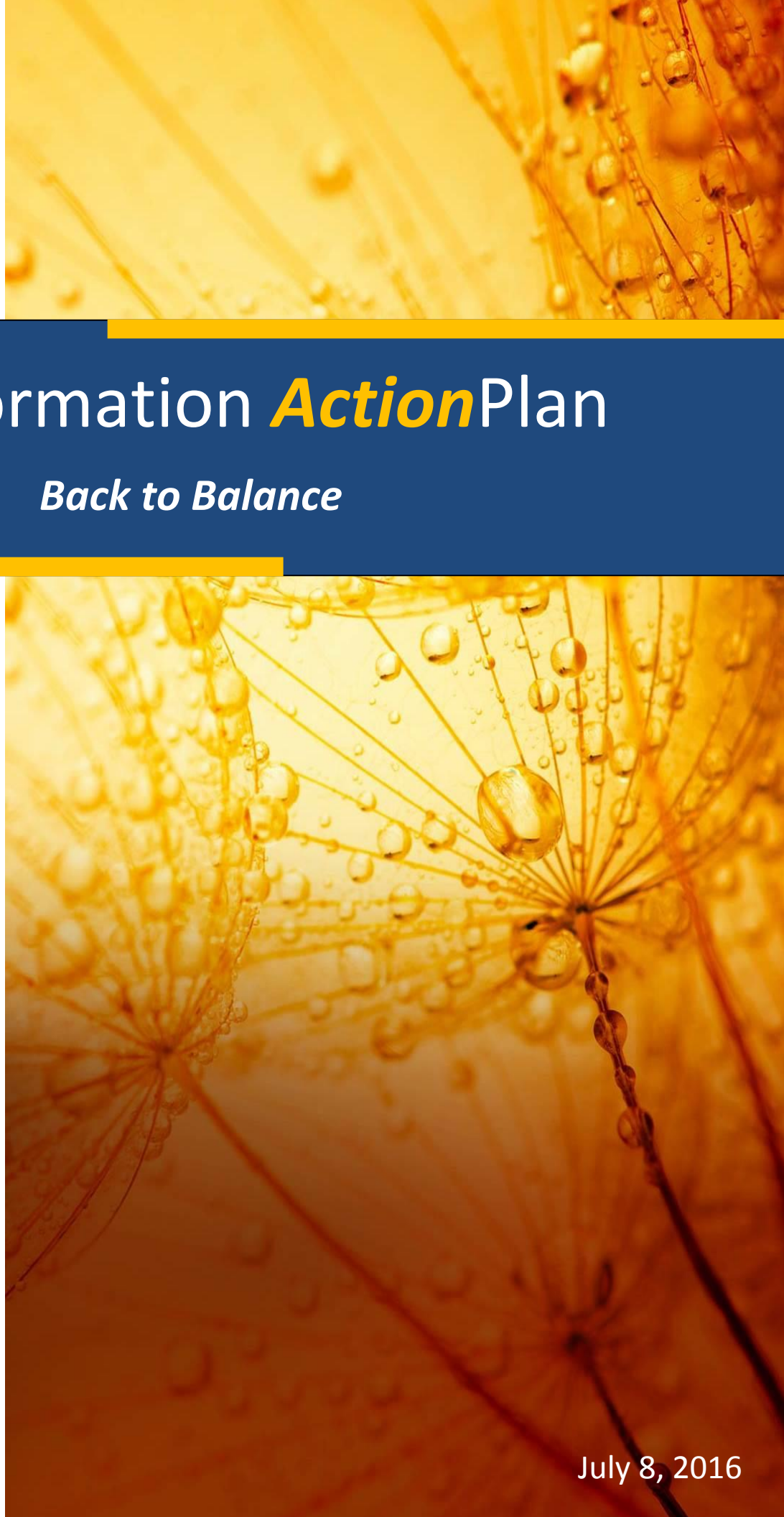
GREY BRUCE Health SERVICES
Quality Health Care Right Here

Transformation *Action*Plan

Back to Balance



July 8, 2016

1.0 Introduction

Grey Bruce Health Services (GBHS) provides a wide range of health services to the residents and visitors of Bruce and Grey counties. Since its creation in 1998 GBHS has earned a reputation for quality care, service excellence and, in recent years, strong financial performance. This legacy is now under siege as the organization strives to adapt to the fast changing, increasingly complex regulatory environment of the Ontario healthcare system; a system of diminishing revenue opportunities, soaring operating and capital costs and unrelenting expectations of ever higher quality and accountability for outcomes.

The direction the Provincial Government, through the Ministry of Health and Long-term Care, is taking the healthcare system is clear; there is more emphasis on being healthy, getting people healthier, keeping them healthy longer and out of hospital unless absolutely necessary. This significant policy focus, which has rocked the hospital sector over the past many years, is continuing with an increasing sense of urgency as the Province strives to constrain costs and provide *"the right care, at the right time, in the right place."*[1]

In 2012 the Province introduced a new funding regime for hospitals, as part of its Health System Funding Reform (HSFR) initiative, designed to drive greater efficiencies and higher quality outcomes into the system. The new HSFR funding regime is a game changer for medium and large sized hospital corporations. With overall hospital sector expenditures frozen for the past six years and hospitals essentially now competing with each other for a set amount of available funding, maintaining the status quo is no longer an option for any healthcare organization.

The new HSFR funding model favours hospitals serving regions with fast growing populations and rewards hospitals that are highly efficient on a standardized cost per case for a growing list of medical and surgical procedures. GBHS is losing ground on both counts – the largely rural population of Grey Bruce is aging and declining overall; our net operating costs and our average cost per case continue to escalate. The truth of this reality is starkly illustrated in a material decline in the fiscal performance of the organization in 2015/16. After a number of years of positive financial results and operating budget surpluses, a year-end operating deficit of $120,000 was realized.

While the situation is serious and cannot be ignored, it is not dire in the short term. We have time to consider our desired future and the path we choose towards that future. What kind of organization do we want to be; what changes do we need to make; how quickly should we make them; what is the right approach to making the necessary changes? Now is time to take action; to begin strategically re-tooling GBHS so that it flourishes within the realities of the

[1] Province of Ontario Action Plan for Healthcare, 2012

current HSFR funding model, is relevant in tomorrow's health care system, and remains responsive to the unique and changing needs of Grey Bruce.

Set out in the following pages is a plan for transforming the organization – a call to action if you will for everyone associated with GBHS. This plan calls for collaborative and creative systems thinking to leverage our corporate and regional strengths, to boldly seek growth opportunities, and to be unafraid to re-invent ourselves as an innovative health system leader. Nothing short of transformative thinking and decisive action will suffice.

2.0 Setting the Stage

Health System Funding Reform (HSFR)

Public Hospitals in Ontario, like GBHS, are independent corporations run by their own board of directors, as set out in the *Public Hospitals Act*. Public Hospitals receive the vast majority of their operating revenues (80% in the case of GBHS) from the Province. In 2012 the Ontario Government began taking steps to fundamentally overhaul the provincial healthcare system, a system that was consuming 42 cents of every tax dollar collected by the government and by the government's own estimates was on track to consume upwards of 70 per cent of the Provincial budget by 2025, if left unchecked.

The Province introduced a wide-ranging health care reform package entitled, *Action Plan for Health Care,* followed by the passage of the *Excellent Care for All Act.* This policy reform package refocused the Province's healthcare agenda towards population health - keeping people healthier and out of hospitals unless absolutely necessary. Funding was frozen for the hospital sector and increased funding directed towards public health, home and community care and primary health care.

A major part of this reform agenda has been the introduction of a new way of funding Ontario hospitals and other government funded health care providers. This funding reform initiative, known as Health System Funding Reform or HSFR, is based on the principles of quality, sustainability, access and integration of services across organizations.

Historic Global Funding

Up until 2012 Ministry funding to support hospital operations came in the form of what is called a global allocation; an annual fixed amount of funding that was based on a number of factors, including: historical budget allocations; rate of inflation; capital investment decisions; negotiations; and politics. The type, volume, and complexity of services provided tended not to be factored into the global budget allocations. While global allocations provided a degree of revenue certainty for providers, it also tended to lead to decreased services and increased patient wait times as providers attempted to stay within set budget limits. Under a global budget model there were few incentives for providers to improve access, quality or efficiency of care. Today small local hospital corporations continue to be funded in this manner, while larger hospitals have migrated to the new HSFR funding model.

Patient-centred Care

The HSFR regime is heavily weighted towards how many patients a hospital looks after, the services that are delivered, the evidence-based quality of those services, and the specific needs of the broader population being served. The benefits of this patient-centred funding model include:

- Funding tied more directly to the quality of care that is needed and will be provided
- Smarter use of limited resources
- Minimizes practice variation between hospitals and allows patients, wherever they may be, to receive leading practice care at the right time and at the right place.
- Encourages hospitals to invest in quality improvement and patient safety activities to provide appropriate care.

There are two components to the patient-based funding model:

Health Based Allocation Model (HBAM)

The HBAM formula is used to allocate funding on a wide range of demographic, clinical and financial data to estimate expected health care expenses at the organizational level. It is expected that HBAM will comprise 40 percent of the Province's operating funding to GBHS within the next two years.

Quality Based Procedures (QBPs)

QBP funding is allocated to specific procedures based on a "price x volume" basis. Providers are reimbursed for the types and quantities of patients they treat, using rates that are adjusted by the Province for patient complexity and quality of health care delivered. The QBPs are identified using an evidence and quality-based selection framework that identifies opportunity for process improvements, clinical re-design, improved patient outcomes, enhanced patient experience, and potential cost savings.

Since 2012/13, twenty-one (21) QBPs have been rolled out, accounting for approximately 14% of the provincial hospital budget, with the promise of more to come. When fully implemented, QBP funding will make up 30 per cent of the Provincial operating grant to GBHS. Global funding will be reduced to 30 percent of the Province's operating grant to GBHS; as noted above, the remaining 40 per cent will come from the HBAM funding stream.

