sound Regional Hospital was almost 90% at the end of 2016; considered higher than preferred and certainly reflective of many protracted periods in the year during which the hospital was near or at capacity. The overall corporate rate, which includes the rural sites, is close to 86%, owing to substantively lower occupancy rates generally at the rural sites

- The volume of many outpatient procedures has increased substantially over 10 years. Oncology and chemotherapy visits increased 45%; services offered through ambulatory care and other outpatient clinics increased 20%; day surgery increased almost 34%; and most strikingly, mental health clinics now serve over 9,000 visits more per year than in 2005, an increase of over 300%.

- Reliance on CT scans and the MRI for diagnostic purposes has grown 20% and 384% respectively. These services are subject to capped funding arrangements; there is demand, so more funding would extend hours of operation to better serve that demand.

Figure 3: Ten-Year Activity Levels at GBHS 2005 – 2016

	2015/16	2008/09	2004/05	% Change 2005-16	No. Change 2005-16
Inpatient Services					
Separations	10,878	10,664	11,376	-4.4%	-498
Patient Days	71,552	66,008	77,095	-7.0%	-5,543
Active Avg. LOS days	5.4	5.3	5.5	-0.1	
Occupancy %	85.8%	84.1%	83.4%	2.5%	
Occupancy O.S.	89.8%	85.8%	85.1%	4.7%	
Births	732	782	692	5.8%	40
New Born Days	2,097	1,952	1,945	7.8%	152
New Born LOS days	2.9	2.5	2.8		
Surgical Cases	2,866	2,967	2,718	5.5%	148
Outpatient Services					
Emergency Visits	93,219	98,965	97,314	-4.2%	-4,095
Amb Care/Clinics	77,235	63,375	64,741	19.3%	12,494
Cancer Therapy	13,624	10,278	9,345	45.8%	4,279
Mental Health Clinic	12,584	10,683	3,109	304.7%	9,475
Surgical Cases	12,519	12,822	9,378	33.5%	3141
Diagnostic and Therapeutic Services					
CT	10,972	10,642	9,167	19.7%	1,805
MRI	9,988	10,892	2,066	383.5%	7922

Hospital Funding

Public hospital corporations in Ontario, like GBHS, receive about 80% of their operating funds from the Provincial government. Community fundraising and some limited government grant programs fund capital and equipment needs for hospitals. Up until 2012, provincial operating funds to all hospitals came in the form of a *global allocation;* an annual fixed amount of funding based on factors, such as: historical budget allocations; rate of inflation; capital investment decisions; negotiations; and politics. Global allocations did not factor in such things as the type, volume, and complexity of services provided by a hospital. Under a global budget model, there are few incentives for providers to improve access, quality or efficiency of care.

Health System Funding Reform

There cannot be sustainable system reform without funding reform. This truism is driving the Province to introduce a new funding model, known as Health System Funding Reform (HSFR), to all but the smallest hospitals in Ontario. The principles of quality, sustainability, access and integration of services across organizations is at the heart of the new model, driving greater efficiencies and higher quality outcomes throughout the system.

The HSFR regime is weighted towards volume of patients served, the types of services delivered, the evidence-based quality of those services, and the specific needs of the broader population served. The intended benefits of this patient-centered funding model include:

- Funding tied more directly to the quality of care that is needed and will be provided
- Smarter use of limited resources
- Minimizing practice variation between hospitals and allowing patients to receive leading practice care at the right time and at the right place.
- Encouraging hospitals to invest in quality improvement and patient safety activities

Upon full roll out of the HSFR model, in the next year or so, only 30% of a hospital's provincial allocation will be global funding. Two new funding streams make up the remainder:

Health Based Allocation Model (HBAM)

The HBAM formula allocates funding on a wide range of demographic, clinical and financial data to estimate expected health care expenses at the organizational level. The HBAM will soon comprise 40 percent of the Province's operating funding to GBHS.

Quality Based Procedures (QBPs)

QBP funding is allocated to an increasing list of specific procedures based on a "price x volume" basis. The Province reimburses providers for the types and volumes of patients treated, using rates that are adjusted by the Province for patient complexity and the quality of health care delivered. QBPs account for approximately 14% of the Provincial operating grant to GBHS now. When fully implemented, QBP funding will make up 30 per cent.

The new HSFR funding regime is a game changer for medium and large sized hospital corporations. It is driving change towards stronger accountability, enhanced quality and efficiency of operations. With overall hospital sector expenditures frozen for six of the last seven years, the competition among hospitals to simply maintain their current levels of funding, let alone attract additional funding, continues to intensify. Maintaining the status quo in this hyper-competitive environment is not an option for any hospital organization.

Grey Bruce Health Services

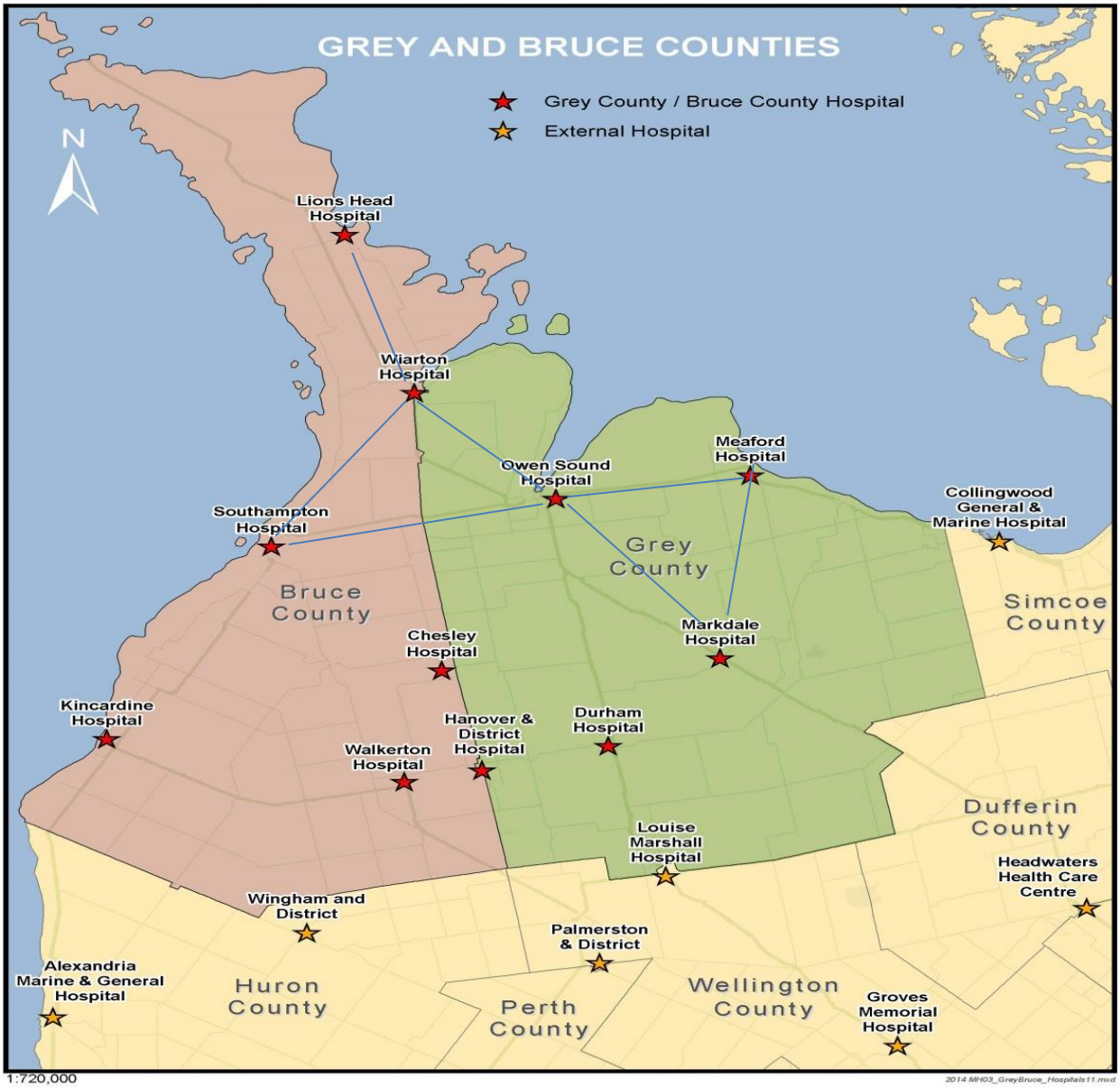
Who We Are

GBHS provides a wide range of hospital and community based health services and programs. Its community hospital programs in Owen Sound, Southampton, Markdale, Meaford, Wiarton and Lion's Head (Figure 4) form an integrated system serving a permanent population of about 110,000 people in northern Grey and Bruce counties, in addition to thousands of seasonal residents and well over 1 million short stay visitors annually. The Owen Sound Regional Hospital and its affiliated Withdrawal Management & Addictions Services (WMS) also serve as the secondary specialist referral centre for all hospitals in Bruce and Grey Counties; a largely rural region with an overall population approaching 165,000.

Figure 4: GBHS Locations

Figure 5 below, shows the location of GBHS hospitals in relation to the other hospitals serving Grey and Bruce Counties; those operated by South Bruce Grey Health Centre (Kincardine, Durham, Walkerton and Chesley) and Hanover & District Hospital. Adjoining the boundaries of Grey Bruce are community hospitals that form part of the larger regional healthcare system. While these adjoining hospitals tend to be oriented towards the communities to the south and east of Grey Bruce, their presence and service offerings have a bearing on the range of services offered at GBHS hospitals.

Figure 5: Map of Hospitals in and near Grey and Bruce Counties



Map Courtesy of Grey County Planning Department

Service Profile of GBHS

Figure 6 below provides a handy summary of GBHS; its mission, vision, values, budget, workforce statistics and a summary of activity levels for the services and programs offered across the organization. The range of services offered and the volume of procedures performed on an annual basis are notable.

Figure 6: 2016 Profile of GBHS

Mission	Exceptional Care - Strong Partnerships - Healthy Communities	
Vision	*Quality Health Care, Right Here*	
Values	*We **CARE: C**ollaboration, **A**ccountability, **R**espect, **E**xcellence* *We **LEAD: L**ead by example, **E**mpower, **A**chieve results, **D**evelop others*	
Employees	▪ 1580 employees: 1150 in Owen Sound; 100 in each of Meaford, Markdale, Wiarton and Southampton; 30 in Lion's Head ▪ Average length of service: 15 years ▪ 63% of employees are between 45-65+ years of age ▪ Average age 46.6 years ▪ 87% female; 13% male ▪ 92% of staff unionized	
Physicians	250+ with privileges	
Volunteers	1,000+	
Foundations & Auxiliaries	Five foundations and six Auxiliaries raise funds for capital expenditures and equipment	
Patient Beds	Owen Sound Meaford Markdale Southampton Lion's Head Wiarton Withdrawal Management TOTAL	169 15 14 16 04 22 17 250
Budget	$190+ million	
Payroll	$95+ million	
Programs	57 programs and services across Grey Bruce, with Owen Sound Regional Hospital providing comprehensive specialist care; all hospitals offer 24/7 emergency care; Meaford, Markdale, Southampton and Wiarton hospitals also provide day surgery.	
Annual Statistics (rounded)	93,000 10,800 72,000 12,500 66,000 11,000 10,000 14,000 3,200	ER visits per year (2/3 at rural sites combined) Admissions Inpatient Days of Care Day Surgery Visits Outpatients visits CT Scans MRI exams Oncology/chemotherapy visits Dialysis treatments

	8200	Mammography exams
	280	Hip Replacements
	460	Knee Replacements
	2,000	Cataract Surgeries
	6,000	Endoscopies
	5,400,000	Laboratory procedures
	27,400	Physiotherapy attendance days
	3,900	Withdrawal Management Patient Days
	2,900	Withdrawal Management and Addiction Visits
	3,750	Mental Health Case Management Visits
	8,700	Assertive Community Treatment Team Visits
	5,000	Diabetes Outreach Visits
	86%	Occupancy

** See Appendix 1 for a more detailed description of available programs and services and other workforce facts.*

Hub and Spoke Model

A voluntary merger of hospital corporations encompassing six hospitals and a medical clinic serving north Grey and Bruce counties created Grey Bruce Health Services (GBHS) in 1998. This was an era of widespread hospital consolidations across the Province. In Grey Bruce for example, the Province considered closing different hospitals, including in Meaford, Durham and Chesley. Over the course of two years, between 1996 and 1998, the number of hospital corporations declined in Ontario from 223 to 150, through corporate mergers and facility closures. The local impetus in creating GBHS was to survive the pressure to rationalize facilities and keep the existing hospitals open.

GBHS is organized using what is called a hub and spoke model; termed after a wheel with its hub and multiple spokes centrally connected; having multiple practicing sites where the "hub" is the anchor site providing corporate services and specialty clinical care and the "spokes" are connecting secondary sites. Owen Sound Regional Hospital serves as the specialty referral centre or hub for five smaller rural hospitals. The main value of the hub and spoke model is in its connectivity: a uniform operating framework across sites; shared language and standardized policy; common information technology, instruments and devices; and a more consistent standardized level of care.[10]

The GBHS model has, from the start, attempted to preserve the identity and unique character of each hospital site while leveraging the advantages of a large, single corporate entity. Most support service areas like administration, procurement, food services, medical imaging, information technology, pharmacy, laboratory services, and facilities management are organized on a corporate level. The medical care model used at GBHS, however, remains largely site specific in nature. Consequently, there remain many operating differences between locations.

[10] Rural Hospitals' Future Depends on Hub and Spoke Models, SG Medical Executive Council posted March 31, 2015

In addition, each hospital community has maintained a separate hospital foundation (with the exception of the merger of Lion's Head and Wiarton) and hospital auxiliary for fund raising purposes.

Population of Grey Bruce

Whether defined by population density, access to services, or proximity to larger urban centres, the Grey Bruce region is largely rural. According to Statistics Canada, more than 50% of the population lives in a rural setting, compared to 15% for Ontario as a whole.The Ontario government on the other hand defines rural as a town of less than 30,000, more than 30 minutes away from any town of more than 30,000. [11] Using that definition, all of Grey Bruce is considered rural; even centres such as the City of Owen Sound, the Town of Blue Mountains, Southampton, Port Elgin, Hanover and Kincardine.

Figure 7 lists the population for Grey Bruce by municipality and First Nation. Overall, Grey Bruce is not a fast growing region. In the past five years, the region's population grew by 3,400 people, or 2 percent, while the Ontario population grew by 4.6 per cent and Canada by 5 per cent. Some communities have shown faster percentage growth than the region overall; notably the Town of the Blue Mountains at 9 % (600 people) and Saugeen Shores at 8.5 % (1,100 people). Of particular note is the growth rate of the Saugeen Ojibway Nation. Although the number is relatively small at 300, it represents a growth rate of over 40 per cent. This is reflective of the national trend in Indigenous communities.