Budget Performance

Following a cost savings and operational improvement exercise in 2009 GBHS performed well within the pre-2012 global hospital funding model, posting annual operating surpluses in each fiscal year from 2009/10 to 2014/15. The new patient-centred funding model (HSFR) was introduced in 2012/13 and its impact on this organization's year-end budget performance was

immediate, as the annual net operating surplus dropped from $1.8 million the year before to $342,000 in 2013/14. Please refer to Figure 1 below.

The new HSFR funding model is being introduced to the system on a graduated basis, with HBAM and QBP funding assuming a progressively larger proportion of overall budget revenues year over year. This, coupled with ongoing inflationary cost pressures and a continued cap on overall hospital sector funding, has weakened the organization's fiscal performance materially. Anticipating such financial disruption to many hospitals, the Province introduced budget stabilization or "mitigation" strategies across the sector in 2013/14 and 2014/15.

For GBHS that meant having some anticipated funding withheld In 2013/14 followed by an unexpected late-in-the-year realization of mitigation funding in 2014/15. The magnitude and timing of the mitigation skewed the year end results for GBHS that year and masked the fundamental dislocation taking place within the organization's fiscal performance relative to the new funding model. The dislocation is, however, starkly apparent at year - end for 2015/16, the first full year of the still evolving new funding model without any budget stabilization/mitigation by the Province, wherein GBHS recorded a year over year swing from a surplus position of $3.6 million to a deficit of $120,000.

Revenues

Well into the third quarter of Fiscal 2015/16 Ministry-derived revenue was unfavorable to budget by about $500,000, largely due to potential Provincial claw-back of budgeted funding not being realized for specific procedures. This shortfall was projected at that time to approach $750,000 by fiscal year-end (including building amortization), fueled by shortfalls in some program areas and specifically-funded activity levels. Patient volumes in some of these funded programs were also lower than expected and our costs continued to escalate.

In its March 2016 budget, the Province of Ontario announced a one–time increase of 1% in hospital base funding, the first increase in the hospital funding envelope overall in five years. This equated to about $640,000 for GBHS in 2016/17. In addition, Cancer Care Ontario advised that as a result of some changes to the funding formulae the claw back for 2015/16 QBP procedures would be in the order of $91,000, considerably less than we had prudently budgeted for. These two announcements combined to radically transform the year end fiscal picture for GBHS in the eleventh hour so to speak.

In April 2016 the Province announced a "re-set" of the HBAM funding for hospitals. The 're-set' included a 1% increase in the overall envelope of HBAM funding available to all hospitals and an adjustment to how the funding is allocated to hospitals to address cited inequities in the formula. GBHS will receive approximately $2 million less than anticipated in each of 2016/17 and 2017/18; significantly worsening the organization's already declining financial position.

Expenditures

Annual inflationary pressures continue to pose a challenge for GBHS, averaging approximately 1.5% to 2% overall. Much of the organization's cost structure is impacted by labour rates (70%) which rely heavily on centrally negotiated factors out of our control. GBHS also incurs pressure in some expenditure categories such as drug costs and utilities, which are outpacing inflation. Inflationary and market pressures of this magnitude are expected to continue, and to accelerate, over the coming years.

The precipitous drop in the value of the Canadian dollar relative to the American dollar in 2015 (30%) will also be a significant factor in driving up hospital costs (even though the dollar has recovered somewhat relative to the American Greenback). Much of the equipment and capital investment within hospitals is sourced from American suppliers and therefore paid for in American dollars. This will place significant upward pressures on our costs.

This structural weakness against the funding formulae is expected to have a continued and growing negative impact on the organization's fiscal performance in the coming years.

Despite the base funding increase and reduced QBP claw back in 2015/16, a fundamental imbalance remains within the GBHS cost structure and will continue to erode the fiscal performance and financial stability of the organization over time if not addressed. The dramatic negative results of the HBAM 're-set' only serves to magnify this underlying financial imbalance. Simply put, expenditure growth is fast outpacing off-setting available revenues.

This is not expected to be a one-off occurrence resulting from unique circumstances; the HSFR funding model will continue to mature towards full implementation over the next few years, and HBAM and QBP funding will continue to assume a larger proportion of the corporation's revenue stream. This structural weakness against the funding formulae is expected to have a continued and growing negative impact on the organization's fiscal performance in the coming years, and is expected to be compounded by anticipated general inflationary cost pressures.

Maintaining the Status Quo

If GBHS continues to operate as it does now, making few changes to its cost structure, a year end deficit from operations in the order of $ 4.5 million is projected for 2016/17; $9 million in 2017/18; and, well exceeding $15 million by the end of 2019/20. This is shown in Figure 1 and supported by data projections in Figure 2. The projections assume increasing annual inflationary pressures on the organization of between 1.5 - 2.5% and continued stagnant or declining revenue growth of no more than 0.8% over the four years. For the purposes of this

broad discussion a rigorous sensitivity analysis of these assumptions and resulting impacts on projections has not been conducted.

Unchecked, the status quo scenario is expected to exhaust the organization's available working capital and cash reserves in less than five years, all things being equal, sooner if inflationary pressures increase beyond the assumed modest levels of today.

Figure 1: Year-end Budget Performance Past and Projected

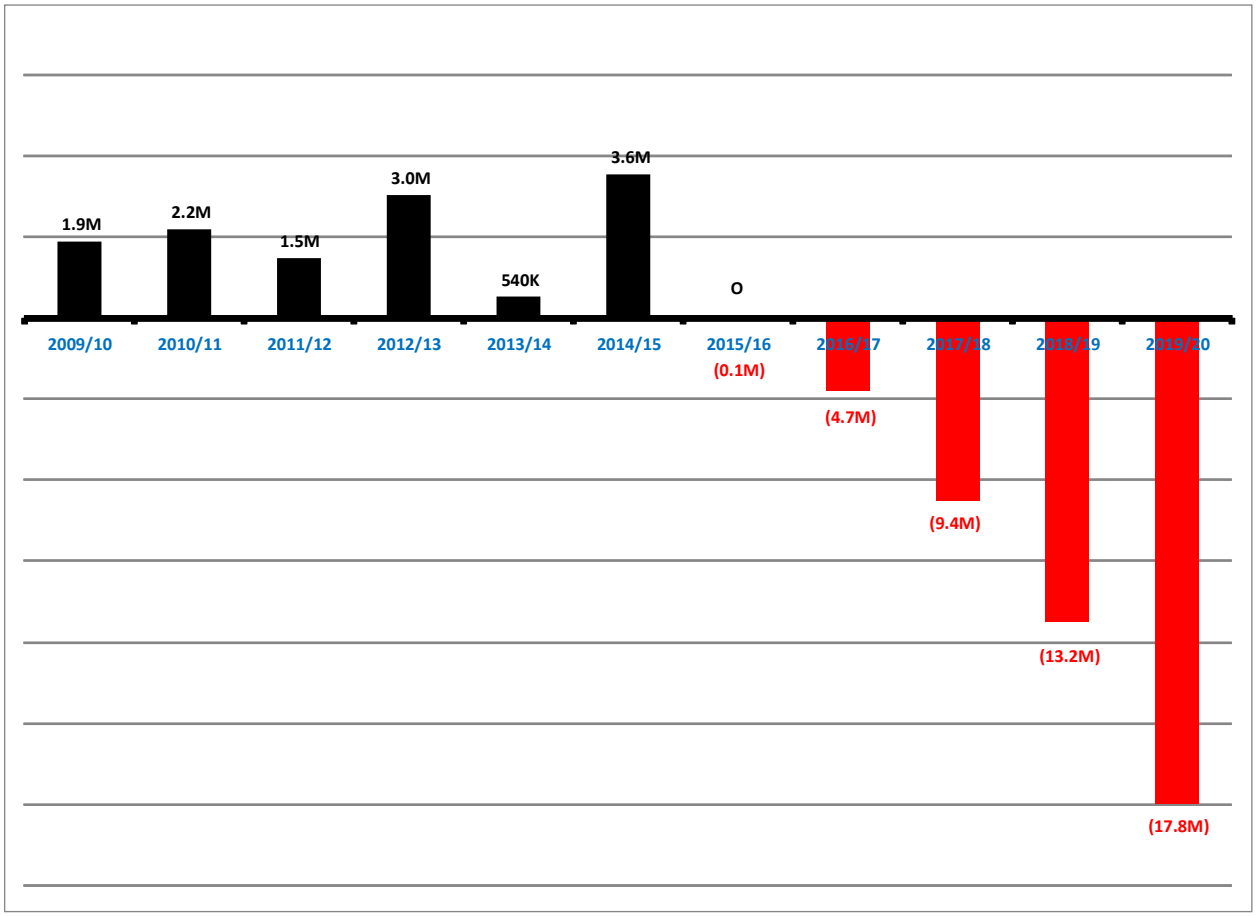


Figure 2: Projected Status Quo Expenditures and Revenues for GBHS ($ millions)

#	Status Quo	Fiscal Year				
		2015/16	2016/17	2017/18	2018/19	2019/20
1	**Expenditures**	$182.0	$184.6	$187.3	$191.1	$195.8
2	**Revenues**	$181.9	$179.9	$177.9	$177.9	$178.0
3	**Operating Deficit**	-$0.1	-$4.7	-$9.4	-$13.2	-$17.8

Status Quo Assumptions

Status Quo Expenditures: The projected annual operating expenditures for GBHS assuming no substantive changes made to cost structure of organization, and assuming annual inflationary factor of: 1.4% in 2016/17; 1.5% 2017/18; 2.0% in 2018/19, 2.5% in 2019/20.

Status Quo Revenues: The projected annual revenues for GBHS, assuming no significant changes to enhance revenue streams: -1.1% in 2016/17; -1.1% in 2017/18; 0.0% in 2018/19; 0.1% in 2019/20.

Status Quo Deficit: Projected annual operating deficit from operations; does not include building amortization.