Meaford is noteworthy in that its population actually declined by 1 percent over the past five years; a loss of just over one hundred people. At the same time, according to the 2016 census, the number of dwellings in Meaford increased by over 4 percent. Municipal officials suggest that this is due in large part to the influence of increased non-permanent resident home ownership – residents who reside in more than one community throughout the year but claim their full time residence (for census purposes) as being elsewhere. It is a trend to watch.

Population projections developed for Grey and Bruce counties, prior to the release of the 2016 Census results, suggest an annual growth rate of less than 1% over the next ten years, compared to a rate of 3% for Ontario. Saugeen Shores and Kincardine are expecting faster paced growth resulting largely from the massive multi-year refurbishment program at the Bruce Nuclear Power Station and the continued popularity of the area for retirees.

[11] Rural and Northern Health Care Report,

Figure 7: Population by Municipality Grey Bruce and area 2011-2016

Municipality	2011	2016	5 Yr. %
West Grey	12,286	12,518	1.9
Southgate	7,190	7,354	2.3
Grey Highlands	9,520	9,804	3.0
Hanover	7,490	7,688	2.6
Chatsworth	6,437	6,630	3.0
Blue Mountains	6,453	7,025	8.9
Meaford	11,100	10,991	-1.0
Georgian Bluffs	10,404	10,479	0.7
Owen Sound	21,688	21,341	-1.6
County of Grey	**94,579**	**95,846**	**1.4**
Kincardine	11,174	11,389	1.9
Saugeen Shores	12,661	13,715	8.3
Southern Bruce Peninsula	8,416	8,413	-
Northern Bruce Peninsula	3744	4,000	6.8
South Bruce	5,595	5,639	-0.8
Huron Kinloss	6790	7069	4.1
Brockton	9,432	9,461	0.3
Arran-Elderslie	6,803	6,810	-
Saugeen Ojibway Nation	726	1,041	43.0
Neyaashiinigmiing	667	615	-7.8
Bruce County	**66,008**	**68152**	3.2
Grey Bruce Total	**160,587**	**163,998**	2.1
Collingwood	19,250	21,793	13.3
Wasaga Beach	17,537	20,675	17.9
Shelburne	5846	8126	39.0
Melancthon	2839	3008	6.0
Ontario			4.6
Canada			5.0

Source: Statistics Canada 2016 Census Report

The Town of the Blue Mountains and Meaford are expecting strong growth in the coming years because of the burgeoning popularity of the south Georgian Bay area as a four-season recreation destination.

Municipal and county planning officials report that more growth is happening on the ground than perhaps anticipated by formal projections. New development and building permit applications with municipalities and counties are often a sound harbinger of growth to come. The Town of the Blue Mountains, for example, has set building permit records two years in a row. The first phase of a new 70 home subdivision now under construction in Dundalk pre-sold in only two days (unheard of

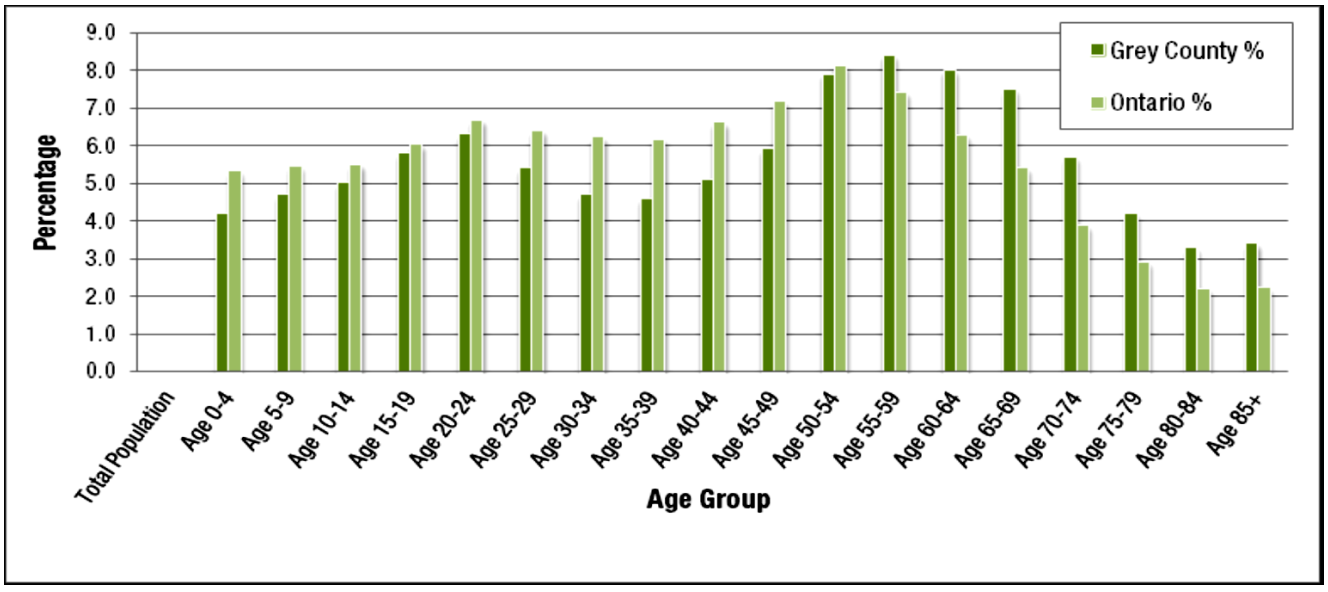
outside of large urban centres). Southgate Township has plans for over one thousand new housing units mostly in the Dundalk area.

Grey County planning officials report a quicker turnaround from approval of new developments to actual construction than experienced in past years. The volume of new development applications received by Grey County in the last few months is almost returning to the high levels experienced in the years before the 2009/10 economic recession[12]. These factors all point to growth expectations that exceed published projections. The challenge for service planning purposes is to determine whether the data suggests a spike in activity, a leveling off to projected levels, or continued growth on pace.

The population of Grey Bruce continues to age more rapidly than Ontario as a whole. Grey Bruce is now home to the highest percentage of residents over the age of 65 in the province. In addition, it has fewer young and middle-aged residents as a percentage of the total population. To this point, Figure 8 below illustrates the age cohort breakdown for Grey County compared with Ontario.

It is prudent to exercise caution when viewing Statistics Canada population data. The methodology of the data gathering is such that it tends to underreport actual population. It does not include seasonal or part time residents or those who have multiple homes that the census counts as living elsewhere but in fact live much of the time here and use local services such as hospitals. There is no other accepted method for capturing these segments of the local population.

Figure 8: Grey County vs Ontario Age Cohorts as Percentage of Total Population



[12] Grey County Planning Department

The Rural Difference

Rural is more than simply the absence of "urban". Rural communities are unique in the characteristics and values they embody, such as:

- Income and social status
- Education and literacy
- Employment
- Social environment and social support networks
- Physical environment
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Language
- Culture

This rural reality has significant bearing on the health status of the population and need for health care services, and should therefore have considerable weight in public policy decisions about the provision of health care services in rural communities.

There are 33 hospital sites in the South West LHIN and 17 of them qualify as small and rural. Of the 155 public, private and specialty psychiatric hospital corporations in Ontario, a total of 51 hospital corporations operating 64 sites meet the Provincial definition of a small or rural hospital:

Small hospitals - fewer than 2,700 total acute inpatient/day surgery expected weighted cases per year in any two of the previous three years

Rural hospitals - located in a community with a population of less than 30,000 and greater than a 30 minute drive, at posted speeds, to a community with a population greater than 30,000[13]

Small and rural hospitals are located within seven LHINs, with the majority located in Northern Ontario. During the 2014 fiscal year, Ontario's small and rural hospitals:

- Operated and staffed almost 2,000 inpatient beds
- Provided more than 570,000 inpatient days of care of all types (acute, CCC, ELDCAP)
- Received 765,000 emergency room visits
- Received just over $1 billion in revenues from all sources
- Employed 7,200 full-time equivalent staff

[13] KPMG Review of Small and Rural Transformation Fund 2014 KPMG LLP

Rural Health Status

Complex interactions between social factors, economic factors, the physical environment and individual behaviours determine health. These factors do not exist in isolation of each other and their combined influence determines health status. The determinants of health include income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture.[14]

The overall health status of rural residents in Canada and Ontario is lower in comparison to their urban counterparts[15]. Rural areas tend to have: higher mortality rates; a proportionately older population; a higher proportion of residents having and reporting fair/poor health; and a significantly greater proportion of residents aged 20-64 years who self-report being overweight.

Young children, adolescents and seniors tend to make up a greater portion of the population in rural regions. These age groups present unique challenges to the health care systems of rural areas. Seniors, for example, are the largest consumers of health care, primarily because they are more prone to disability and disease. In terms of mental health, depression is a prevalent concern among older adults. Isolated and rural seniors often face barriers that impede their ability to maintain good mental health.

With respect to physical health, elderly Canadians are more susceptible to malnutrition, osteoporosis, reduced sight and hearing, and other physical impairments, which can severely reduce their mobility. According to Statics Canada, residents of rural regions have, on average, the lowest "disability-free life expectancy" in Canada.

Studies also show that the disparity in health status of rural communities in Canada is a direct function of their distance from urban centres. The distances that rural people must travel to reach appropriate and adequate health services is a concern that is expressed by many rural residents nationwide, and certainly in Grey and Bruce counties.

As a general trend, the distance to health care providers is increasing for rural residents, as hospital services consolidate and physicians move to urban and urban fringe areas. While the Grey Bruce region has experienced its share of the impact of centralization of care, it has managed to sustain a strong integrated rural health care system of local hospitals, primary care and community care providers.

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[14] Rural Health: A Qualitative Research Approach to Understanding Best Practices for Rural Health Service Delivery in a Public Health Setting Norfolk Haldimand Public Health Unit, 2007

[15] Statistics Canada

The recruitment and retention of physicians is a significant challenge for rural communities (Grey Bruce is no exception). Personal and professional considerations (e.g., social isolation and longer hours with less support) consistently rank as the most important factors in the location decisions of physicians.[16]

"Solving rural health problems may require new ways of thinking or doing things which may not be welcomed by some rural residents or health care practitioners who resist change or are skeptical of novel approaches" [17]

The Grey Bruce Difference

Strikingly, the health status of Grey Bruce residents is significantly lower than the average or median values for rural Ontario and Canada as a whole. According to Statistics Canada and analysis provided by Grey Bruce Public Health, this region has:

- The highest percentage of residents over 65 years of age of any area in Ontario, being almost 30% higher than the Ontario average
- A significantly higher median age than Ontario – 45 years vs 39 years; the median age has increased rapidly, by 2.5 years in a 5-year time span
- A significantly higher median age than the surrounding counties of Simcoe, Dufferin, Huron and Wellington
- 22% of its population is aged 0-18 years
- A significantly lower percentage of residents in the 20 to 44 age group as compared to the province (27% and 35% respectively)
- A growing Plain People (e.g. Mennonite and Amish) population and two First Nations territories, which present unique health and health care challenges
- An age-standardized death rate that is significantly higher than Ontario
- A death rate from motor vehicle collisions more than 30% higher than both the provincial and national averages
- Other causes of death with higher rates locally than provincially, including: ischaemic heart disease, cerebrovascular disease, colorectal cancer, and unintentional injuries
- A significantly higher rate of incidence for Arthritis than the Ontario and Canadian rates
- A significantly higher rate of high blood pressure (22%) than Ontario (17%) and Canada (16%)
- A significantly higher rate of heavy drinking (54%) among those 20 years and older than Ontario (37%); the highest reported rate in Ontario
- A rate of overweight and obesity significantly higher than that for Ontario and Canada
- A high and increasing rate of reported mood disorders

[16] Waterloo Wellington Local Health Integration Network Rural Health Care Review Appendices January 19, 2010

[17] The Health Transition Fund (HTF), a joint collaborative effort between federal and provincial governments to encourage and support "evidence-based decision-making in health care reform"

- A rate of hospitalization due to unintentional injury 50% higher than for Ontario; the main contributors being falls, motor vehicle accidents, and poisoning
- Post-secondary educational attainment is lower than the provincial average
- Rates of smoking higher than the provincial average

The lower health status in Grey Bruce is a significant factor when planning health services.

Rural Ontario – Under Siege

Grey Bruce, like much of Rural Ontario, is under siege - socially and economically. Public policy and global economic forces have combined to ravage many small towns and rural communities in recent years. Communities in the region have watched once vibrant businesses close or pull up stakes to relocate elsewhere, taking with them thousands of well-paying jobs. Many communities are being "hollowed out" as young people and families leave in search of work and opportunity; schools close; service clubs, sports and cultural groups and churches decline; hospitals struggle to survive and preserve services, and the local tax base shrinks putting upward pressure on residential taxes to maintain valued services. The remaining population tends therefore to be older, less mobile, with fixed incomes and increasing healthcare needs.

In this dire economic climate, small towns and rural communities covet their hospitals, not only to satisfy their healthcare needs, but as community economic engines. Hospitals provide relatively stable, good paying jobs and inject money into the local economy from outside the region. The goods and services hospitals purchase from other businesses create additional economic value for the community; what economists call the multiplier or ripple effect.

Research compiled by the American Hospital Association indicates that on average[18]:

- $1 of hospital spending generates $2.30 of business activity within the community
- 1 hospital job supports 2 additional jobs within the community

The Ontario Medical Association has determined that on average each physician[19]:

- Creates and supports 4 jobs in the community
- Contributes $205,000 to national GDP
- Pays more than$50,000 in taxes (all levels of government) annually

[18] BEA RIMS-II (1997/2006) multipliers, released in 2008, applied to 2008 American Hospital Association Annual Survey data.

[19] B.Kralj, OMA Economics Department and E. Mansfield, MNP LLP. "Impact of physician practice overhead spending on the Ontario economy". Ontario Medical Review (May 2013).

In addition to economic importance, a hospital is a significant part of defining a sense of community or place for many residents. Like good schools, a viable hospital is an asset that draws and retains new people and business investment. The community economic development literature strongly supports the conclusion that for any community (especially small towns and rural communities) to prosper and attract investment and new residents, it must have ready access to quality health care[20].

The literature also points out that the top four predictors of viable retirement locations are: safety; recreational facilities and opportunities; quality housing that meets the needs of retirees; and available health care. It is notable that the issue is availability and access to health care, not necessarily hospital care. This supports the Province's drive to ensure the right care in the right place and is a central point of consideration in GBHS service planning.

Economic Impact of GBHS

GBHS is a $ 650 million economic engine that supports over 4,000 direct and indirect jobs in Grey Bruce, if we apply the above noted economic multiplier factors from the American Hospital Association and the Ontario Medical Association.