Impact on Capital Program

Hospitals do not receive regular annual provincial funding for capital and equipment needs. Apart from periodic 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 capital and equipment needs of the organization surpass $10 million annually. The organization is currently supporting an annual capital budget allocation of approximately $6 million, with about half of that amount raised through the ongoing efforts of our Foundations and Auxiliaries. The other half comes from special grant programs that may be offered by the Province for which hospitals must compete annually, with no guarantees of consistent funding levels year over year. For example, the Small, Rural and Northern Hospital Transformation Fund that GBHS has accessed in recent years for some shared information technology projects over the past several years, is coming to an end in 2016/17. What was an annual allocation of in excess of $2 million at the outset has now declined to about $1.1 million shared among GBHS' five small hospitals and those of Hanover & District Hospital and South Bruce Grey Health Centre. Clearly there is a gap between the organization's needs and available funding; and this gap grows larger with every passing year as equipment and buildings age.

A key financial strategy of the organization over the past five years has been to create operating surpluses, when possible, that could then be reallocated to capital and equipment needs. This strategy helped to build the organization's cash reserves and enable it to undertake some longer term capital planning. In the absence of annual year-end operating surpluses, our capital and equipment program will be deprived 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.

Maintaining the status quo is not an option for the long-term sustainability of GBHS and we must be looking for year-end budget results that exceed simply a balanced position, if we are intent on self-financing at least a portion of the organization's capital and equipment program. It is essential therefore that we understand the new funding reality of HSFR and effectively take action to manage the breadth and depth of organizational change needed to succeed in maintaining the continued relevance of GBHS.

Financial Strength

GBHS is a financially sound organization in spite of its ebbing annual budget performance. A summary of some key year-end financial indicators is provided below:

Figure 3: Financial Report, Year End 2015/16 (March 31, 2016)

Key financial indicators	2014/15 31-Mar-15	2015/16 29-Feb-16	2015/16 31-Mar-16
Statement of Rev & Exp			
Operating surplus (deficit)	$3.6M	($199K)	($18K)
Operating margin	2.06%	-0.12%	0.01%
Net surplus (deficit)	$3.6M	($360K)	($107K)*
Balance Sheet			
Cash position	$29.9M	$28.2M	$28.9M
Working capital	$21.7M	$20.1M	$19.5M
Current ratio	1.81	1.87	1.79

***Year- end audited deficit was actually $120, 000**

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 is known as "liquidity" and is an indicator of financial soundness. GBHS has worked very diligently over the past several years to build up its cash reserves. As the above data show, our Cash position remains strong, however it is ebbing.

Current Ratio

Current Ratio is also 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 we can readily access a dollar to offset every dollar of liability we have.

A ratio of greater than 1.0 provides a greater measure of comfort that an organization has more than adequate resources to cushion against known liabilities and unanticipated circumstances (i.e. the value of our assets is greater than that of our liabilities). At year-end 2015/16, GBHS had a Current Ratio of 1.79. According to the Corporation's Balanced Score Card, our corporate target is to maintain a ratio of at least 1.73. Figure 4 provides a trend line from 2012-2016 to illustrate the strong but ebbing financial position of the organization.

Working Capital

Working Capital is another important metric for assessing an organization's financial soundness. It is calculated as 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. The appropriate level of Working Capital for an organization is informed by its Current Ratio and professional judgment of its financial advisors.

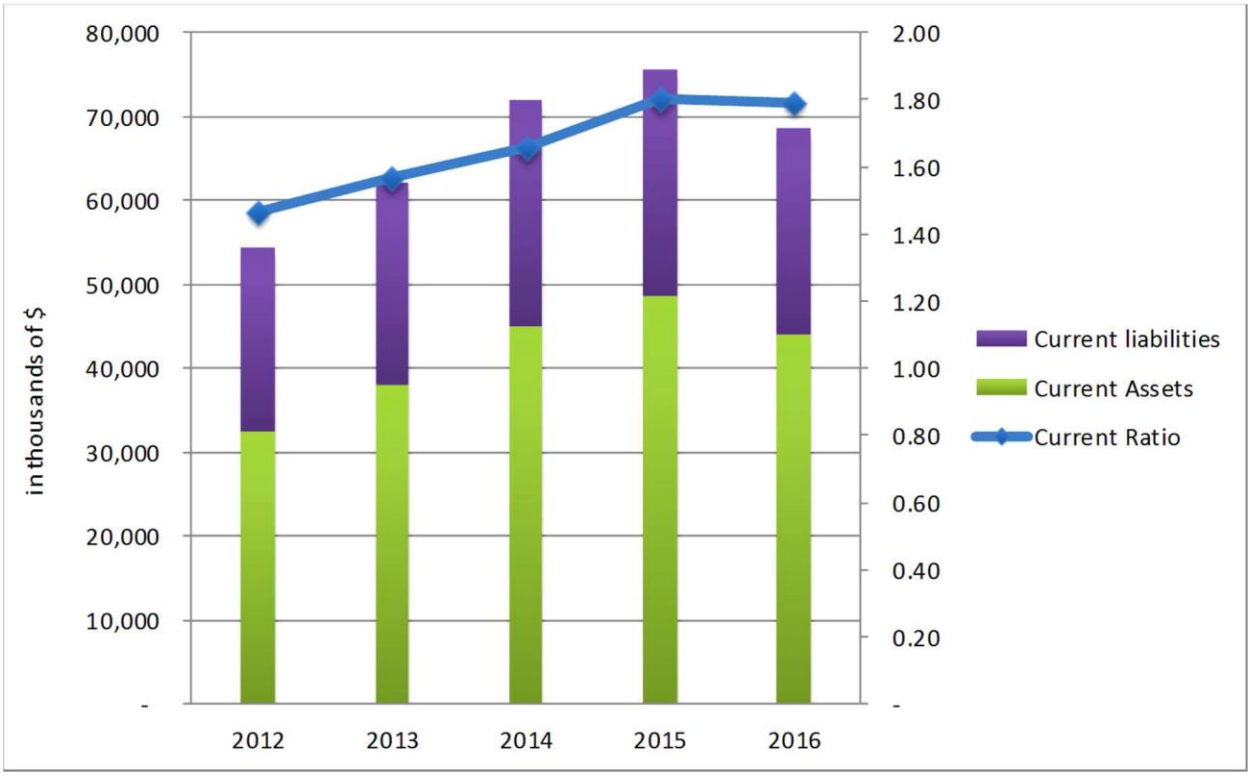
A financial analysis of the corporation's cash position against its ongoing and anticipated fiscal requirements over the coming years suggests that it is prudent to maintain a level of Working Capital of at least $8 -$10 million. Our current level of Working Capital (19.5 million) is above the minimum desired range. This relatively strong cash position is expected to decline over the coming years, all things being equal, as inflationary pressures and unfavourable funding formulae performance exact their toll.

Leveraging our Financial Strength

With increasing annual operating deficits being projected for the organization over the coming years, the urgency of taking advantage of our current strong financial position to invest in altering the cost/revenue structure of the organization is increasingly palpable. If we do nothing, the current cost structure of the organization will drain the cash reserves of the organization over the medium term, as GBHS would be forced year over year to dip into its cash reserves to offset revenue losses and pay for cost escalations, stabilize our operating budgets and support our capital program.

Now is the time to consider the appropriateness of leveraging our current strong cash position to assist in re-tooling the corporation over the short to medium term so that it will flourish in the longer term.

Figure 4: Current Assets vs Current Liabilities 2012-2016



Source: BDO Canada LLP

3.0 Optional Approaches

GBHS has choices as to how it goes about the process of re-tooling itself in the coming years. The course we choose is dependent on the kind of organization we want to be and the nature of the changes we need to make to achieve that goal. The choices include:

Status Quo

***Maintaining the current course; doing nothing extraordinary to alter the revenue/cost structure of the organization*.**

Under this option, the organization would continue its slide ever deeper into *"the red"* with annual operating deficits expected to increase year over year as the fundamental revenue/cost structure of the organization would remain unchanged and unresponsive to the new HSFR funding model. This is not a sustainable option. *NOT RECOMMENDED*

Disjointed Incrementalism

Ad hoc best-effort attempts to increase revenue opportunities and/or constrain cost increases.

This is generally the path the organization has been on. It has yielded some positive results in some areas but will not provide the substantive system-wide adjustments to our cost structure necessary to counter-balance the significant revenue losses and cost escalations that are expected in the coming years. The challenge before us calls for more strategically focused interventions. *NOT RECOMMENDED*

Immediate Arbitrary Reductions

Reducing or eliminating identified services over the short term, either in a targeted fashion or through across the board cuts; the aim being, to reduce costs quickly.

This is the approach most often used by organizations facing a current or imminent fiscal challenge. Such an approach is exceptionally disruptive in the short term and may in fact serve to weaken the longer term viability of the organization by weakening its functional footprint within the region and the hospital sector.

Since staffing is the single biggest expense for hospitals (greater than 70%), invariably the more significant cost cutting measures involve reduced staffing levels. Many hospital organizations are forced to resort to this option because of limited time to make more thoughtful systemic changes and a lack of financial resources to consider other less immediately disruptive alternatives. As an example, in 2015 alone over 730 hospital nursing positions have eliminated

across the province according to organized labour reports[2]. A non-exhaustive sampling of media reports from 2015, as shown in Figure 5**,** illustrates the dire impact of service and job loss in many community hospitals across Ontario.

Such cuts hit all communities hard, but rural areas particularly so, as they result in valued services and hard-to-come-by expertise and economic vitality being forced to leave the region and forcing residents to seek the services in other distant urban centres communities. This regional exodus actually leads to the lowering of the health status of the population[3] and destabilizes and threatens the necessary critical mass of resources and expertise required to operate a hospital organization in a rural setting. Unless done in the context of a well-articulated strategic framework such cuts only serve to weaken the sustainability of organization and degrade the economic wellbeing of the community (See Appendix 2 for economic impact data for hospitals in general and GBHS in particular).

If, as our Strategic Plan states, the overall aim of GBHS is to contribute to healthy communities and sustain the relevance of this organization well into the future, then this is not the preferred option. *NOT RECOMMENDED*

Figure 5: Selected Media Reports of Hospital Job Losses in 2015

North Bay	158
Runnymede	33
Timmins	40
Ottawa	87
CHEO Ottawa	42
Midland	25
Lindsay	4
Newmarket	17
Cambridge	19
Sault Ste. Marie	42
Windsor	150
Grand River	45
St. Joseph Hamilton	58
London Health Sciences Centre	97
St. Joseph London	24
Sudbury	42
Quinte	86

[2] Ontario Nurses Association

Planned Transformation

A deliberate, balanced, evidence-based approach to transforming the revenue/cost structure of the organization over a period of time through strategic investments in our people, new enabling technologies, leading business practices and aggressive process improvement efforts.

A Planned Transformation agenda, as envisioned here, would require the organization to leverage available cash reserves over a period of three years by investing in strategic change management capacity building initiatives, maximizing revenue opportunities and systematically reducing operating costs through process redesign efforts and targeted service adjustments; all the while ensuring continued high quality of patient care. Such a transformation agenda would alter the revenue/cost structure of the organization in a deliberate and measured way, placing the organization on a more sustainable operating footing.

This Planned Transformation approach is premised on having the financial means to withstand short term fiscal challenges, the bravery to invest some of our cash reserves on a plan to future-proof the organization , and a stoic resolve to resist the allure of ad hoc, quick fixes that may be counter to the longer term sustainability goal.

RECOMMENDED

This Planned Transformation approach is premised on having the financial means to withstand short term fiscal challenges, the bravery to invest some of our cash reserves on a plan to future-proof the organization , and a stoic resolve to resist the allure of ad hoc, quick fixes that may be counter to the longer term sustainability goal.

4.0 Transformation

GBHS exists to provide quality health care to the residents of Grey and Bruce Counties and their visitors. While that fundamental purpose may not change appreciably over time, the means by which we strive to fulfill that purpose need to reflect changing circumstances and expectations, if we wish to remain relevant. The degree of change required of the organization in order to become sustainable is significant and will be disruptive. It is more than just doing things incrementally better than we have in the past. It will require a bold *transformational* mindset across the organization at all levels; an approach not constrained by past practice, but rather, forward looking and inspired by our imagination and courage.

Transformation is the process of shaping the organization's future with an unwavering focus on its fundamental purpose and core values, while adjusting the way these are pursued in response to ongoing changes in the external environment that threaten the relevance and/or ongoing viability of the organization. It requires a long-term perspective firmly rooted in a deliberate and sustained strategy.[3] The capabilities and capacity needed to improve care delivery and spread new practices across systems cannot be fully embedded in an organization in short order.

Success Factors

Successful transformation efforts have a number of common elements[4]. These have been incorporated into the thinking and design of this 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 organisation*
2. *Organisational Capacity and skills to support performance improvement*
3. *Quality and system improvement as a core strategy*
4. *Robust care 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*

[3] Ted Ball, *Designing Integrated Healthcare Delivery Systems, Managing Change; Winter 2009*

[4] National Health Service in Great Britain[4], Ross Baker

Strategic Positioning

Adopting a longer-term transformational strategy for the organization and allowing time for an intelligent 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 heavily rewarded. Corporate tolerance for risk and the unblinking resolve of corporate leadership to stay the course are required.

This Action Plan is an essential part of the GBHS Strategic Management Framework. Strategic Management is the means by which the organization establishes corporate direction, develops and implements policies, aligns priorities and allocates resources in service of its strategic objectives, assesses how well the objectives are being met, and makes adjustments as necessary to stay on point. It answers the questions: *Where are we now as an organization? Where do we want to be in the future? What are we going to do to achieve that future? And, how are we going to do it?*

The elements of the GBHS Strategic Management Framework are illustrated and explained below.

The Strategic Plan

'Strategy' is about making choices. Determining how the organization intends to affect change to succeed in the years ahead. What is success? How will we know when we have achieved it? A Strategic Plan is an organization's '*change agenda'*. The adoption of a Strategic Plan is the first step in shaping a strategic management framework.

The Corporate Operating Plan

A strategic plan is a static document of little value to an organization unless it is activated and used to inform policy directions, resource allocation decisions, management actions and day-to-day operations in a manner that is consistent with the stated Mission, Vision and Values of the organization. An organization therefore needs a mechanism to manage and monitor the activation and ongoing implementation of its strategic plan.

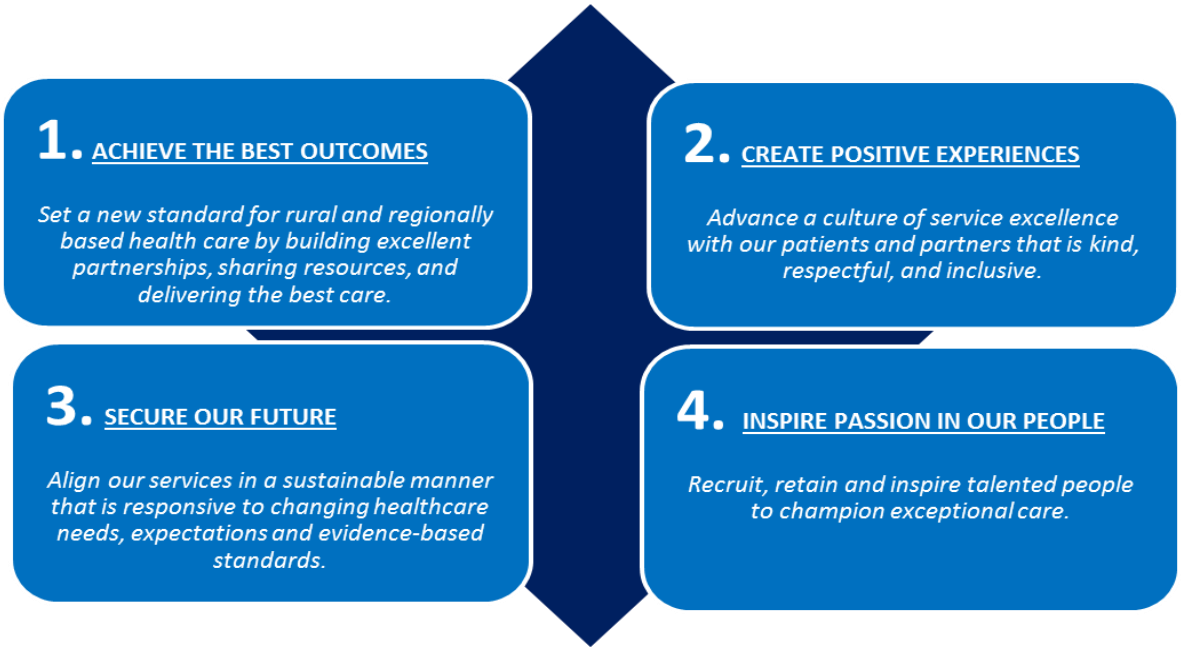
The Corporate Operating Plan provides the necessary linkage between strategy and action. It outlines **"what"** strategic initiatives the corporation is pursuing and intends to pursue over the next few years of the planning cycle. It sets expectations of strategic initiatives, the metrics to be used to measure performance, alignment between strategic initiatives, time lines for achieving expected outcomes, and accountabilities for the results.

Action Plans

'How' the strategic initiatives outlined in the Corporate Operating Plan are undertaken and by whom or what department or business unit, is detailed within Department/Business Unit Plans and related project action plans such as this Transformation Action Plan. Each department or functional area within the organization is expected to develop and refresh on a quarterly basis a three year 'rolling' plan that outlines its involvement and accountabilities in identified strategic initiatives. Rolling in the sense that each year the three year plan is renewed and rolled ahead a year.

On October 28, 2015 the GBHS Board of Directors took the first step in this bold journey of transformation by approving a new Strategic Plan for the organization. The elements of the strategic plan, including the corporation's mission, vision, values and broad strategic directions, will serve to inform the development of an appropriate transformation agenda for GBHS. Four Strategic Directions are outlined in the Plan to focus and steer the organization's efforts in the coming years (Figure 6). Collectively, the four strategic directions will serve as the underpinnings for many corporate initiatives over the coming years aimed at strengthening the organization. A corporate transformation agenda transcends the four strategic directions; its central point of departure, however, is Direction 3 - *To Secure our Future.*

Figure 6 Strategic Directions from GBHS Strategic Plan



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:

- ✓ ***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.

- ✓ ***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*.

✓ ***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.

Organizational capabilities and capacity, or "Enablers" are identified in the Strategic Plan as being essential to the success of the Strategic Directions, namely:

Enabler	Description
 Change Leadership/Management	An ability to effectively support and build capacity in our people to execute, realize and sustain strategic goals. This is supported by the development of key organizational tools, processes and training to support our people.
 Continuous Improvement	A rigorous and systematic approach to proactively and routinely assess processes, programs, services, behaviours and care models to maximize performance outcomes.
 Financial Sustainability	A mindset and approach committed to making decisions that ensure the long-term success of our organization. These choices will be guided by our commitment to the patients and communities we serve, evidence and best practice and demonstrated value for money.

Enabler	Description
 Information Management and Communication	A practice to ensure that clinical, administrative and educational information is available across the organization and broader health system to inform decision-making, reduce duplication and ensure that providers, patients, families and communities have the information they need, when they need it.

5.0 The Plan of Action: Getting Back to Balance

5.1 The Context

1. The goal of Provincial health system change is to create systems of care across traditional boundaries so that primary care, acute care, tertiary care, home and community care are woven together rather than being "silos". The aim is to put patients at the centre of care; to improve continuity and coordination and to enhance quality outcomes.
2. The status quo is not sustainable given the new economic and political landscape. To survive and thrive, GBHS must change – transform in new and creative ways.
3. GBHS has the opportunity and ability to shape transforming rural and regionally based health care by leading, actively influencing and advocating with our partners.
4. Our capacity to transform depends, as always, on our people. We are committed to engaging all of our stakeholders in a respectful, transparent and inclusive way.