- 1600 GBHS jobs support and additional 3200 additional community jobs
- 200+ physicians create and support an additional 800+ jobs in community
- $195 million GBHS budget generates $448 million of additional business activity[21]

One could argue the applicability of some of the multiplier factors to the Grey Bruce context. In the absence of any local or Canadian data, however, they serve to make the point that GBHS is a significant contributor to the local economy.

Another advantage of a hospital is that is provides a wide range of different types of employment opportunities, which brings greater opportunity to residents and stability to a community. Figure 9 provides a sampling of positions at GBHS.

[20] Measuring the Economic Importance of the Health Sector on a Local Economy: A Brief Literature Review and Procedures to Measure Local Impacts by Gerald A. Doeksen, Tom Johnson, Chuck Willoughby 1997

[21] Does not include physician remuneration

Figure 9: A Sampling of Employment Opportunities at GBHS

Position	Number	Position	Number
Information Technology	50	Pharmacists	10
Building Mechanics	15	Pharmacy Technologists	27
Technologists	200	Physiotherapy	27
Environmental /General Support Workers	100	Registered Nurses	475
Food Services	47	Registered Practical Nurses	160
Finance	15	Human Resources	15
As of 2/2/17			

Planning for Rural Health Care

"While the demographic shift compels us to reform health care, today's fiscal reality requires that we act now to make Ontario's health care system sustainable."[22]

The aging demographic of Grey Bruce has significant healthcare planning and delivery implications. It is placing pressure on primary care, hospitals, long-term care and EMS services. The literature shows, for example, that about 60% of hospital expenditures in Canada are directed to serving the older population. Rural hospitals must be innovative and develop evidenced-based and responsive elder-friendly service models.

What about when the baby boom era passes through the system? What changes will there be to hospitals and other parts of the health system? The current experience of school boards across much of rural Ontario is perhaps the harbinger of things to come for healthcare in slow growing rural areas – closures and consolidation of resources. This, points to the imperative for rural Ontario to attract youth and retain newcomers to sustain our communities.

Service Level Planning

There is no one right decision as to what health services ought to be provided where and by whom. It varies by geography. As part of its ongoing analysis of healthcare cost drivers, the Minister of Health and Long-term Care received a report[23] in 2006 entitled, *The Core Service Role of Small Hospitals in Ontario,* from the Ontario Joint Policy and Planning Committee (JPPC) Multi-Site/Small Hospitals Advisory Group. The report recommended the establishment of guidelines for determining the availability of services within small rural hospitals. While it is not clear if the findings and recommendations of the report became policy, non-the-less they serve to inform the deliberations of this Board.

[22] Ontario Action Plan for Health Care, 2012

[23] *The Core Service Role of Small Hospitals in Ontario,* from the Multi-Site/Small Hospitals Advisory Group of the Ontario Joint Policy and Planning Committee (JPPC), December 18, 2006.

The Advisory Group identified several key considerations to help interpret and provide context for its core service recommendations:

- A basic core of services may be different for different types of rural communities

- Core services should be available to communities or regions – not all individual institutions (or sites) should be expected to deliver all core services. The Provincial Government, for example, has used 40 km as the optimal distance between hospitals that have 24-hour emergency room coverage.[24]

- For multi-site corporations, the corporation as a whole would be expected to provide the same core set of services to its catchment population as any of the single site small hospitals. This does not require every site within a corporation to provide the same complement of core services.

- Planning for health services must take into account the diverse health needs and different circumstances of different communities. It will require extensive discussion and consideration, through a collaborative community planning process, of the unique position of individual facilities, the available evidence in the context of Local Health Integration Network planning and the services provided by other providers serving the catchment area.

The Advisory Group recommended that core services for small hospitals of less than 1,500 weighted cases include:

- Emergency Department:
- Medicine program with inpatient medical beds;
- General/Family Practice supported by broadly-trained nurses;
- Inpatient allied health services (physiotherapy, clinical nutrition, occupational therapy, respiratory
- Therapy, speech pathology and pharmacy
- Diagnostic Imagining
- Laboratory

The Advisory Group identified five potential strategic directions for small hospitals to consider, in relation to these challenges:

- Enhance and extend primary care
- Expand community networks
- Expand hospital networks
- Integrate and manage primary, acute and long-term care more effectively
- Make greater use of technology

[24] Ministry of Health. The Rural and Northern Health Care Framework. Ontario Ministry of Health June 1997. p7. http://www.cranhr.ca/pdf/RURAL_HEALTH_FRAMEWORK_June_1997.pdf

Figure 10 provides a summary of the weighted cases for each of the GBHS sites for the 2015/16 year. All sites, with the exception of Owen Sound, have weighted cases well below the 1,500 mark cited in the above standards. For the most part, it would seem that the GBHS small rural hospitals meet the guidelines noted above, with the exception of Southampton, Markdale and Meaford, which provide some elective surgical services typically now found in only larger community hospital settings. It is worth noting that both Hanover & District Hospital and South Bruce Grey Health Centre provide limited elective surgery.

Figure 10: GBHS Inpatient Weighted Cases 2015-2016 Fiscal Year

GBHS Site	Total Cases	Total Days	Weighted Cases
Owen Sound	7,479	33,256	7,729.90
Southampton	590	4,481	665.22
Meaford	688	4,231	651.02
Markdale	584	3,575	624.90
Wiarton	432	3,985	583.93
Lion's Head	146	862	153.05
Total	9,919	50,390	10,408.02

Source: GBHS Medical Records and Utilization Management

Locational Considerations

In the mid-2000s the Provincial Government commissioned a study entitled, Rural and Northern Health Care Report. That report recommended the introduction of a series of standards for allocating hospital resources across rural and northern Ontario:

- 90 % of residents in a community or local hub receive primary care within 30 minutes road travel time of their residence
- 90% of residents in a community or local hub receive 24/7 emergency services within 30 minutes road travel time of their residence
- 90% of residents in a community or local hub receive basic inpatient hospital services within one hour driving time of their residence
- 90% of residents in a community or local hub receive specialty inpatient and tertiary diagnostics within four hours travel time of their residence

The travel time and distance data provided in Figure 11 provide the local context for the above recommended standards. It would appear that the allocation of hospital-based resources across the region is generally consistent with the locational guidelines. These standards may have weight in future regional service delivery considerations.

Figure 11: Grey Bruce Travel Distances between Grey Bruce Hospitals

Hospital Proximity

Location	Distance (km)	Minutes to Travel
TOB (FHT) - LH	48 km	35 min
SO - WI	41 km	33 min
SO – KIN	46 km	39 min
MA - OS	40 km	32 min
ME - MA	39 km	30 min
SO - OS	37 km	32 min
ME – C'WOOD	34 km	32 min
LH - WI	34 km	26 min
WI - OS	31 km	30 min
ME - OS	30 km	26 min
MA – DUR	28 km	21 min
HAN - CHES	20 km	18 min
HAN – DUR	18 km	16 min
HAN – WALK	11 km	11 min

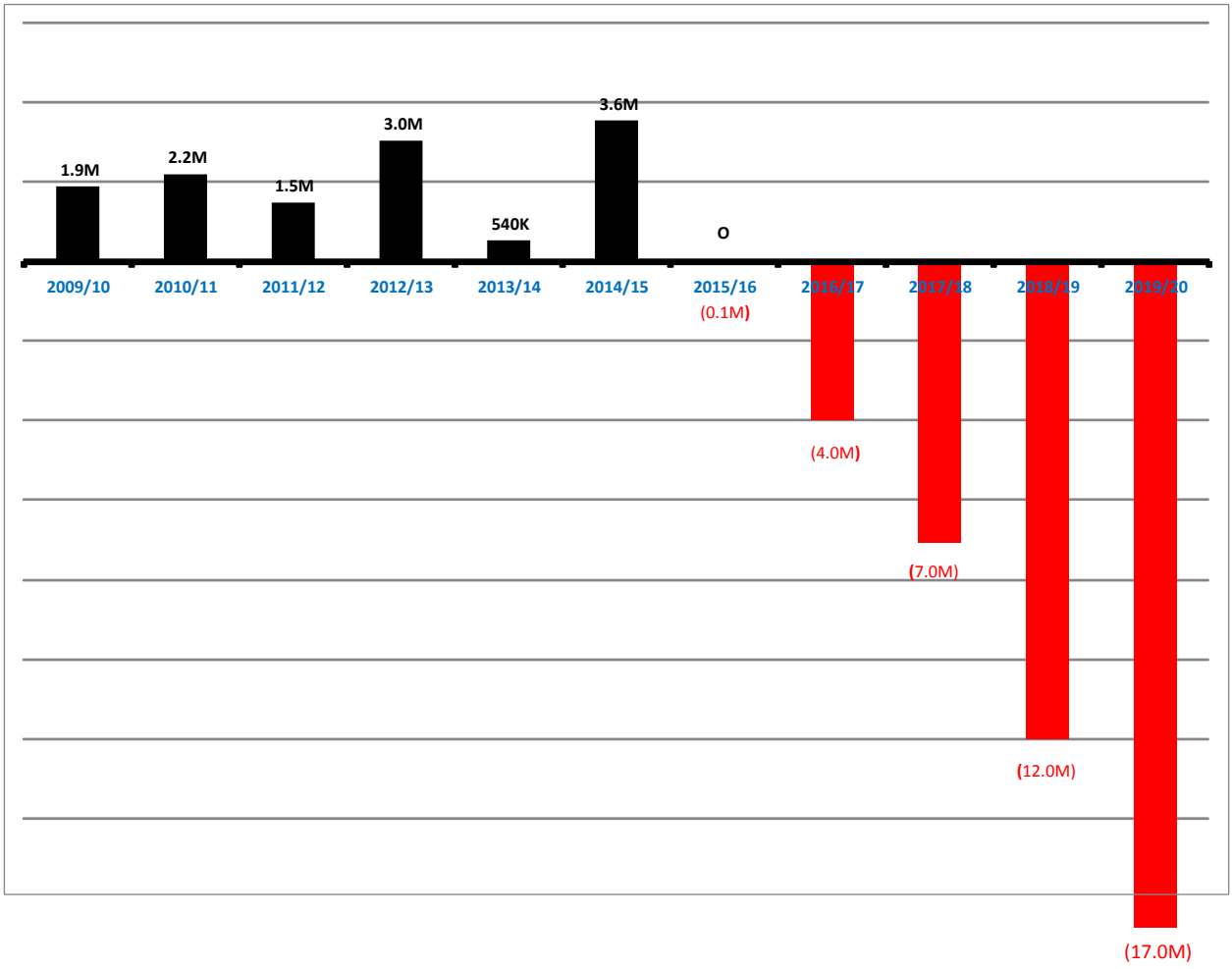
55

Source: Google Maps

Finance

GBHS is projecting year-end operating deficits in the order of $3-$4 million for 2016/17; $6-$7 million in 2017/18 and up to $17 million by the end of 2019/20 (Figure 12). This is not a one-off occurrence resulting from unique circumstances; it is largely due to the introduction of the new HSFR funding model that now applies to GBHS.

Figure 12: Year-end Budget Performance Past and Projected



Funding History

The Province introduced a new funding model to large hospital organizations like GBHS in 2013/14 as part of its Health System Funding Reform initiative. Although deliberately incremental in its introduction, the impact on GBHS was immediate and negative, as shown in Figure 12. The organization's year-end surplus dropped by $2.5 million compared to the previous year, largely due to "mitigation", a method of reallocating funding between hospitals to ease the introduction of the new model.

In year two of the funding model roll-out (2014/15) the Province ended mitigation and GBHS had its funding level restored. As a result, it enjoyed a year-end surplus of $3.6 million. By year three, with the new funding model (HBAM and QBP funding) maturing and making up a larger share of its funding, GBHS ended Fiscal Year 2015/16 with a deficit; its first in six years.

To make matters worse for GBHS, the Province adjusted or "re-set" the HBAM portion of the new funding model in 2016/17. As a result, GBHS received $2 million less in HBAM funding than expected, and will receive a further $2 million reduction in 2017/18 as the final installment of the HBAM re-set. The HBAM re-set negatively affected thirty-four (34) hospitals in Ontario. Of those, the hardest hit was GBHS.

The net effect of the new funding model and re-set of the HBAM formula has been an $8 million swing in the year-end operating position of GBHS over a two-year period; from a surplus of $3.6 million in 2014/15 to a deficit of $3-$4 million in 2016/17. Unchecked, that swing becomes $10 million by 2017/18.

The HSFR funding model favours single site hospitals serving fast growing communities (HBAM portion), and those that are highly efficient on a standardized cost per case for a growing list of medical and surgical procedures (QBP portion). GBHS is at a disadvantage on both counts. Its net operating costs and average cost per case continue to increase largely because it is a multi-site organization serving a slow growth rural population. (A more detailed discussion is available in the Transformation ***Action***Plan report). Clearly, the status quo is not sustainable.

Financial Strength

Three key indicators of an organization's financial strength are: Cash on hand; the Current Ratio; and, available Working Capital.

Cash

An organization's cash position is an important indicator of financial health. Cash is important to have on hand as a precaution for meeting short-term obligations, for investment or speculative purposes and of course for making transactions. An organization's ability to mobilize sufficient cash to address immediate issues, known as "liquidity", is an indicator of financial soundness.

Current Ratio

Current Ratio is a metric used to judge relative financial health of an organization. It denotes whether or not an organization has sufficient readily available resources to pay its debts over the short term – usually the next 12 months. It compares Current Assets to Current Liabilities as denoted in the organization's balance sheet. GBHS is required by its Accountability Agreement with

the LHIN to have a Current Ratio of at least 1.0, meaning it can readily access a dollar to offset every dollar of liability it has.

A ratio of greater than 1.0 indicates that an organization may be in a better financial position to cushion against known liabilities and unanticipated circumstances (i.e. the value of assets is greater than liabilities).

Working Capital

Working Capital is Current Assets minus Current Liabilities. Positive Working Capital is required to ensure that an organization is able to continue its operations and have sufficient funds to satisfy both maturing short-term debt and upcoming operational expenses. Current Ratio and professional judgment inform the appropriate level of Working Capital for an organization.

Analysis

In 2008/09, GBHS emerged from a bruising financial review and restructuring process designed to bring the organization back to financial health. The organization was at its lowest point financially since its creation in 1998 (for a history of GBHS finances 1998-2016 see Appendix 2). As shown in Figure 13 below, its cash on hand was very low, its working capital non-existent and a Current Ratio well below the desired 1.0.

The organization righted itself over the course of the next six years through a lot of hard work and a favourable funding model. By 2014/15 (the year that the new funding model was introduced) GBHS had amassed Cash reserves in the order of $35 million, Working Capital of $20 million, and an enviable Current Ratio of 1.81. Since then, the financial position has eroded; still strong, but weakening as the organization wrestles with the new funding formulae, addresses its growing capital needs, and draws from its cash reserves to make up for projected operating budget shortfalls.

When the Board embarked on the Transformation ***Action***Plan in 2015/16, it knew that the window of opportunity to make and sustain necessary changes to the operating model of the hospital would be fleeting, as its financial strength wanes. The data shows that the window is indeed closing. Working Capital now stands at about $17 million, down from $35 million only a couple of years ago. As a rule of thumb, $10 - 12 million in Working Capital is the minimum this organization should maintain on an ongoing basis.

Figure 13 : Financial Position

Fiancial Health Indicator	2008/09 $ million	2014/15 $ million	2015/16 $ million	2016/17* $ million
Cash	7.3	34.9	28.9	26.0
Working Capital	(4.9)	21.7	19.5	16.9
Current Ratio	0.77	1.81	1.79	1.72
Note: *Dec 31, 2017				

This is not a unique situation for small and rural hospitals; even those that remain on the block-funding model for small hospitals. An analysis of reported financial information indicates that the majority of small and rural hospitals (56%) have experienced a decrease in their reported working capital since the 2010 fiscal year, with 28% of small and rural hospitals reporting negative working capital as at March 31, 2014. [25] Interestingly, while on the same block-funding platform as small hospitals, GBHS excelled by amassing substantial working capital.

Impact on Capital Program

Hospitals do not receive regular annual provincial funding for capital and equipment needs. Apart from periodic and one-time limited provincial funding programs, hospitals must rely on funding their capital needs through contributions from the annual operating budget, community fundraising, reallocating year-end operating budget surpluses, and investment income.

At GBHS, the identified immediate and medium-term capital and equipment needs of the organization that well surpass $15-20 million annually. Yet, the organization supports an annual capital program of only $5- $6 million, with about half of that amount raised through the ongoing community fundraising efforts of our Foundations and Auxiliaries. The remaining amount comes from special grant programs offered by the Province for which hospitals must compete annually, with no guarantees of consistent funding levels year over year. The gap between the organization's needs and available funding grows with each passing year as equipment, building systems and facilities age.

A key financial strategy of the organization over the past five years has been to create operating surpluses, when possible. This strategy helped to build the organization's cash reserves and enable it to undertake some longer term capital planning. The absence of annual year-end operating surpluses deprives the capital and equipment program of a significant funding source, placing greater pressure on an already stretched volunteer fundraising sector to raise even more funds within communities that are facing significant and spiraling economic challenges of their own as noted previously.

[25] KPMG Review of Small and Rural Transformation Fund, KPMG 2014

FCAP

Through its Health Infrastructure Renewal Program (HIRF), the Ministry of Health assists hospitals in addressing their ongoing capital facility needs. Qualifying capital facility projects may receive funding to supplement an organization's own capital renewal program. To bring a measure of rigour to this process, the Ministry has adopted the Facility Condition Assessment Program ('FCAP'). It provides an indication of infrastructure deficits/needs that exist within Ontario hospitals. Expressed in terms of a percentage, the FCAP score delineates condition assessments as follows:[26]

Figure 14: Facility Condition Assessment Program Scoring

Score	Rating	Description
0-10%	Good	The facility and its components are functioning as intended; normal deterioration observed on major systems.
10-30%	Fair	The facility and its components are functioning as intended; normal deterioration and minor distress observed.
30-60%	Poor	The facility and its components are not functioning as intended; significant deterioration and distress observed.
60%+	Replace	The facility and its components are not functioning as intended; significant deterioration and major distress observed, possible damage to support structure; may present a risk to people or materials; must be dealt with immediately.

Appendix 3 contains facility assessment ratings for all GBHS sites. It shows that our facilities have FCI ratings that fall for the most part in the Fair to Poor categories (there are notable exceptions in site component ratings for some sites). For 2016/17 GBHS identified over $47 million in potential capital improvement initiatives that would qualify for consideration in the Province's Health Infrastructure Renewal annual funding program. GBHS typically receives only a small fraction of this amount in any given year. This is by no means the full capital needs of the organization, but it does provide a useful proxy for discussion purposes.

Small and rural hospitals tend to have a higher infrastructure deficit than larger hospitals that tend to have other sources of funds, leading to a significantly lower percentage of facilities rated as good (14% vs. up to 31% for larger hospital groupings).

Performance Benchmarking Review

Figure 15 below provides a summary of some performance data for the GBHS hospitals used to benchmark against comparable hospitals in Ontario. A review conducted by Garrison Health in 2016 compared the Owen Sound hospital to other similar sized community hospitals. Garrison also benchmarked our five small rural hospitals against other small hospitals in rural settings.

[26] KOPMG Review of Small and Rural Transformation Fund

A summary of key performance outcomes from that exercise are outlined in Appendix 4. Overall, GBHS hospitals benchmarked well against comparators for efficiency and effectiveness of service. In no category was GBHS an outlier from the comparator group. The fact that this is not acknowledged or rewarded by the new HSFR funding model, only highlights the need for a funding model change.

Transformation *Action*Plan

The Transformation ***Action***Plan is an ambitious measured, balanced, evidence-based approach to transforming the organization over time, through strategic investments in people, new enabling technologies, leading business practices and aggressive process improvement efforts. Click here to view the Transformation ***Action***Plan.

The GBHS Strategic Plan

'Strategy' is about making choices; choices in how the organization intends to survive and thrive in the years ahead. The Strategic Plan is the organization's blue print for the future, its change agenda. The GBHS Strategic Plan is rooted in strong organizational values, a clear sense of mission and an aspirational yet realistic vision for the organization's future.

The Strategic Plan embraces a number of broader trends in rural health care that are influencing ongoing planning and decision-making of our leadership, clinical and administrative teams, including:

- ✓ Developing a more detailed understanding of our patient population, particularly populations that are poorly served in today's health system with a high degree of unmet care and support needs
- ✓ Integrating and coordinating care models across multiple providers and health care settings
- ✓ Responding to policies and funding models that are increasingly informed by evidence
- ✓ Enabling information sharing and developing innovative ways to deliver clinical and non-clinical services with emerging and disruptive technologies, and
- ✓ Engaging patients and families more fully in their care journey

Four Strategic Directions outlined in the Plan (Figure 15) serve to focus the organization's efforts in the coming years. The corporate transformation agenda arises from the Strategic Plan and transcends all four strategic directions; its central point of departure, however, is Direction 3 - *To Secure our Future*.

To Secure Our Future

The Provincial Government is challenging health service providers to deliver higher quality health care within ever-tightening financial constraints. GBHS, like all health service providers, must optimize the use of its available resources to demonstrate value for money in providing access to innovative and high quality health services. The Strategic Plan outlines three broad goals to advance this strategic direction:

- ✓ *We will scale and align our services and resources with community needs while maintaining the critical mass required to ensure quality and efficiency*

  Opportunities for service improvements will be explored to maximize *quality of care and efficiency of delivery*. As a matter of priority, this will include an examination of surgical services, cancer care and cardiac care to ensure continued excellence through the optimization of hospital capacity and investments.

Figure 15: Strategic Directions from GBHS Strategic Plan

- ✓ *We will enhance organizational capacity to lead, plan for and manage change*

  We will strengthen our organizational capacity to support innovation and enhance performance by expanding our capabilities in change leadership, data analytics and quality improvement. Transfer of information will be enhanced across providers and care settings through various initiatives, such as optimizing the utilization of enabling technology to better connect providers dispersed across a vast geography. These optimizations will include

maximizing our yield from current funding models and revenue generation opportunities in order to secure a sustainable future.

- ✓ *We will continue to invest strategically in information technology*

  Information management and technology is a key enabler of the strategic plan. Through our leadership role in the Georgian Bay Information Network, we will expand and strengthen services in alignment with eHealth Ontario directions. We will continue to invest in technologies that support our patients, physicians and staff with the secure, timely and comprehensive information they need to make treatment decisions. We will strengthen our infrastructure ensuring that the safety and security of information is paramount.

Success Factors

Successful transformation efforts have a number of common elements. These have been incorporated into the thinking and design of the Transformation Plan, along with consideration of the organizational Enablers cited in the Strategic Plan.

1. Consistent leadership that embraces common goals and aligned activities throughout the organization
2. Organizational Capacity and skills to support performance improvement
3. Quality and system improvement as a core strategy
4. Robust teams
5. Engaging patients in their care and in the design or redesign of care
6. Professional Cultures supporting teamwork, accountabilities, continuous improvement
7. Promoting seamless care transitions
8. Information systems and technology as a platform for guiding improvement
9. Effective learning strategies and methods to test and scale up
10. An enabling environment buffering short-term factors that undermine success

Guiding Principles

This Transformation effort:

1. Reflects a strategic and systematic planning process with the long-term sustainability of the organization as the critical priority

2. Is informed by: our corporate Vision, Mission and Values; our ethical decision-making framework; and the Strategic Directions laid out in the 2016-2020 Strategic Plan
3. Is inclusive, transparent and respectful in engaging all stakeholders
4. Fosters systems thinking, encouraging the development of enhanced collaborations, new partnerships and integrated care models within and across care settings
5. Is evidenced-based with measurable outcomes
6. Leverages creative opportunities and innovations that advance the health and well-being of our communities, align services & resources with community needs, and foster excellence in high quality, patient-centre care
7. Is consistent with the SW LHIN's Integrated Health Service Plan, and informed by the Province's *Action*Plan for Health Care Reform and Patients First legislative agenda

Decision Tool

The following decision-making tool was adopted by the Board to guide it in assessing the relative merit, appropriateness and priority of specific actions under consideration to ensure consistency with the organization's core values and strategic directions.

Figure 16: Decision Tool

1.1 Does the decision reflect systematic planning process 1.2 Is this decision sustainable 1.3 Would this decision contribute to the long-term viability of the organization
2.1 Does this decision reflect a systems approach (rather than protecting or entrenching a silo) 2.2 Does this decision reflect collaboration and/or partnerships across health care settings 2.3 Does this decision reflect or advance integrated models of care
3.1 Is this decision based on sufficient evidence 3.2 Does this decision include measurable outcomes 3.3 Is an impact analysis based on sound data and best practice
4.1 Would this decision advance health and well-being of our communities 4.2 Does this decision contribute to the alignment of services and resources based on community needs 4.3 Would this decision foster high quality, patient-centered care
5.1 Is there evidence that stakeholder engagement has occurred and has shaped the decision
6.1 Is decision consistent with GBHS Vision, Mission and Values & ethical decision-making framework 6.2 Is this decision consistent with the 2016-2020 GBHS Strategic Plan
7.1 If this decision consistent with the SW LHINs strategic directions 7.2 Does this decision advance the strategic interests and directions of the MOHLTC
8.1 Is there an identified and reasonable return on investment, direct and indirect ($ and process)

Building the Foundation for Success

The foundational work begun in 2015/16 continues as we set about the task of assembling the necessary internal capacity and capabilities to pursue the transformation initiatives:

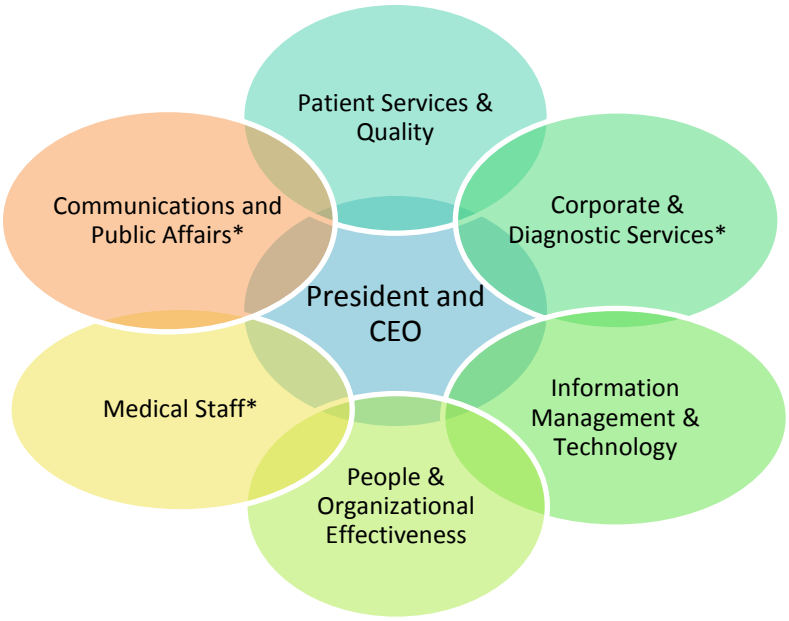
1. Aligning staffing and resources;
2. Securing necessary expertise to supplement internal resources;
3. Undertaking essential primary and secondary research, data collection and analysis that will inform specific initiatives through the next phase of the process

Organizational Design

Successful organizational transformation relies on the alignment of internal stakeholders, from front line patient care through all levels of the organization. Realignment of service areas and reporting relationships can be an effective tool for advancing organizational effectiveness objectives. This is an important part of activating the Transformation ***Action***Plan. Executive Team portfolios were adjusted and renamed recently to align with the strategic plan and to enable this transformation effort (Figure 17).

Figure 17: New Corporate Alignment

Strategic Directions & Enablers	Focus of Executive Portfolio
Best Outcomes	Direct patient care, quality improvement and risk
Secure our Future	Financial and support systems sustainability
Positive Experiences	Communications & public affairs
Our People	Our people & organizational effectiveness
Technology and Data Enablers	Information management & technology



Change leadership and effective change management are keys to sustaining the gains identified in the Transformation ***Action***Plan effort. The executive team is the steering committee for this initiative, providing advice to the Transformation group and information to the Board of Directors, the organization and others as required. The new People and Organizational Effectiveness Group is the steward of this Back to Balance effort, providing project management and change management services to facilitate the work of the organization.

Implementation Initiatives

The Transformation ***Action***Plan identifies some initial opportunities for cost savings/increased revenues. A working group of staff and physicians was assigned to each of these initiatives to explore in detail. These are referred to as the Wave 1 Initiatives; i.e. the first of what may be several groupings or "waves" of initiatives to be examined over time (See summary in Figure 18). In undertaking their work, the groups identify and assess the risks associated with each initiative. Risks assessments look at many different elements, including: patient experience and outcomes; finances; community impacts; health and safety; business continuity; staffing impacts; physician attraction and retention considerations, etc.

With the Wave 1 initiatives being completed or winding down, a second wave (Wave 2) of initiatives has been identified and staff teams assigned (See Figure 18 as well). Subsequent "waves" will be initiated, as time and capacity allow, from a roster of ideas being maintained by the Transformation group. From the outset of the Back to Balance journey, staff, physicians and volunteers have been encouraged to provide ideas for potential cost savings or new revenues. The list (See Appendix 5) is long and growing, as people offer insights for potential savings. These ideas will be vetted by the executive team and assigned to working groups to explore over time.