5.2 Our Guiding Principles

This Transformation effort will:

1. Reflect a strategic and systematic planning process with the long-term sustainability of the organization as the critical priority.
2. Be 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. Be inclusive, transparent and respectful in engaging all stakeholders.
4. Foster systems thinking, encouraging the development of enhanced collaborations, new partnerships and integrated care models within and across care settings.
5. Be evidenced-based with measurable outcomes.
6. Leverage 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. Be consistent with the SW LHIN's Integrated Health Service Plan, and informed by the MOHLTC Patients First White Paper.

5.3 Goal

To transform GBHS into a sustainable organization, by achieving a balanced operating budget position by the end of 2018/2019 and sustained thereafter, while remaining true to our corporate values in service of our stated Mission and Vision.

5.4 Objective

By investing in a comprehensive multi-year corporate program aimed at reducing overall net expenditures for the organization by approximately $ 17 million in four years.

5.5 By the Numbers: Status Quo vs Transformation

The financial basis for this plan is summarized in the Figure 7 below. Figure 7(a) shows the projected expenditures and revenues for the corporation under the Status Quo option.

Unchecked, the status quo scenario will exhaust the organization's available cash reserves within five years, sooner if inflationary pressures increase beyond the assumed modest levels.

Status Quo

If GBHS maintains the status quo and continues to operate as it does now, with few substantive changes to its revenue/cost structure, the deficit from operations is expected to increase from $120,000 in Fiscal Year 2015/16 to over $17 million by the end of 2019/20 (Figure 7(a)). This is assuming increasing annual inflationary pressures on the organization of between 1.5 - 2.5% and stagnant/declining revenue growth over the four years (see following explanatory notes for assumptions behind the data). It is well appreciated and understood that changes in any one of the assumptions may have substantive impacts on the financial projections.

Figure 7: Financial Model

Figure 7(a): Financial Projections 2016 - 2020 Status Quo Option		**Fiscal Year**				
		$ millions				
		2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
1	**Expenditures**	**182.0**	**184.6**	**187.3**	**191.1**	**195.8**
2	**Revenues**	**181.9**	**179.9**	**177.9**	**177.9**	**178.0**
3	**Operating Deficit**	**-0.1**	**-4.7**	**-9.4**	**-13.2**	**-17.8**

Figure 7(b) below demonstrates the impact of the proposed Transformation agenda in bending the cost curve of the organization over the next four years (as illustrated

in Figure 8).

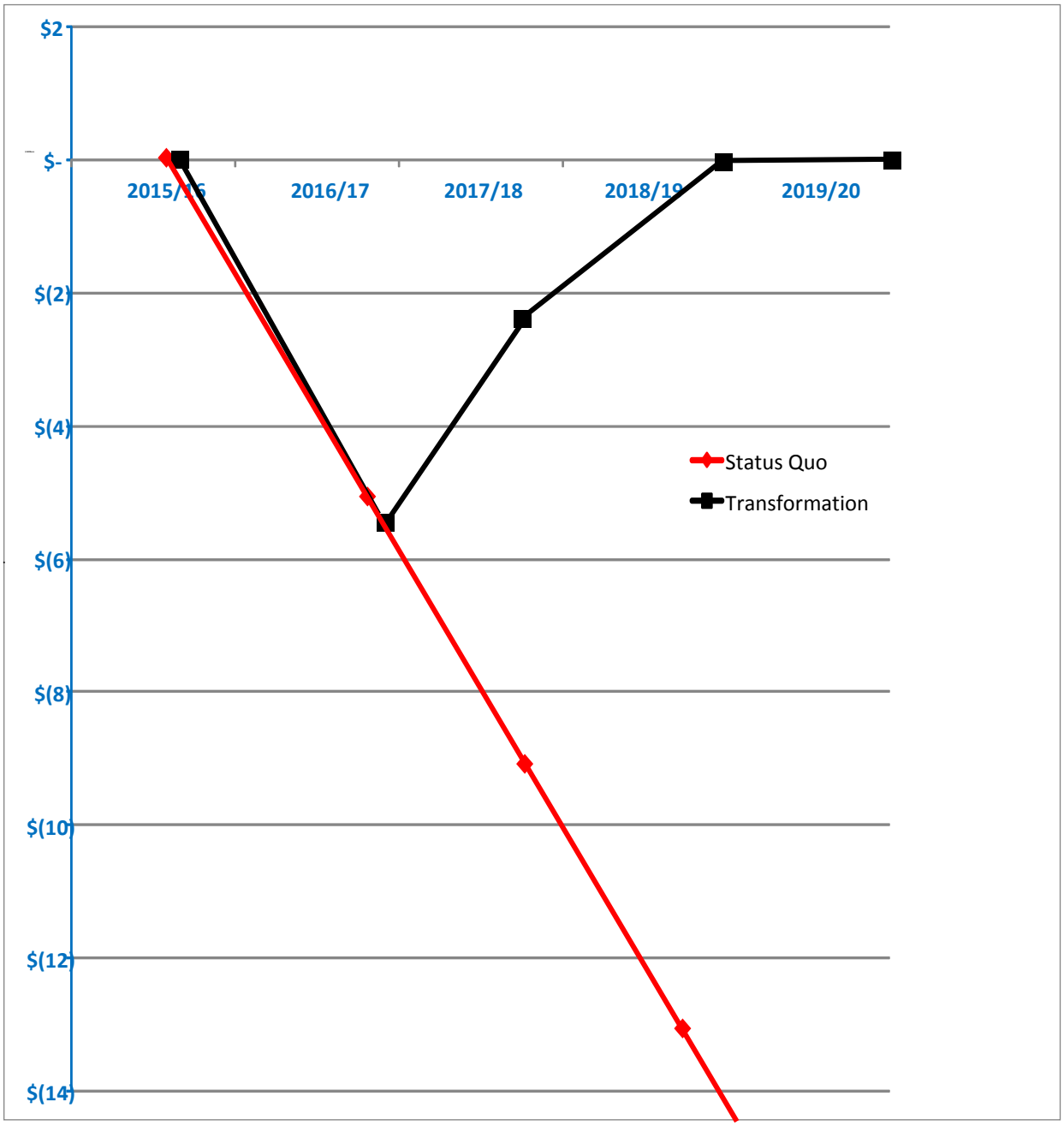
	Figure 7(b): Financial Projections 2016-2020 Transformation Option	Fiscal Year $ Millions				
		2015/16	2016/17	2017/18	2018/19	2019/20
4	Gross Expenditure	**182.0**	**184.6**	**187.7**	**186.6**	**185.6**
5	+ Transformation Investment	0	0.7	0.7	0.5	0.3
7	- Efficiency Target	0	-0.5	-5.5	-6.0	-4.0
8	**Adjusted Expenditures**	**182.0**	**184.8**	**182.9**	**181.1**	**181.9**
9	**Adjusted Revenues**	**181.9**	**179.9**	**179.9**	**181.0**	**181.9**
10	**Adjusted Operating Deficit/Surplus**	**-0.1**	**-4.9**	**-3.0**	**-0.1**	**0.0**

Explanatory Notes for Figures 7(a) and 7(b)

#	Title	Description
1	**Expenditures per Status Quo Option**	The projected annual operating expenditures for GBHS assuming no significant changes made to cost structure of organization, and assuming a gradually increasing inflationary factor of: **1.4% in 2016/17** **1.5% 2017/18** **2.0% in 2018/19** **2.5% in 2019/20** This does not factor in the decline in the exchange rate for Canadian Dollar or other unusual or one time unanticipated cost escalations.
2	**Revenues per Status Quo Option**	For 2016/17 the total revenues are expected to decline by at least $2 million from all sources, largely due to the HBAM "reset". For 2017/18 the second year of HBAM reset will further reduce provincial revenues by $2 million. Thereafter revenues would be assumed to be static.
3	**Deficit per Status Quo Option**	Projected annual operating deficit from operations; Line 1- Line 2; does not include building amortization
4	**Gross Expenditures per Transformation Option**	Expenditures projected year over year within Transformation model. Adjusted expenditure from previous year with annual inflationary factor from Line 1 factored in.
5	**Total Transition Costs**	Costs associated with transformation agenda. 15/16 costs are relatively small as it is early days for capacity building; costs increase in 16/17 as capacity building investment ramps up and is maintained the following year. In 18/19 the

		transformation capacity begins to wind down as studies and research is completed.
6	**Efficiency Target**	Annual target for net operating cost reductions, including: sustainable cost reductions, cost avoidance strategies and internally generated revenue enhancements. Does not include revenue enhancements arising from provincial funding changes, which are captured in Adjusted Revenue- Line 9. In F16/17 a modest target of $0.5 million has been set, recognizing that this is the first year of the transformation initiative and much time will be spent on capacity building, planning and organizing transformation projects. It is expected that a number of small, easier to achieve initiatives will account for at least 0.5 million in reduced costs. In F17/18 the target is increased substantially to 5.5 million, in anticipation of a number of transformation initiatives being staged for implementation over the year. This is an ambitious target. F18/19 and F19/20 target $6 million and $4 million respectively. Necessarily ambitious targets if we are to achieve balance in 2018/19 and sustain it through 2019/20.
7	**Adjusted Expenditures**	Annual Total expenditures adjusted for transformation cost, efficiency target and inflationary factor.
8	**Adjusted Revenues**	For 2017/18 it is assumed that anticipated reduction in HBAM funding of about $2 million will be reversed through advocacy efforts to adjust that funding formula to better reflect the realities faced by GBHS and its integrated hub and spoke business model. It is assumed other funding levels will remain static. For 2018/19 it is assumed that revenues will increase by $2 million as a result of continued HBAM performance, enhancements to other funding sources as a result of internal transformation efforts, and inflationary adjustments by the province. A modest increase in revenue is assumed for 2019/20.
9	**Adjusted Operating Deficit/Surplus**	Projected operating deficit as adjusted by transformation efforts. Line 8 –Line 9.

Figure 8: Projected Year End Operating Budget Position 2015-2020; Status Quo vs. Transformation



5.6 Phased Approach

The Transformation Action Plan is an ambitious change agenda with three distinct phases: Building the Foundation for Success; Targeted Interventions; and Wrap Up.