Separate from the Wave 1 and 2 initiatives, the management team has found additional savings by doing a line-by-line examination of the operating budget, looking for internal efficiencies. This belt tightening effort has resulted in a long list of adjustments to budgets across all departments in the organization that together will yield in excess of $1 million in sustainable annualized savings (See Figure 18).

Figure 18: Back to Balance Initiatives & Savings Estimates

Savings Initiatives 2017/18*	Detail	Estimate
Wave 1 Initiatives		
Surgical Review	Consolidation of surgery	$550,000
Non-OHIP fees	Increase fees to industry levels	$500,000
Physician OHIP billing	Reconciliation process	$500,000
Patient Transport	Chairs vs stretchers	$100,000
Staff Mileage/Transportation	Best practice	50,000
QBP Revenue Capture	patient record coding project	$200,000
Ambulatory Care Review		TBD
Skill Mix Review		TBD
Sub-total		**$1,900,000**
Wave 2 Initiatives		
Retail Pharmacy Expansion	Owen Sound site	TBD
Energy Management	Variety of opportunities	TBD
Service Reviews	Cafeteria, Laundry, Procurement, other	TBD
Case Costing Project	Ontario Case Costing Project	N.A.
Internal Efficiencies		
Budget reductions	Misc. with no lay-offs	**$1,200,000**
Annualized Total		**$3,100,000**
Projected Year End Deficit	2017/18	**$6,000,000**
Difference		**$2,900,000**

TBD=To Be Determined

Advocacy

As staff and physicians work to reduce the organization's gross operating costs, GBHS is advocating to the LHIN and the Ministry for adjustments to the funding model that are sensitive to and reflective of the unique needs of rural Grey Bruce and the multi-site nature of this organization. The LHIN is supportive of these efforts and has greatly assisted us in our efforts.

The Ministry has committed to reviewing the model, stating that the formula ought not to be a disincentive to successful multi-site rural hospital integration models like GBHS. We expect to hear from the Ministry on this matter before the end of March 2017.

While our immediate concern is sustainable hospital funding, it is clear that the issue is far larger than just healthcare; it is about ensuring that public policy is supportive of the long-term sustainability of rural Ontario.

APPENDIX 1: Scope of Services Offered at GBHS

GBHS provides a wide range of services and programs to the communities it serves, including:

Ambulatory care clinics - (often referred to as walk-in clinics) provide medical services that do not require an overnight stay in hospital. Patients receive their care in hospital and go home to recover, which is often preferable for patients, cost effective for the hospital, and can reduce the risk of hospital-acquired infections. We have many different types of clinics, including the following:

Cancer Care – The Outpatient Medical Oncology program provides a comprehensive range of services. A multidisciplinary team that includes three Medical Oncologists, Registered Oncology Nurses, a Nurse Practitioner, a Physician Assistant, Oncology Pharmacists, Clinical Dietitian, Social Worker and clerical staff, provides services.

The program includes onsite chemotherapy treatment and a twice monthly Radiation Oncology follow up clinic serviced by the Radiation Oncologists from the London Health Sciences Centre. GBHS does not offer radiation therapy at this time.

Critical Care Unit – This unit provides care to our most acute seriously ill inpatients. Specially trained nurses, respiratory therapists, and inter-professional staff, along with Intensivist physicians provide care. This includes Intensive Care, Cardiac Care and the Step-Down Unit.

Family Medicine – Each of GBHS' six hospitals has a family medicine department. There are independent, group and clinic models of practice across the corporation. In the rural hospitals, family physicians provide 24/7 emergency coverage and General Practitioner anesthesia in Meaford, Markdale and Southampton. The hospital in Owen Sound includes a small number of family physicians who continue with emergency and obstetrics practices, in addition to their office practices and inpatient care.

Internal Medicine – The Service currently has eleven full or part time members. Subspecialties include Cardiology, Neurology, Endocrinology, Respirology and Gastroenterology.

Diabetes – Diabetes Grey Bruce offers teaching and support to adults and children with diabetes. It offers individual appointments and group education classes to help you manage your diabetes. The team is made up of Registered Nurses, Registered Dietitians and a Nurse Practitioner. These certified Diabetes Educators work with endocrinologists, paediatricians and family doctors.

Diagnostic Imaging – General Radiography (X-Ray), Gastrics, Angiography, BMD (Bone Mineral Densitometry), CT (Computed Tomography), Mammography, OBSP (Ontario Breast Screening Program), Ultrasound, Nuclear Medicine, and MRI (Magnetic Resonance Imaging). Nine radiologists cover all hospitals. A picture archiving and communication system (PACS) is fully implemented at all six GBHS hospitals and throughout the regional hospital network.

Cardiac Services – Non-invasive diagnostic procedures including ECG, Stress Testing, Echocardiography, Arrhythmia and Pacemaker management, Holter monitoring, and Ambulatory Blood Pressure Monitoring, and electroencephalography (EEG).

Dialysis – Currently accommodates up to 24 patients. It operates 12 hours/day, 6days/week. Patients have access to nurses, dieticians, social workers and pharmacists to answer their questions. This clinic operates a satellite of the London Health Sciences Centre Regional Renal Program and is expanding to meet growing demand.

Emergency Department – All six hospitals have 24/7 fully staffed Emergency Departments.

Laboratory – Lab Services are available at all six hospitals. The Owen Sound laboratory does testing for in-patients only, as well as blood work for some patients who are attending clinics within the hospital. The pathology service provides a range of surgical pathology, hematopathology, cytopathology, as well as medico legal and hospital autopsies. This department is well supported by the hospital with strong technical and equipment resources. The pathologists provide consultative services to all hospitals in Grey Bruce.

Mental Health and Addiction Services – GBHS supports a Schedule 1 inpatient service and provides consultation to three community-based multi-agency mental health teams practicing from offices at the Owen Sound hospital. The psychiatrists support a wide range of comprehensive inpatient and outpatient services, including an acute care psychiatric inpatient unit as well as a psychiatric intensive care unit in Owen Sound. A Community Outreach Treatment Team connects with patients while in hospital and continues to see patients on a short-term basis following discharge.

GBHS operates the North Bruce Team that is one of 5 teams operated by Mental Health Grey Bruce. Through this partnership, mental health services are provided to all Grey and Bruce Counties. The main focus of the team is to provide service to people 16 years and older with a serious mental illness (i.e. Schizophrenia, bipolar disorder and depression). The team provides counseling, case management and housing support.

The hospital also provides specialized services to those patients with a Developmental Disability who are also experiencing a mental health problem, those individuals experiencing their first episode of psychosis, clients dealing with sexual assault (past or present) and partner abuse. Crisis services are available 12 hours a day.

Withdrawal Management Services – Offers assessment, treatment and referral, as well as a 3-week day treatment program and ongoing relapse prevention groups. Wellness and recovery through a non-medically supervised withdrawal from drugs and alcohol is also available.

Pharmacy – Pharmacy services at all hospitals are provided through and coordinated by the central Pharmacy Department in Owen Sound.

Rehabilitation and Restorative Care – Rehab services specializes in vigorous rehabilitation of people who have suffered from a disabling physical illness or injury. We help people who have impairment from events such as a spinal cord injury, stroke, amputation, etc. to maximize their independence.

Restorative Care service helps patients regain their independence. Most patients in this program are admitted after they have been treated for a sudden illness and who need to re-build their strength in order to return home. The patients receiving Restorative Care usually are not strong enough for Rehab. Patients who enter this program often are able to return home rather than moving to long-term care.

Sexual Abuse/Partner Abuse Care Centre – This service includes a team of nurses and social workers who are trained in providing emotional support, medical care and counselling for victims of recent sexual assault , adult survivors of sexual abuse and survivors of partner abuse. A team of nurses is available 24/7 to provide emergency care.

Sleep Lab – The Sleep Lab provides diagnostic testing for patients with disruptive sleep patterns. Conditions such as Sleep Apnea can lead to health problems such as hypertension, potential heart conditions, excessive daytime sleepiness, or difficulty concentrating.

Spiritual Care – Each hospital has its own Day Chaplain and on-call Chaplains who are part of the healthcare team. A group of volunteer chaplains also provides services at the Owen Sound hospital.

Stroke Centre – The Owen Sound Regional Hospital is designated as the District Stroke Centre for this area and offers complete stroke care. It is part of the provincial Telestroke program. Inpatient and outpatient services including community rehab clinics are provided.

Surgery – Five general surgeons, five orthopaedic surgeons, three urologists, four otolaryngologists and three ophthalmologists in the department. This is supported by a team of ten anaesthesiologists covering six operating rooms in Owen Sound. This is complemented by General Practitioner/Anaesthesia at three rural hospitals.

Women and Child Care Unit – located in the Owen Sound Regional Hospital, providing care for women and children (up to 18 years of age). The multidisciplinary team includes four Paediatricians, five Obstetrician/Gynaecologists, specially trained Registered Nurses, Social Workers, support services, clinical nutritionists and midwives.

There is a Level II Intensive Care Nursery with the capacity to deliver assisted ventilation (CPAP) and TPN. The Department supports routine deliveries to premature infants as early as 32 weeks gestation. The paediatricians also have admitting privileges to the ICU. The Paediatricians' office-based practice is referral-based and serviced through the Ambulatory Paediatric Clinic at the hospital. The Department offers regular Paediatric Diabetes Clinics supported by a CDE-qualified RD and RN, an Asthma clinic, and a truly unique and comprehensive Paediatric Mood Disorder/Mental Health clinic. The paediatricians also provide outreach paediatric services to the communities of Kincardine, Hanover and Walkerton.

Physician Training – A Family Medicine Residency program affiliated with McMaster University and the Rural Ontario Medical Program is offered at GBHS. The residents complete all two years of their training with GBHS including working with our specialists in the Emergency Department, Paediatrics, Obstetrics/Gynecology, Internal Medicine, and Psychiatry, Oncology, and Hospitalist departments.

In addition, GBHS has a well-established medical education program with an average of 20 medical students and/or residents every month from McMaster, Western, Toronto, Queen's and Ottawa, who complete from 2 weeks up to 3 month-long electives with a physician in one of the 6 sites.

Administration and Support Services – A full suite of administrative and support services are provided to ensure an effectively run organization. GBHS manages the health information system for four other hospital corporations - Hanover and District Hospital, South Bruce Grey Health Centre, Muskoka & Algonquin Health Care, Orillia Soldiers' Memorial and Almonte General Hospital.

APPENDIX 2:

Financial history

- Key metrics, 1st decade from inception of GBHS:

	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
REV. (all)	82.3M	87.7M	98.1M	101.6M	109.2M	123.8M	129.3M	140.3M	150.5M	159.3M
EXP. (all)	85.3M	90.6M	100.3M	104.9M	114.0M	124.7M	133.4M	138.8M	150.9M	161.8M
NET	(3.1M)	(2.9M)	(2.2M)	(3.3M)	(4.8M)	(1.0M)	(4.1M)	1.5M	(0.4M)	(2.6M)
CASH	24.9M	21.3M	21.0M	19.5M	9.0M	10.7M	7.9M	6.1M	11.3M	4.0M
WORK CAP	16.7M	12.3M	13.5M	11.9M	7.3M	3.4M	2.2M	0.6M	(1.0M)	(4.4M)
CURR ratio	2.25	1.87	1.96	1.83	1.54	1.21	1.12	1.03	0.96	0.78

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Financial history

- Key metrics, 2nd decade of GBHS:

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	BUD 2016/17
REV. (all)	159.3M	161.9M	167.1M	170.9M	171.0M	170.2M	172.2M	181.0M	189.1M	187.5M
EXP. (all)	161.8M	166.1M	166.6M	170.1M	170.8M	168.5M	171.9M	177.5M	189.2M	192.1M
NET	(2.6M)	(4.3M)	0.6M	0.9M	0.2M	1.8M	0.3M	3.6M	(.1M)	(4.6M)
CASH	4.0M	7.3M	10.3M	16.9M	22.4M	26.7M	33.4M	34.9M	28.9M	20.7M
WORK CAP	(4.4M)	(4.9M)	0	4.6M	10.3M	13.8M	17.8M	21.7M	19.5M	11.5M
CURR ratio	0.78	0.77	1.00	1.19	1.47	1.57	1.66	1.81	1.79	1.50

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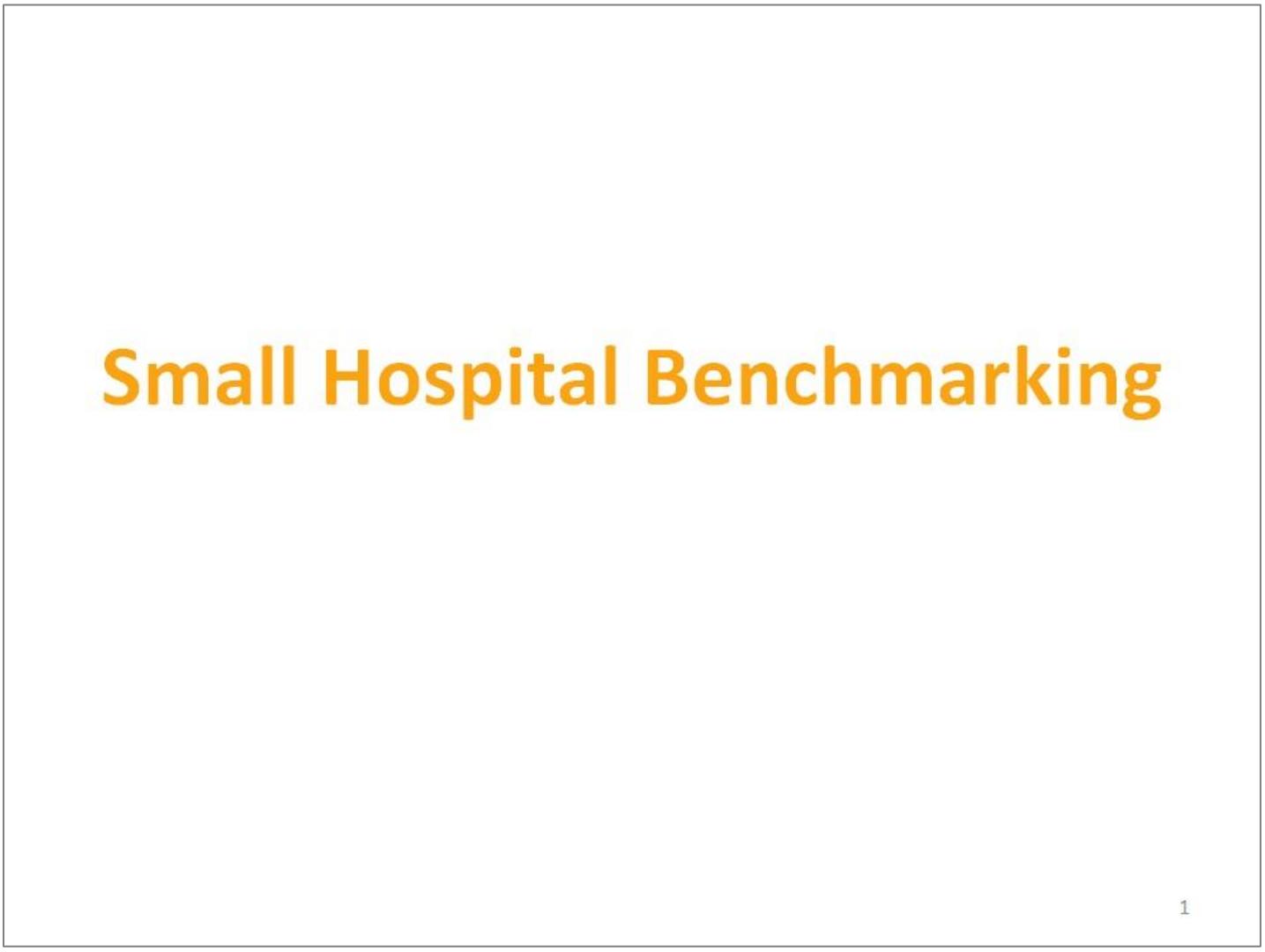
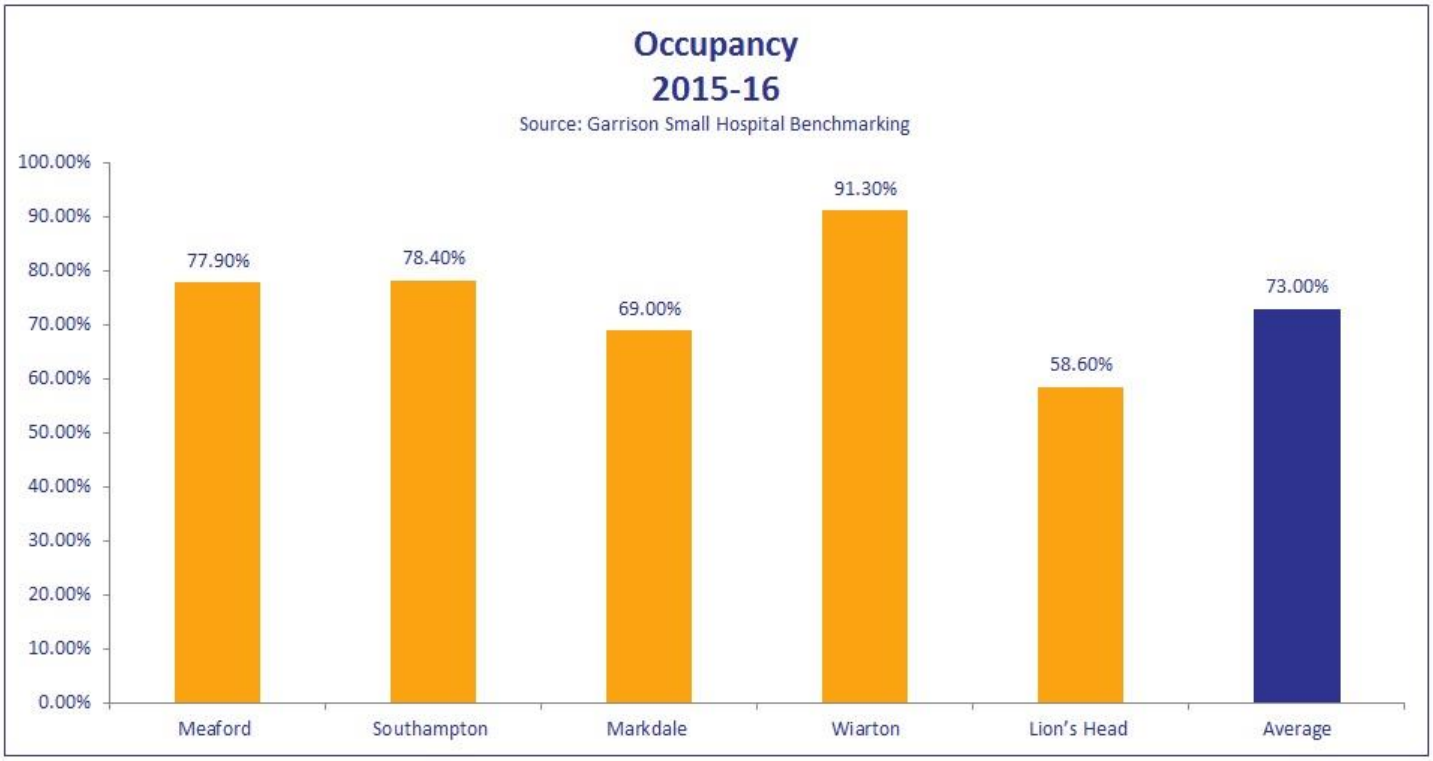
APPENDIX 3: Facility Condition Assessment

Year	Asset Name	FCI Index	Requirement Name	Estimated Requirement Costs (CAD)	Priority
2016-2017	Grey Bruce Health Services - Lion's Head Site - Lion's Head Hospital	0.38		$ 512,967.00	
2016-2017	Grey Bruce Health Services - Markdale Site - Centre Grey Hospital	0.48		$ 2,828,694.00	
2016-2017	Grey Bruce Health Services - Markdale Site - Garage	0.34		$ 14,698.00	
2016-2017	Grey Bruce Health Services - Markdale Site - Portable	0.39		$ 16,207.00	
2016-2017	Grey Bruce Health Services - Markdale Site - Site Components	0.81		$ 260,059.00	
				$ 3,119,658.00	Total
2016-2017	Grey Bruce Health Services - Meaford Site - Meaford Hospital	0.41		$ 3,997,927.00	
2016-2017	Grey Bruce Health Services - Meaford Site - Site Components	0.60		$ 169,882.00	
				$ 4,167,809.00	Total
2016-2017	Grey Bruce Health Services - Owen Sound Hospital	0.34		$ 20,919,979.00	
2016-2017	Grey Bruce Health Services - Owen Sound Hospital - Implement Shed	0.34		$ 48,520.00	
2016-2017	Grey Bruce Health Services - Owen Sound Hospital - Trades and Laundry	0.52		$ 1,006,655.00	
2016-2017	Grey Bruce Health Services - Owen Sound Hospital -8 Units	0.58		$ 3,647,412.00	
2016-2017	Grey Bruce Health Services - Owen Sound Hospital Site - Site Components	0.53		$ 1,980,111.00	
				$ 27,602,677.00	Total
2016-2017	Grey Bruce Health Services - Southampton Site - Site Components	0.64		$ 91,654.00	
2016-2017	Grey Bruce Health Services - Southampton Site - Southampton Hospital	0.38		$ 2,692,205.00	
				$ 2,783,859.00	Total
2016-2017	Grey Bruce Health Services - Wiarton Site - Site Components	0.32		$ 269,868.00	
2016-2017	Grey Bruce Health Services - Wiarton Site - Wiarton Hospital	0.37		$ 6,530,124.00	
				$ 6,799,992.00	Total
				$ 44,986,962.00	**Grand Total HIRF**

APPENDIX 4: Summary of Benchmarking Results

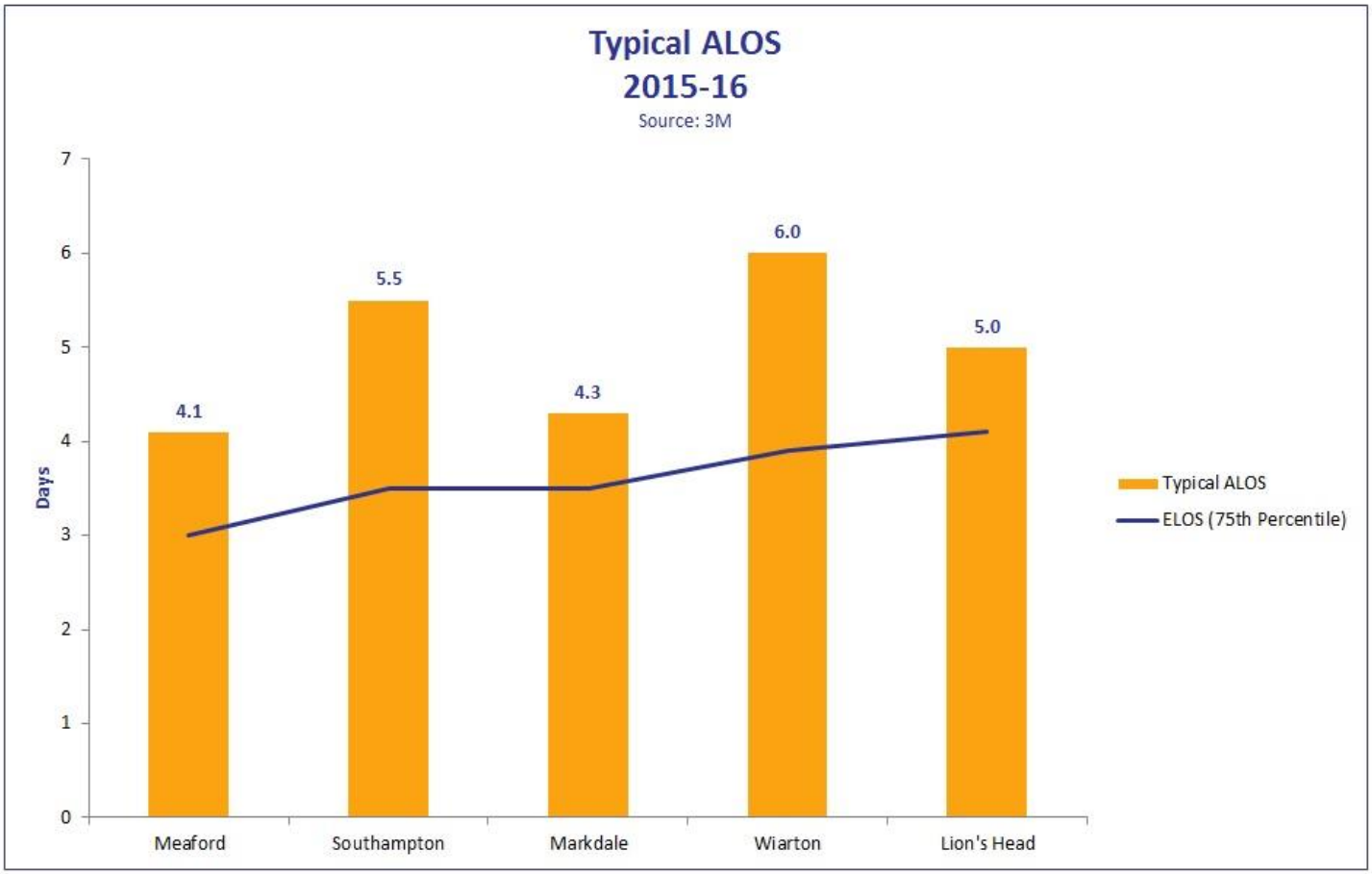


OCCUPANCY


Occupancy
2015-16
Source: Garrison Small Hospital Benchmarking
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
77.90%
78.40%
69.00%
91.30%
58.60%
73.00%
Meaford
Southampton
Markdale
Wiarton
Lion's Head
Average