1) Building the Foundation for Success: Q4 2015/16 – Q2 2016/17

As an organization we may have a general sense, based on the experience and knowledge of our staff, as to the direction we need to be taking to address our sustainability challenge, There is, however, much that we do not know about the new HSFR funding formulae and their impacts on our revenues/costs, or the cost structure of the organization. We need a deeper understanding of these and other factors, based on well researched and analyzed data, so that we can develop useful targeted truly transformational strategies.

This vital foundational work began in Q4 2015/16 and will continue into 2016/17 as we set about the task of assembling the necessary internal capacity and capabilities to pursue the transformation initiatives:

i. Aligning staffing and resources;

ii. Securing necessary expertise to supplement internal resources;

iii. Undertaking essential primary and secondary research, data collection and analysis that will inform specific initiatives through the next phase of the process.

2) Implementation: Q2 2016/17- Q4 2018/19

Having assembled the necessary staffing and third party resources to execute the Transformation effort, and armed with data and analysis from our research activities in Phase 1, we will begin in earnest to develop and implement strategies that will lead the organization towards our goal. This Transformation Action Plan will be adjusted and refined as information becomes available and specific strategies confirmed.

Making significant changes to services and processes within service areas takes time to do right. Engaging stakeholders throughout this process is essential. Therefore this phase of the process has a nominal window of two and a half years.

1. Annual Strengthening Targets
   The plan is ambitious and requires that significant progress be made on an annual basis. Having specific annual targets established as a frame of reference and goal for the organization to shoot for is essential to keep the ***Action***Plan on track. The targets are notional and will be reviewed regularly and refined as more accurate data becomes available and the initiatives proceed.

To monitor corporate performance against established annual targets a corporate registry of strengthening initiatives will be maintained. There are two categories of initiative: Direct, meaning a quantifiable expenditure or revenue; and, Indirect, meaning an initiative that is not easily measured in quantifiable terms, yet will contribute to improved efficiency and/or effectiveness.

2. Early Wins
   While the focus of this transformation effort is on organizational capacity building and longer term sustainability measures, it is also important for the organization to be looking for shorter term "wins". Early successes can set the tone for organizational change and build momentum for the longer term corporate effort. For example: revisiting budgets for further potential savings; setting limits or controls on spending beyond just budgetary limitations; or, adjusting routine staff on-boarding practices. Looking for the small savings along the way can add up to substantial savings over time. The Executive Team will explore the potential for such early wins in parallel with this transformation ***Action***Plan.

3) Wrap-up Fiscal 2019/20

While it is acknowledged that the process of change is a constant and will continue beyond 2020, it is important to set an end date for this initiative, as a planning tool, so that we have a context for measuring success of the strategy. During this phase, consideration will be given to the appropriateness of ending, extending, operationalizing or otherwise adjusting transformation initiatives.

5.7 Building the Foundation for Change

Change Leadership

The literature tells us:

1. Greater than 75% of change initiatives fail because of a lack of engaged leadership and true corporate commitment to the cause; and,
2. Successful transformation requires the dedicated and consistent application of specialized leadership and management skills over a sustained period of time.

Change and the commitment to change management must be a corporate priority and positioned within the organizational structure and resourced accordingly. It must be championed actively and openly by the governance and executive levels of the organization. A change initiative of this magnitude, complexity and importance cannot be managed from the side of a person's desk, so to speak.

This plan calls for the creation of a governance and management framework that will animate and drive the transformation agenda through the organization. This structure will be established immediately upon approval of this Plan by the Board of Directors:

1. *Board of Directors*
   Transformational leadership must begin at the organizational governance level, the Board of Directors. The Board will be directly engaged in the development, approval and oversight of the Transformation Action Plan. It will receive regular updates from the Transformation Steering Committee.

2. *Executive Lead*
   While accountability for the overall transformation agenda lies with the Board, the CEO and Executive Team, it is essential that operational oversight responsibility of this important function be assigned to a member of the executive team.

   The executive lead has been assigned to the Chief Human Resources Officer; as such a transformation function is very much a part of the organizational development element of the HR Department's mandate. In addition, the interim V.P. Clinical has been paired with the CHRO to provide leadership to this effort. The Executive Assistant to the CEO has been seconded to serve as the Transformation Coordinator.

   Together these three senior executives will serve as the core of the transformation effort, around which other staff and resources will be assembled. This group will secure, assemble, coordinate and/or gain access to the expert competencies required to orchestrate the complex, often disruptive change necessary to achieve the expected breakthrough value of this transformation agenda. Every effort will be made to free up and utilize existing staff expertise within the organization to take on the necessary transformation work. Where expertise is either absent or cannot be freed up, third party resources will be secured to supplement the organization's available capabilities.

3. *Transformation Steering Committee*
   The Executive Team will serve as the steering committee for this initiative, ensuring the breadth and depth of corporate alignment necessary to make things happen. It will address emerging issues and challenges such as conflicting directions and priorities that often face the different functional areas of an organisation.

   The Steering Committee will leverage established communication networks within the organization and in the community to build awareness, seek insights and communicate regularly about the transformation agenda, including: Fiscal Advisory Committee/Labour Management Committee; Medical Advisory Committee; Five Foundations Committee, Hospital Foundations and Auxiliaries; Corporate Leadership Council; and community

partnership forums like the Healthy Communities Forum, Grey Bruce Health Network, the Grey Bruce Integrated Health Coalition, and local and county municipal councils.

Investing in Managing Change

Effectively executing and managing change on a continual basis and leveraging organizational change capability is a decided competitive advantage in today's rapidly changing healthcare environment[5]. Organizations that do this well, succeed; those that do not, fall behind. Dedicating time and resources to the transformation agenda is of utmost importance if we are serious about success.
The magnitude of re-tooling required of the organization to bring itself into a sustainable positive year-end fiscal position cannot be overstated. Enabling and creating this necessary transformation capacity must be viewed as an investment in the future of GBHS, not as a cost *per se*.

Enabling and creating transformation capacity must be viewed as a necessary investment in the future of GBHS, not as a cost to the organization to be avoided.

This Action Plan calls for an investment of approximately $2 million in transformation capacity and initiatives over four years. The key elements of this investment are explained below and further costed in Figure 9. The costing estimates are notional at this time and will be refined as the plan matures. Further, care will be taken to ensure that such investment is prudently made only as required. The costing estimates do not include new equipment or other resources and costs necessary to implement new strategies. Those costs will be identified as initiatives are developed.

The key transformation competencies required are:

1. *Cost Structure Analysis*

   The Province's new funding regime integrates the pursuit of quality care with the rigors of financial accountability. Understanding and being able to adjust the fundamental revenue/cost structure of the organization, in relation to that of other hospitals against which we find ourselves now competing for limited funding, demands a heightened capacity and capability for financial analysis than we are able to provide at this time. We have identified the need to undertake the following financial investigations as part of this transformation action plan:

[5] Organizational Change Capability a Competitive Advantage, Rick Torban, Meliorate

- ✓ Adopting the Ontario Case Costing Initiative (OCCI) methodology so that we can have a strong, consistent and comparable baseline understanding of our cost structure relative to other hospital corporations;
- ✓ Focusing improvement opportunities in how costs are and should be aligned;
- ✓ Targeting areas with significantly increasing cost pressures identified by trending analysis for cost management focus (we need to understand the documented 4% increase in our cost per weighted case (CPWC), a proxy for efficiency, above the 1% increase anticipated by the HBAM formula);
- ✓ Understanding relative cost structure against peers for nursing, nursing overhead, diagnostics use, and administration, and review opportunities for realignment of resources; and,
- ✓ Understanding relative cost impacts of medical and surgical supplies, sick time, and overtime use as compared against peers to identify process improvement opportunities for optimizing resource use.

This important work has begun through use of a specialized third party and is yielding valuable insights for the organization. This work is the basis for informing strategic decision-making to sustain the organization in the long term, both in terms of maximizing revenues and constraining costs to within acceptable best practice limits.

> ***"If we don't understand systems dynamics, or how to find the key leverage points within systems, we will forever reproduce flawed systems that don't do what we need and want them to do."*** ***Louis Savary***

2. *Continuous Quality Improvement*

   Finding process efficiencies and cost savings through targeted process improvements is an essential practice that will be undertaken throughout this transformation effort and ongoing. The organization is embracing the "Lean" quality improvement methodology as a major driver in this effort. A Lean approach focuses on driving out wasteful practices so that all work adds value and serves identified objectives.

3. *Research, Data Analysis and Utilization Management*

   Data drives performance management systems and determines financial reward or penalty for a hospital organization. Data analysis and management (data set design, data gathering, analysis, synthesis, evaluation and ongoing management in support of utilization management and decision-making processes) must be a high functioning core competency for any successful hospital organization.

GBHS has a small cadre (one full time and two part time positions) of skilled data management specialists. Additional staffing and third party support in this area for a period of time will assist significantly in avoiding costly funding surprises and will help in identifying revenue opportunities in a more proactive manner. Having sufficient staffing capacity to dig deep into the nuances of the HBAM and QBP funding formulae and offer insights as to how to improve processes that will maximize revenue opportunities and avoid costs is essential for the organization if we hope to take full advantage of the new funding model.

Basic research is also required into issues fundamental to future policy and program development, such as the demographics of Grey Bruce within the Provincial context, social determinants of health implications, labour market trends and expectations, etc. There are many partner organizations that can assist us in this work, such as Public Health, Health Quality Ontario, Canadian Institute of Health Information, the Ontario Hospital Association, the SW LHIN, municipalities/counties, and academia.

4. *Project Management*

   Project management is the disciplined application of knowledge, skills, tools, and techniques to project activities to meet project requirements. There are many projects being undertaken across the organization at any given time. As part of the larger transformation effort there will be additional projects developed and executed. Project management (PM) skills and capacity are in short supply now across the organization. Adding additional PM capacity is an important element of this plan.