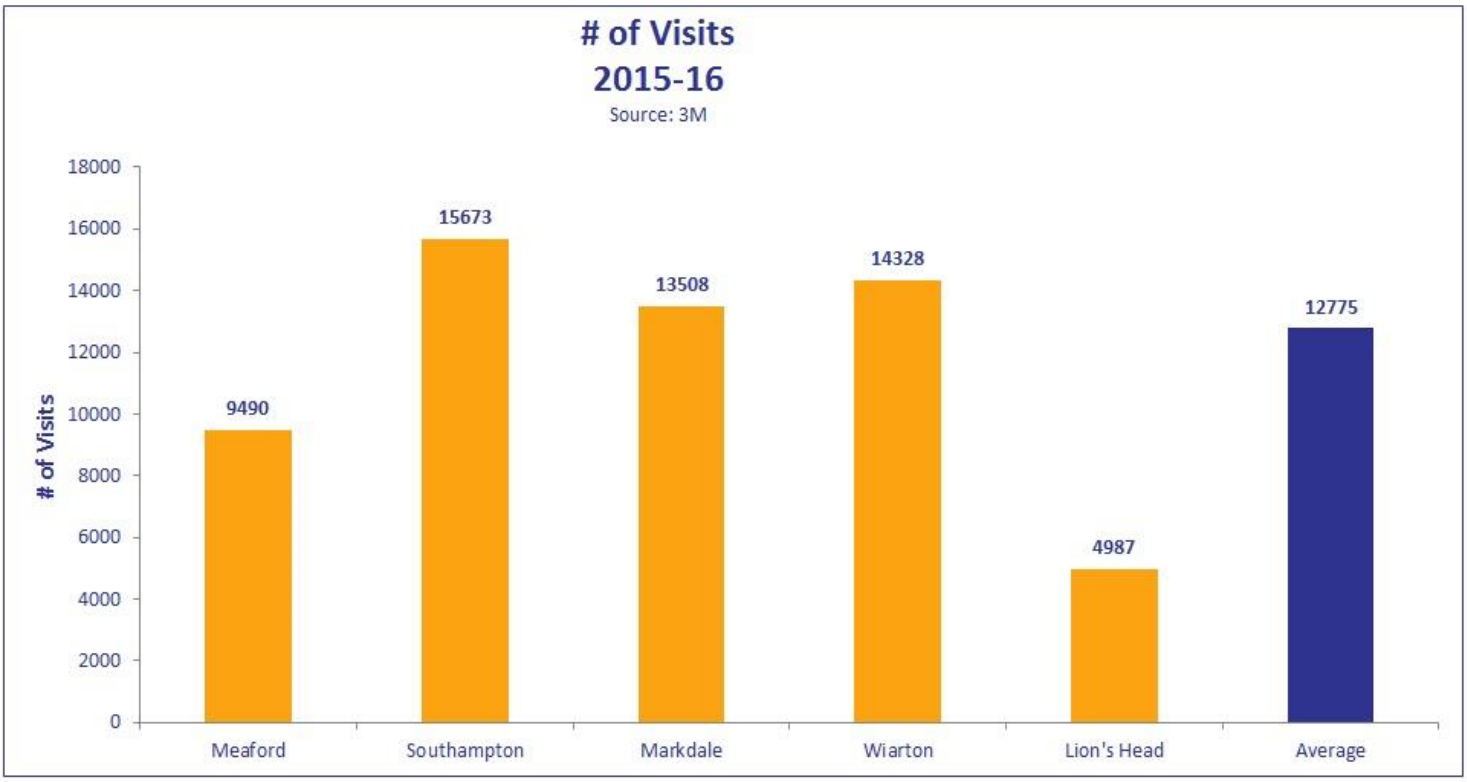
2

LENGTH OF STAY



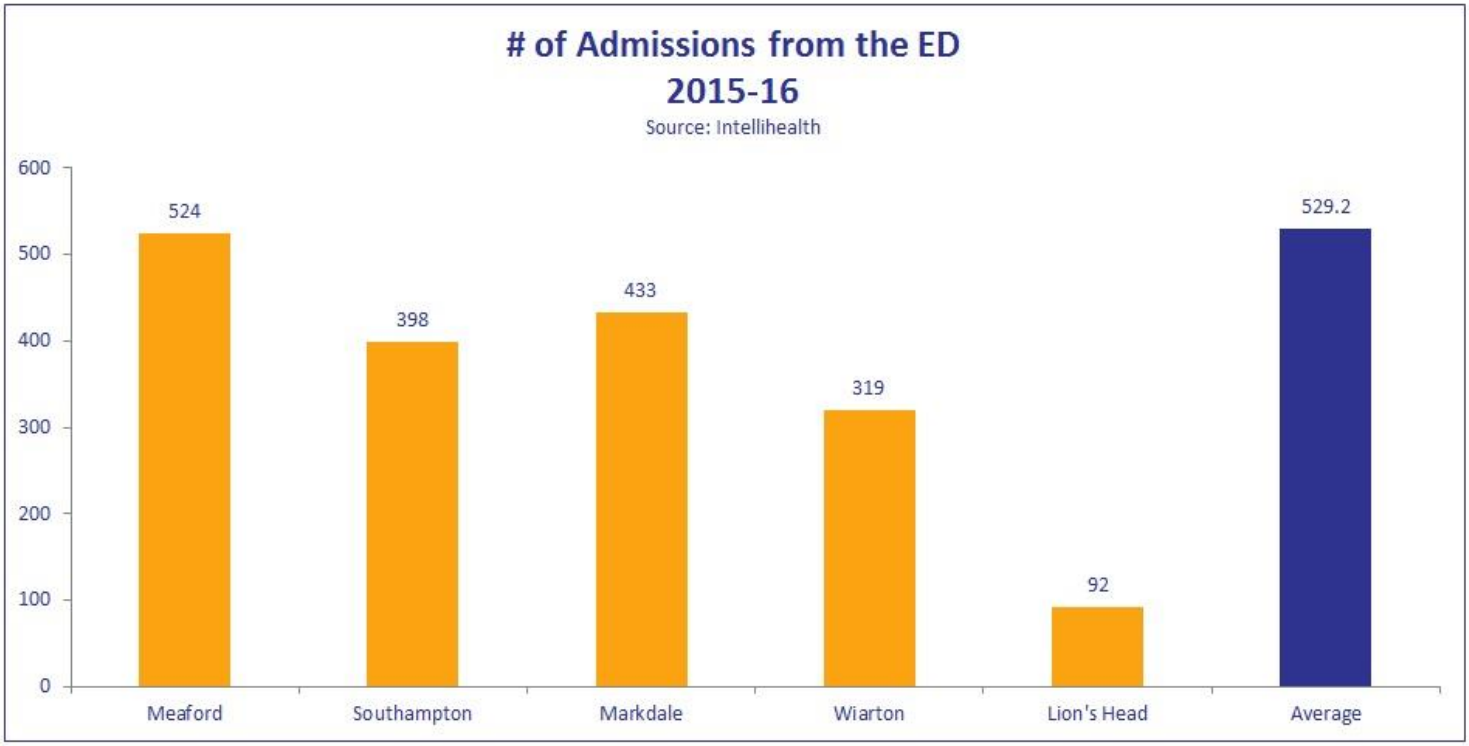
3

EMERGENCY DEPARTMENT VISITS



4

OF ADMISSIONS FROM THE ED



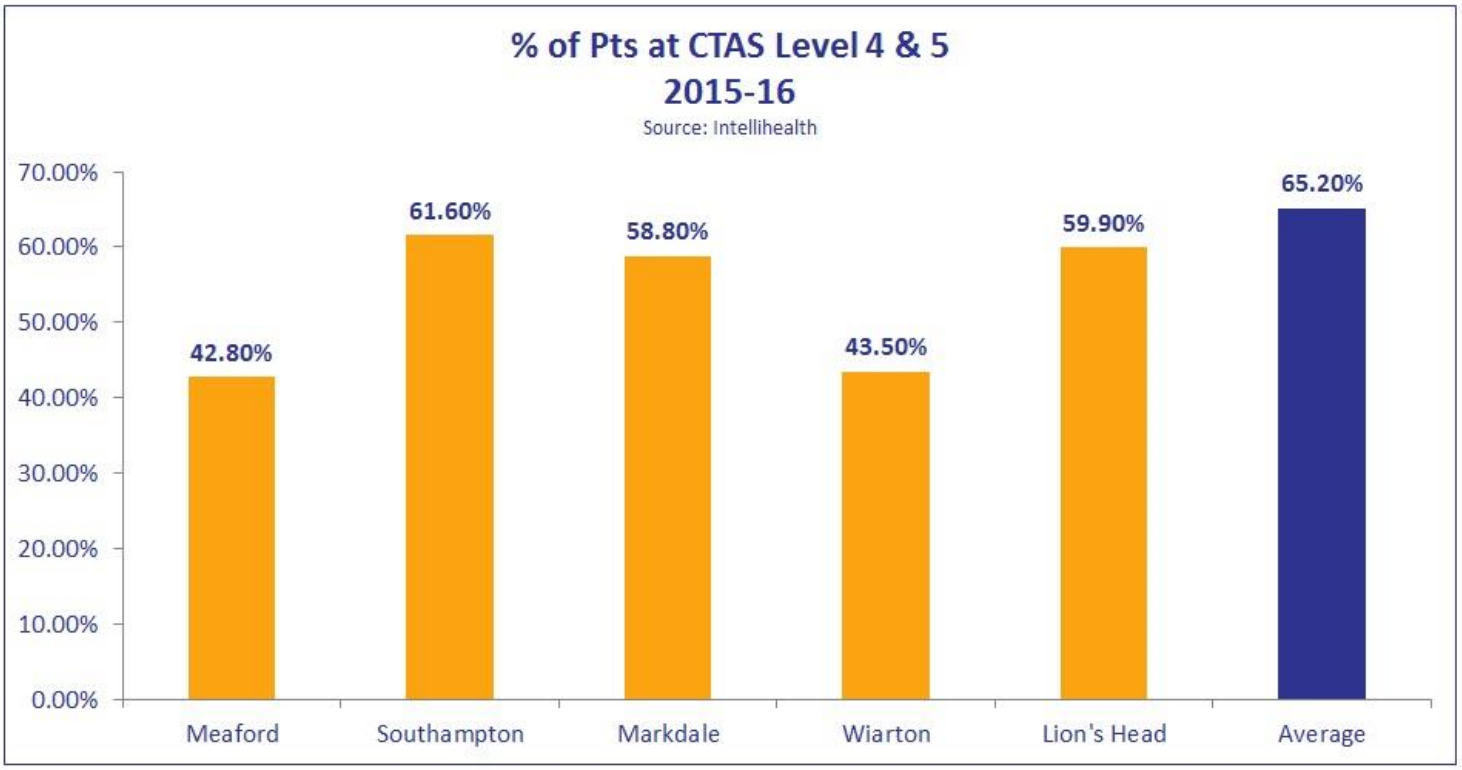
5

Canadian Triage and Acuity Scale (CTAS) National Guidelines

- **CTAS Level 1** Resuscitation – Patients need to be seen by a physician immediately 98% of the time
- **CTAS Level 2** Emergent – Patients need to be seen by a physician within 15 minutes 95% of the time
- **CTAS Level 3** Urgent – Patients need to be seen by a physician within 30 minutes 90% of the time
- **CTAS Level 4** Less-urgent – Patients need to be seen by a physician within 60 minutes 85% of the time
- **CTAS Level 5** Non-urgent – Patients need to be seen by a physician within 120 minutes 80% of the time

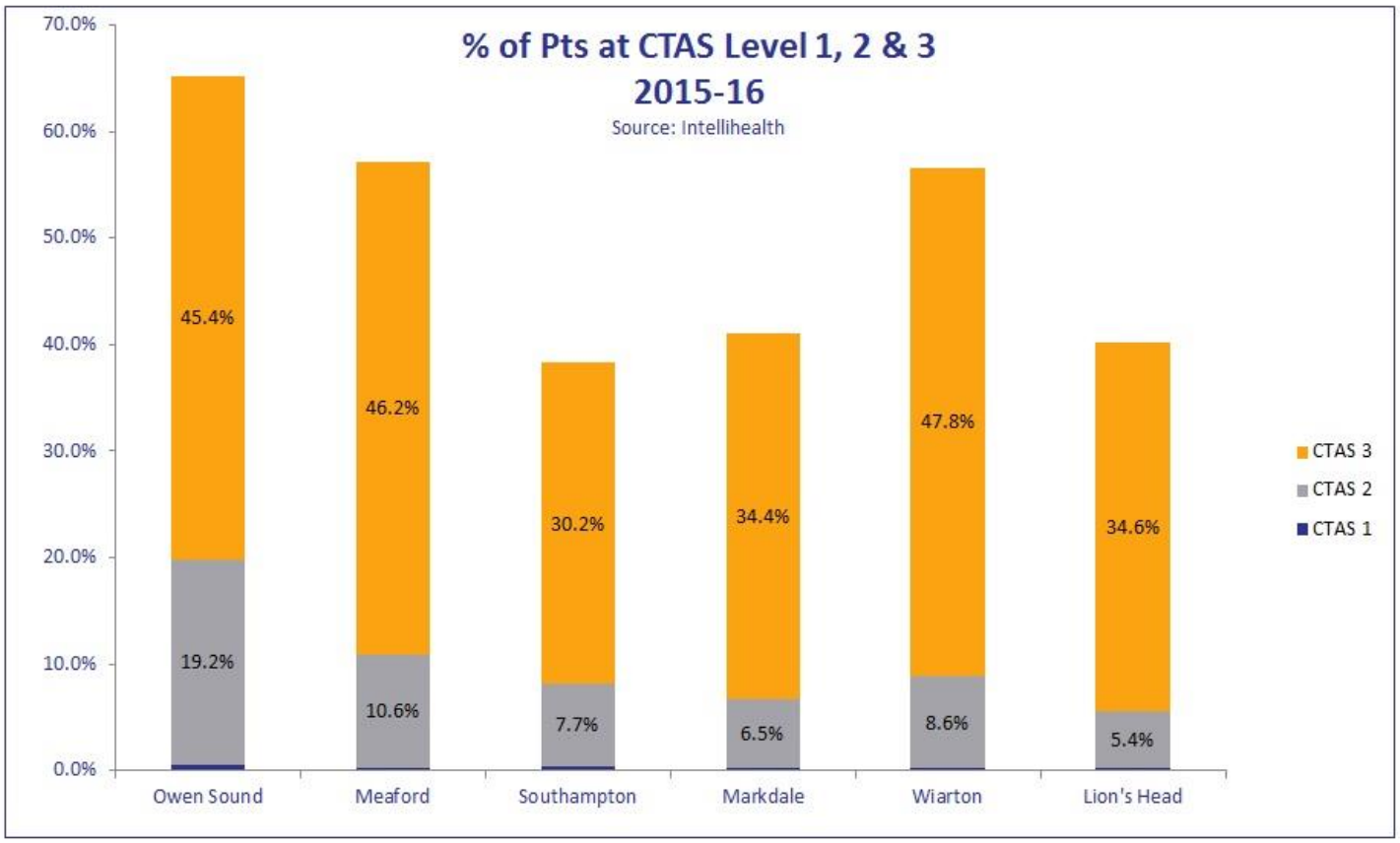
6

% OF PATIENTS AT CTAS LEVEL 4 & 5



7

% OF PATIENTS AT CTAS LEVEL 1, 2 & 3

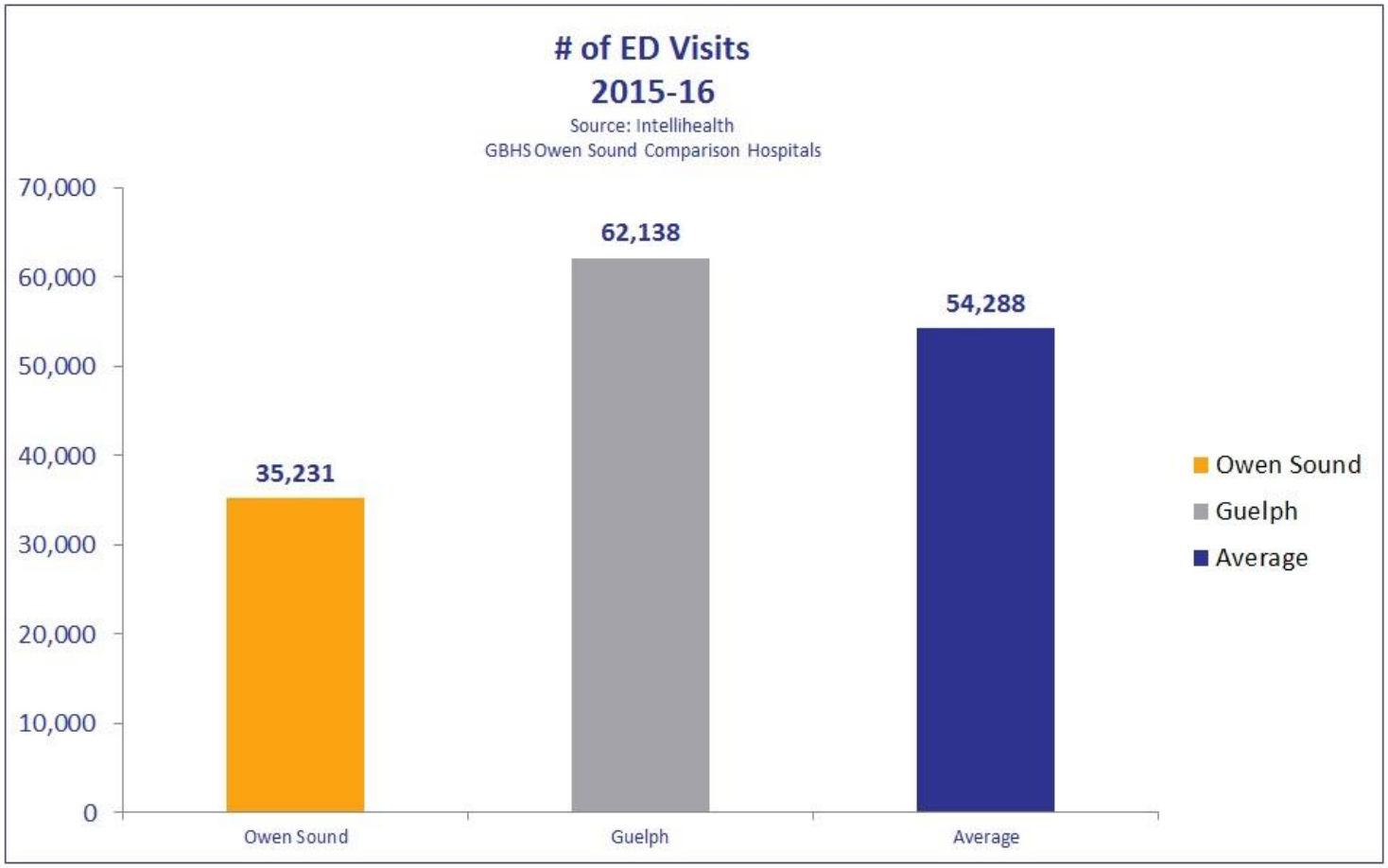


8

Community Hospital Benchmarking

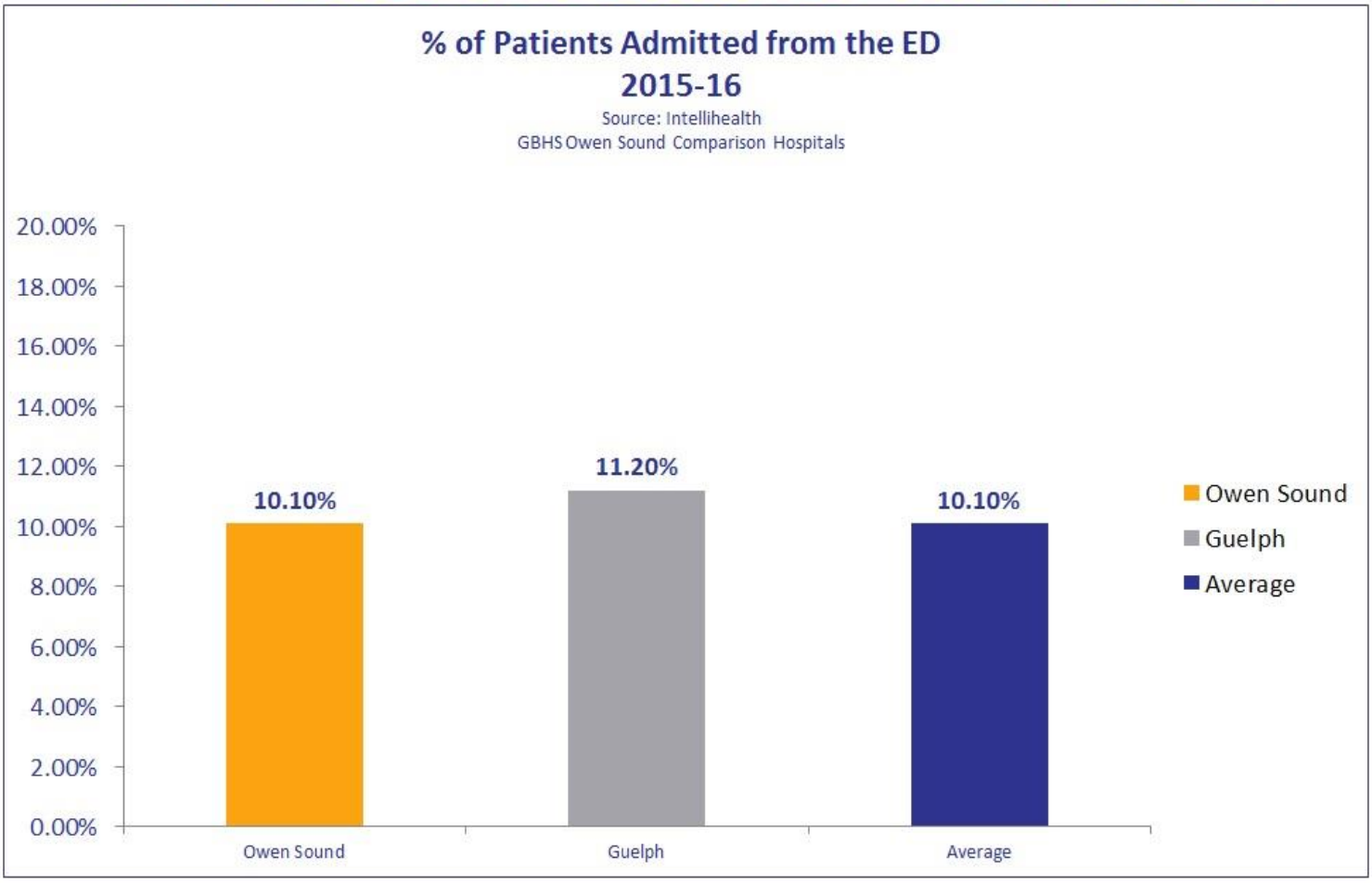
9

EMERGENCY DEPARTMENT VISITS



10

% OF PATIENTS ADMITTED FROM THE ED



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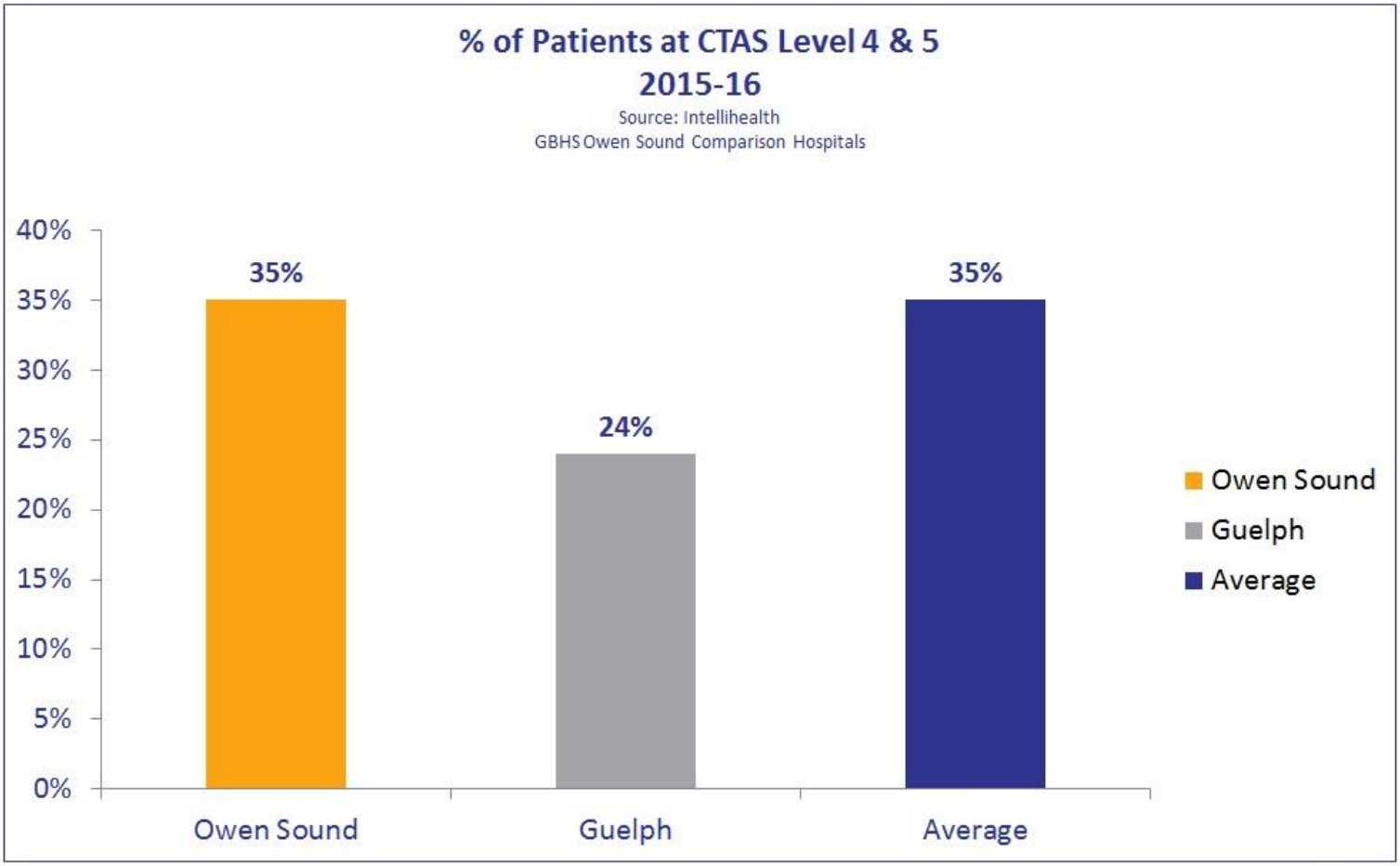
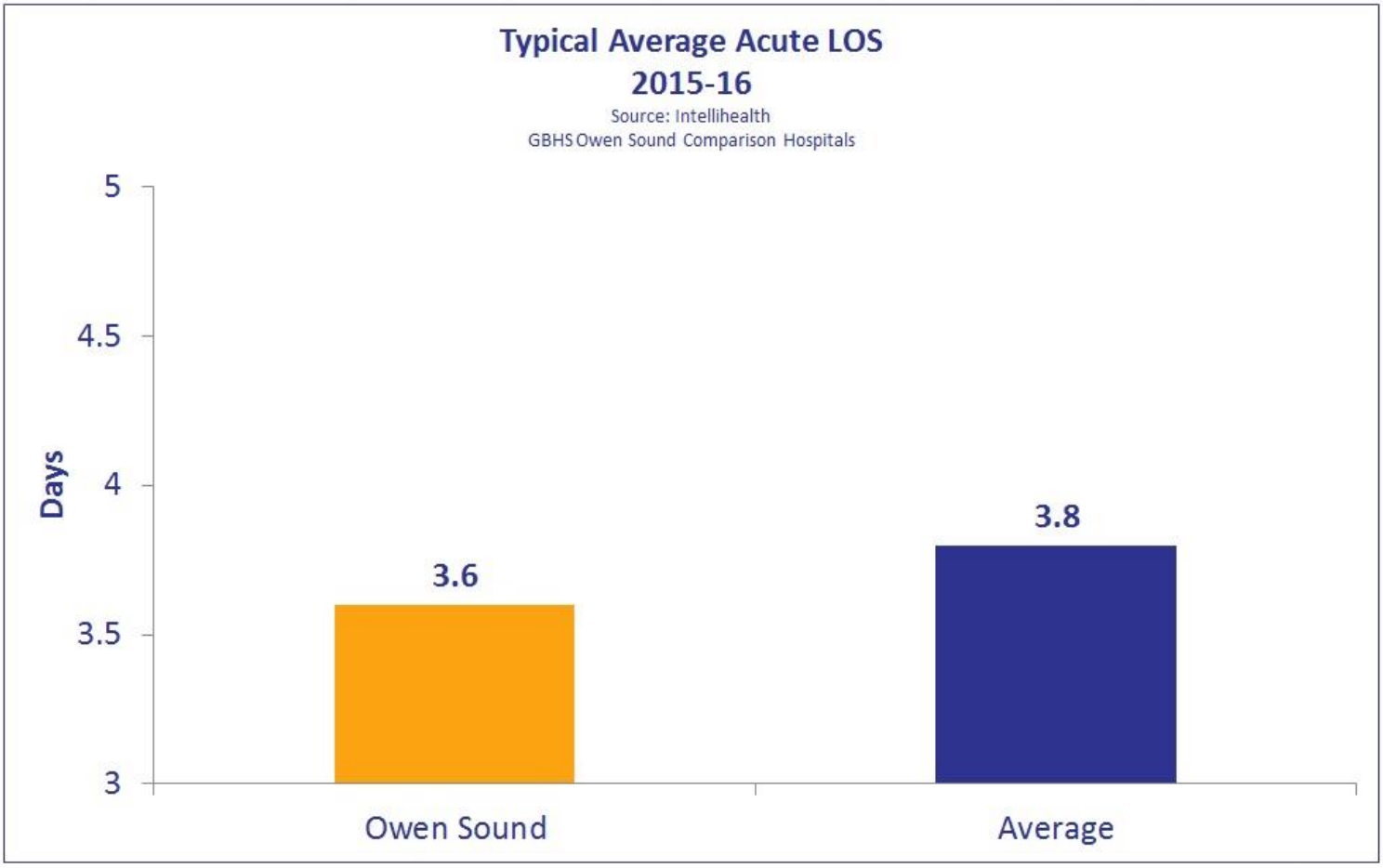
% OF PATIENTS AT CTAS LEVEL 4 & 5



12

TYPICAL AVERAGE ACUTE LENGTH OF STAY



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APPENDIX 5: List of Ideas for Future Consideration

Theme	B2B Initiative in Progress	Worth Exploring	Other
Close a peripheral site			TBD
Patient Transportation	✓		Implemented
Review number of management positions	✓		
Review nursing unit model	✓		
Review of staffing models/overtime reduction	✓		
Skill Mix/Scope of Practice			TBD
Expand discharge lounge		✓	
Surgical Services Review (Maximizing OR usage and resources, Novari, PSS)	✓		
Solar power/energy conservation	✓		
Review mandatory training			No savings
Implementing Clinical Pharmacists/Pharmacy Order Restructuring	✓		
Retail Pharmacy – billable items	✓		
Supply Chain/Material Management/Procurement (inventory control)		✓	
Length of Stay and Improved Discharge Planning	✓		
Outsourcing of Services (e.g. laundry)			TBD

Theme	B2B Initiative in Progress	Worth Exploring	Other
Transportation travel practices	✓		
Reduce printing costs		✓	
Parking Revenues			Frozen by legislation
Track hospital equipment (e.g. wheelchairs)		✓	
Review of service agreements	✓		
Review partnership agreements (SWAHN, MNCYN, etc.)	✓		
Cafeteria revenue generation			TBD
Long-term capital planning	✓		
Space Planning for revenue generation		✓	
Back-office integration	✓		
Volunteer driver program for Outpatient MHS			Not feasible
Reducing LTC patient admissions			TBD
Review MRSA testing practice		✓	
Review use of consultants			Legislated
Ambulatory Care Revenue	✓		
Uninsured services (Blue Cross, WSIB) – maximizing revenue	✓		
Service Ontario Kiosk		✓	

Theme	B2B Initiative in Progress	Worth Exploring	Other
Regular building service maintenance checks			Achieved through PM schedule, OHS inspections
Repurpose the Meaford Hospital			TBD
Market the Release Of Information office			Not feasible
Review fundraising efforts	✓		
Enforce smoke-free policy and impose fines			Not feasible
Organization-wide Lean training implementation	✓		
Food waste (inpatient and catering)	✓		
Case costing	✓		
Review physician compensation models			TBD
Review rural physician office practices where items are “piggy-backed” onto GBHS (e.g. shredding, equipment – sterilization costs)		✓	
Payroll entry training as part of orientation for all clerical staff			No direct savings
Repurpose the Lion’s Head Hospital – Urgent Care Centre			TBD