5. *Service Reviews*

   The magnitude of change required within the organization to achieve the financial goals of this transformation is significant and will require a deep examination of the services and methods of delivery currently provided by GBHS. The recently completed surgical services review is an example of this. Other service reviews such as the ongoing review of community mental health services, a review of ambulatory care offerings, work being done on back office integration both at the LHIN level and with our local service partners and non-emergency patient transportation are other examples of this important work that is being coordinated throughout the organization and the region. Every opportunity must be explored over the coming year or two.

6. *Business Case Development*

   Undertaking the necessary rigorous research and development of business cases for new or enhanced services is another important undertaking for an organization looking for bold opportunities to generate added revenues, extend availability of needed services and avoid unanticipated cost escalations. Ensuring that a credible corporate

approach is developed and used in all instances will provide greater consistency in methodology and confidence in results.

7. *Electronic Health Record Documentation*

   Accurate and timely coding and complete patient record documentation ensures the organization receives the proper weighting of cases (and ultimately revenues) within the HSFR funding formulae. Less accurate documentation reflects poorly in our reported complexity and length of stay statistics that ultimately drive funding received. Strengthening patient record coding therefore is critical to the long-term sustainability of this organization. Significant effort has and will continue to be placed on improving this important element of our operations and cost structure.

8. *Clinical Optimization of Technology*

   Many clinical staff and physicians are uncomfortable with or do not feel they have the time to properly learn how to use the ever changing technologies and system applications they are being asked to use in their everyday work. One means of optimizing our investment in technology and for improving the efficiency and levels of satisfaction among users is to develop capabilities within the organization to address this critical need. Clinical Informaticists are clinicians with solid information technology backgrounds that provide technical training and support on an ongoing basis to end users (physicians, nurses, etc.). Two new staff resources in this area were added late in 2015/16 because of a provincial funding opportunity and will be continued through the life of this Plan.

9. *Information Systems & Technology*

   A significant focus of this transformation agenda must be on technology, applications and systems. The findings and recommendations of the KPMG review of the GBHS Health Information Services Department serve to inform this element of the transformation plan and the long-term information technology and systems investments required to sustain GBHS.

10. *Stakeholder Engagement*

    Communicating the transformation message; keeping people informed, involved and motivated; and sharing important learnings across the organization, are all keys to success. Dedicating resources and time to communications is required across the organization. The need for additional staff support within the Communications group may be a consideration as the Plan unfolds, depending on identified need.

Figure 9: **Notional Envelope** for Transformation Capacity

Position	Staffing Positions (FTE)		Year				Comments	Funding Source
	Exist	New	2016/17	2017/18	2018/19	2019/20		
Executive Lead	0.5		0	0	0	0	CHRO and VP Clinical shared exec lead.	Current budget
Coordination	1.0		0	0	0	0		Current Budget
Manager Utilization	1		$25,000	$25,000	$25,000	0	Second incumbent. Backfill 0.2 FTE at HDH and SBG	Reserves
Project Management		1	$100,000	$100,000	$85,000	$85,000	New term position to facilitate various initiatives	Reserves
Data Analyst		1	$40,000	$80,000	$80,000	$45,000	Add 1 FTE to existing complement of 2.0 FTE	Reserves
Data Analysts	1.5		0	0	0	0	Existing staff; 0.5 FTE Health Links thru 16/17	Budgeted, Health Links
Clinical Informaticists		2	$170,000	$170,000	$175,000	$85,000	2 FTE specialists hired in Q4 15/16 on term re optimizing clinical adoption of technologies	Transformation grant 15/16
Lean Process Facilitation		*	$75,000	$75,000	$75,000	$50,000	Facilitation, training, supplies, and backfilling of positions	Explore grants
Cost Structure Analysis		*	$50,000	$30,000	0	0	Continued engagement of Garrison Health Inc. to understand HBAM, QBP and overall GBHS cost structure	Reserves
Service Reviews		*	$75,000	$50,000	$25,000	0	Targeted service reviews to identify opportunities as required and identified	LHIN integration $
Financial Analyst		1	$40,000	$85,000	$85,000	$85,000	1 FTE to support Case Costing Initiative and other work	Reserves
Business Development		0.5	$30,000	$50,000	0	0	Phys billings, revenue generation, non-OHIP fees, agrmts/lease	Reserves
Incidentals		*	$40,000	$35,000	$10,000	$5,000	Travel, meetings, supplies, other	Reserves
Communications		0.5	$25,000	$40,000	0	0	Part time assistance as required	Reserves
TOTAL	4.0	6.0	**$670,000**	**$740,000**	**$560,000**	**$355,000**		

Notes to Figure 9:

1) Costs are inclusive of salary, wages, and benefits; not annualized for 2016/17.
4) *Third party expertise

5.8 The Work Ahead

The Transformation agenda requires innovative systems thinking, bold actions and a collective tolerance for significant disruption to the organization. By following a principled, thoughtful and engaging approach over the next four year period, it is expected that changes to processes, services and other adjustments to the cost structure of GBHS can be identified, researched, designed and introduced in measured, well communicated and anticipated ways that will help to mitigate the disruption to the organization and our people.

The leadership team has identified a number of initiatives to date that offer direct and indirect cost reduction/savings/revenue enhancements over the course of this plan. These initiatives are grouped into four "buckets" or categories for ease of reference and tracking and summarized in Appendix 1:

1) System Integration
2) Efficiency and Productivity
3) Revenue Generation/Expense Reduction
4) Information Systems and Technology

The identified initiatives are an initial point of departure for this transformation effort. The initiatives on the list will be explored, refined and validated. Additional initiatives will be identified as we proceed along this journey. Some will prove workable and help us towards our goal, others may not.

It must be pointed out that any costs to implement identified strategies have not have been factored into the identified strengthening opportunities. For example, one time equipment or technology purchases needed to enable longer-term process efficiencies. These costs will have to be quantified as part of the exploration of initiatives and given due consideration in the ultimate decision-making.

Bucket 1: System Integration

Surgical Services Realignment

Surgical services are performed in seven (7) locations across Grey and Bruce Counties including four (4) sites at GBHS, two (2) at SBGHC and Hanover. A regional review has been completed by Deloitte, with a series of recommendations that if implemented will have long-term impacts on how surgical services are organized and delivered across the region. More immediate changes are required within GBHS if we are to attain necessary efficiencies to remain relevant in surgical procedures now funded through the new QBP formulae. Within GBHS alone we are aware of a

number of opportunities to create greater efficiencies and conservatively expect to realize $500,000 in savings if process changes are implemented over time.

Back Office and Clinical Support Integration

We are participating in several back office projects including one being led by the SW LHIN. We can expect over time that this initiative, as well as other ones that may arise out of our surgical services review and other reviews, will lead to process efficiencies that are difficult to measure and savings in staffing and equipment costs. At this point we have conservatively estimated $100,000 in savings in 2017/18.

System Redesign and Service Integration

Our strategic plan states that we will seek opportunities to lead efforts to coordinate regional strategies and resources across our shared health system in Grey and Bruce. To that end, we have begun to position GBHS with the SWLHIN and the Ministry of Health as a prominent player in the health system restructuring taking place in Ontario. We are confident that significant efficiencies and cost savings are possible, if existing barriers between sectors are removed.

Bucket 2: Utilization and Efficiency

Length of Stay and Capacity Review

Inpatient care is the most costly function in a hospital (staffing, equipment and supports) and therefore must be considered as part of this transformation agenda. Recent advances in treatment modalities and system changes such as Health Links create a more favourable climate than in previous years for considering such opportunities.

A review of our actual length of stay versus best practice length of stay indicates there are significant opportunities to reduce the length of patient stays, while maintaining quality of care. This is a complex undertaking that will have to involve multiple physicians, staff and programs. In order to ensure success it must be an inclusive, evidenced-based process. Done appropriately it will ensure we maintain quality, volumes and service levels.

Scope of Practice Review

We have identified potential opportunities in some clinical areas to consider better alignment of nursing staff scope of practice with patient acuity, to achieve sustainable cost savings without jeopardizing patient care. Such a review is not entered into lightly. This effort will require much consultation with our staff and organized labour groups.

Reductions in Non-Productive Time

We are in the process of establishing a nurse staffing resource team to provide a more cost effective approach to managing patient transport and related staff replacement. Cost savings are preliminary at this time but estimated at $100,000 over four years.

Supply Chain

We participate in several buying groups and have achieved considerable savings in purchase prices. However, supply chain remains a set of highly manual and fragmented processes and we believe there are opportunities to streamline. We are active participants in a SWLHIN-wide back office integration project that includes a review of supply chain best practices. Combined with that, we propose undertaking a review of supply chain processes after the surgical service realignment with the intent of further reduction in supply costs across the corporation. There are advances in electronic inventory management and control that have significant potential to create process efficiencies (e.g. bar coding).

Payroll System Improvements

The payroll function has been identified as being under resourced. New software programs are being considered that will bring significant efficiencies to this essential function, enabling redeployment of some staff time to other necessary tasks.

Bucket 3: Revenue Generation/Expense Reduction

We have identified several areas of focus to generate additional revenue as well as mitigate future losses due to changes in the funding formulae. We advocated successfully for additional QBP revenue for stroke care and we have begun detailed analyses of our procedure coding practices and internal cost structures at all sites. We are confident in stating that this analysis is essential to mitigate future loss of revenue and to provide us with necessary data upon which to make sound evidence-based decisions.

Areas to be considered include:

- Reviewing and harmonizing our revenue recovery from physician billings, third party contracts and rental income
- Explore the opportunity to expand retail sales from our outpatient pharmacy and gift shop
- Explore the opportunity to shift more patient transfers from stretcher to wheelchair vehicles

- Examine the potential for savings by shifting from reliance on staff using their private vehicles to appropriate use of rental vehicles. Consideration should also be given to the merits of having a small corporate fleet of vehicles or an established arrangement with vehicle rental firms to reduce travel costs for staff who are engaged in a multitude of regional and provincial initiatives requiring extensive travel.

We estimate that there are opportunities to enhance revenues and constrain or reduce costs by almost $2 million through these initiatives over four years. It is expected that other opportunities will be identified by staff as this process gets underway.

Bucket 4: Information Systems & Technology

We have begun to introduce technologies to automate labour intensive processes. Two examples include patient self-registration and voice recognition software for physicians. We will also be implementing web-based software being encouraged by the SWLHIN, called Novari, which is showing great promise in other jurisdictions for streamlining and managing surgical bookings. We estimate approximately $300,000 in operating savings over the next 2 – 3 years, with technology advances having the potential for a much larger impact in coming years.

Consideration must also be given to expanding GBIN (the Georgian Bay Information Network), our electronic patient health record system that we currently share with four other hospital corporations operating 14 hospitals across Muskoka, Simcoe, Grey and Bruce counties. Additional partners give us the potential of expanding our net revenue base by approximately $250,000-$300,000 per year per new partner.

A number of other technology based initiatives are identified in Appendix 2, which have great promise in providing improvements to efficiency and quality of care. While some are in process now or will be shortly, others, like the introduction of CPOE (computerized provider order entry) are a number of years away from yielding desired outcomes.

Advocacy

It is clear from the financial modeling outlined in Figure 7 of this Plan that in spite of our efforts to bring the organization back to a balanced budget position within four years, the current hospital financial model is not sustainable over the longer term. Unless there is fundamental systems change, inflationary factors are expected to outstrip available revenue tools for hospitals like GBHS, leading in time to a significant

Public policy and funding must acknowledge and reflect the reality that RURAL is not just the absence of urban

diminishment in service availability and access to care for residents. Every effort must be made to advocate for sustainable system change within the health care sector, particularly in rural areas, for this reason.

While our immediate concern is sustainable hospital funding, it is clear that the issue is far larger than just healthcare; it is about the long term sustainability of rural Ontario. Rural Ontario is under siege from disruptive social, economic, political and cultural forces. Every sector of rural life is being affected through job losses, school closings, out migration, collapse of social structures (e.g. churches, service clubs). Public policy and funding mechanisms at the Provincial level generally are not seen to be sensitive to the rural reality – i.e. 'Rural' is more than just the absence of urban; it is fundamentally different and requires public policy, programming and funding approaches to acknowledge and reflect the differences. For an overview of the **Grey Bruce rural difference**, please refer to Appendix 3.

In April 2016 the Province announced a "reset" of the HBAM formulae that applies to the HSFR funded hospitals (including GBHS). As a result of this "reset", the revenue allocation to GBHS has been reduced by $4 million for 2016/17. The Province is mitigating this reduction by spreading the $4 million decline over two years - $2 million in each of 2016/17 and 2017/18. A reduction of this magnitude is both shocking and not well understood, either locally or at the provincial level.

Senior staff of GBHS have met with the LHIN and Ministry of Health officials in an effort first to understand why the organization is not performing as well as anticipated against the HBAM formula, and secondly to advocate for a change in the funding formula to better reflect the realities of GBHS – namely, being a multi-site organization of five small rural hospitals integrated with a medium sized regional facility serving an aging, declining rural population dispersed over an extensive geography.

While integrated service models like that of GBHS are encouraged by the Province and the LHIN, it has been acknowledged by the LHIN and the Ministry of Health and Long-term Care that the unique nature of the GBHS operating model is not served appropriately by the HBAM formula. The Ministry has committed to reviewing the model, stating that the formula is not meant to be a disincentive to successful integrated models like that of GBHS. Unfortunately, change will not come quickly and GBHS must manage its challenge for 2016/17. It is hoped that changes to the provincial funding formula will be announced and put in place for the fiscal year 2017/18 that will better serve this organization.

Decision-making Evaluation Tool

As we explore potential transformation interventions, care must be taken to ensure that our choices for implementation are consistent with the organization's core values and strategic

directions. To that end, the following decision-making tool will be used to assist decision makers assessing the relative merit, appropriateness and priority of specific actions being considered.

PRINCIPLE	YES	NO
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-centred care?		
5.1 Is there evidence that stakeholder engagement has occurred and has shaped the decision?		
6.1 Is this decision consistent with the 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)		

5.9 Initial Focus for 2016/17

The Executive Team has established an initial list of transformation initiatives to be pursued through 2106/17:

Surgical Review
Length of Stay Review
Ambulatory Care Review
Skill Mix Review
Revenue Optimization
OHIP Billing Practices
Health Record Coding
Transportation Cost Reduction
HIS Implementation

Project leads, executive sponsors and staff members have been identified for each project, project charters are being developed, initial research and data gathering and analysis is underway.

6.0 Conclusion

The status quo for GBHS is unsustainable over the medium to long term. Unchecked, a do nothing scenario will exhaust the organization's available cash reserves within five years, sooner if inflationary pressures increase beyond the assumed modest levels and/or revenue sources continue to diminish. Now is the time to leverage the current financial strength of the organization to retool for a sustainable future.

The GBHS Transformation ***Action***Plan is a good start on this corporate journey towards sustainability. It is an ambitious undertaking that will yield considerable measureable results towards our goal of securing and sustaining the delivery of the range and quality of healthcare needed in the small towns and rural communities we serve in Grey Bruce and beyond.

Despite its ambition, the ***Action***Plan falls short of the projected financial targets. As shown in Appendix 2, the ***Action***Plan has so far only identified about $7 million of the more than $10-12 million in net expenditure reductions required to bring the organization into a sustainable positive fiscal position over four years.

We are confident that additional opportunities will be identified and implemented as we dig deeper into the cost structure of the organization, look for revenue opportunities and make process improvements. We are mindful that the need to find efficiencies and adjust our cost structure will not cease in 2020 (the end of this planning period), but will continue year after year. It remains to be seen if the current GBHS rural service model – i.e. a regional secondary care hub supporting multiple geographically dispersed small rural hospitals, can withstand the unrelenting fiscal challenge of the Provincial funding model.

As an organization we can only do so much on our own, given how the broader health care system is structured, funded and operated. We will need the collective wisdom and assistance of the Province, the SW LHIN and our other system partners, including the communities we serve, to address our larger sustainability challenge. Deep, fundamental and bold system change is required.

Health and Long-term Care Minister Dr. Eric Hoskins' health system transformation agenda, *Patients First,* referenced earlier in this report, offers hope and a once-in-a-generation opportunity for an intelligent redesign of the health care system. As an organization, GBHS is well positioned to play an active leadership role in such an endeavor. While the benefits are difficult to measure in quantitative terms, advocating for system change and changes to the funding formulae to better reflect the realities of rural Ontario and sustain a relevant health delivery system for our communities in Grey Bruce is an essential element of this transformation effort. It

APPENDICES

APPENDIX 1

Transformation Initiatives

Transformation Initiatives 2016-2020
NOTIONAL Annual Net Expenditure Reduction Targets

INITIATIVE	HOW	2016/17	2017/18	2018/19	2019/20
SERVICE INTEGRATION					
Surgical Services Realignment	Complete surgical review with the intent of consolidating and rationalizing services		$500,000		
Back Office Integration	Through SWLHIN work identify opportunities to consolidate		$50,000	$50,000	$75,000
Clinical Supports Integration	Work with partners to identify opportunities to integrate clinical support services such as DI, Lab, MDRD		$50,000	$50,000	$100,000
System Redesign – e.g. mental health, Health Links, EPIC, Meta Phi	Advocacy for change and working with partners to make changes			TBD	TBD
UTILIZATION & EFFICIENCY					
Length of Stay and Capacity Review	Focused utilization review and reductions to benchmark length of stay combined with process redesign		$2,000,000		
Scope of Professional Practice	Review professional staff mix and identify areas of opportunity		$75,000	$75,000	$75,000
Reduce Non-Productive Time	Reduce overtime related to pt. transfers, use of transport team model, and sick replacement, etc.	$25,000	$25,000	$25,000	$25,000
Supply Chain	Undertake a review in 2016/17 to identify opportunities. Bar coding and RFID technologies to enhance inventory management and control		$50,000	$50,000	$50,000
Payroll System Improvements	New software will bring process efficiencies; enabling redeployment of staff to other necessary tasks			TBD	
Ambulatory Care Review	Determine the services to be offered within the Amb Care space available as first step in a longer term plan to improve efficiencies, space utilization and ultimately revenue generation potential	TBD			
REVENUE GENERATION/EXPENSE REDUCTION					
Maximize QBP and HBAM	Proactive management and	$400,000	$400,000	$300,000	$300.000

INITIATIVE	HOW	2016/17	2017/18	2018/19	2019/20
revenue and retention	advocacy				
Expand O.S. Gift Shop & Retail Pharmacy	Increase revenue by offering more services to staff			$50,000	$100,000
Non-emergent patient transfers	Utilize wheelchair versus stretcher vehicles	$150,000	$25,000		
Corporate vehicle and travel policy	Review use of personal vehicles (mileage), leasing, rental for business travel		$25,000		
Bulk transport options	Review of options for moving laundry, specimens, etc. between hospitals.		TBD	TBD	
Increase Revenue from Contracts/Rent and Physician Billings	Improvement and harmonization of processes, rates vis a vis industry best practices and collections. E.g. commercial food service, space rentals.	$25,000	$100,000	TBD	
INFORMATION SYSTEMS & TECHNOLOGY					
Introduction of technologies to automate processes and achieve staffing and supply efficiencies	Examples include: patient self-registration, voice recognition , surgical scheduling-requisitioning		$100,000	$100,000	$100,000
Systems Optimization	Training for clinicians to optimize existing software applications to increase efficiencies, improve quality outcomes. Introduction of Zynx.	TBD	TBD		
Computerized Provider Order Entry (CPOE)	Improve efficiency and accuracy of pt. record. Introduction of new tech. and implementation of Choosing Wisely				$200,000
Expand Georgian Bay Information Network	Expand services and sales	$300,000	TBD	$400,000	$400,000
	Initiative TOTAL	$500,000	$3,400,000	$1,100,000	$ 1,425,000
	Year over Year CUMULATIVE		$3,900,000	$5,000,000	$6,425,000
	Annual Target	$500,000	$5,500,000	$6,000,000	$4,000,000

APPENDIX 2

Economic Impact of Hospital Spending

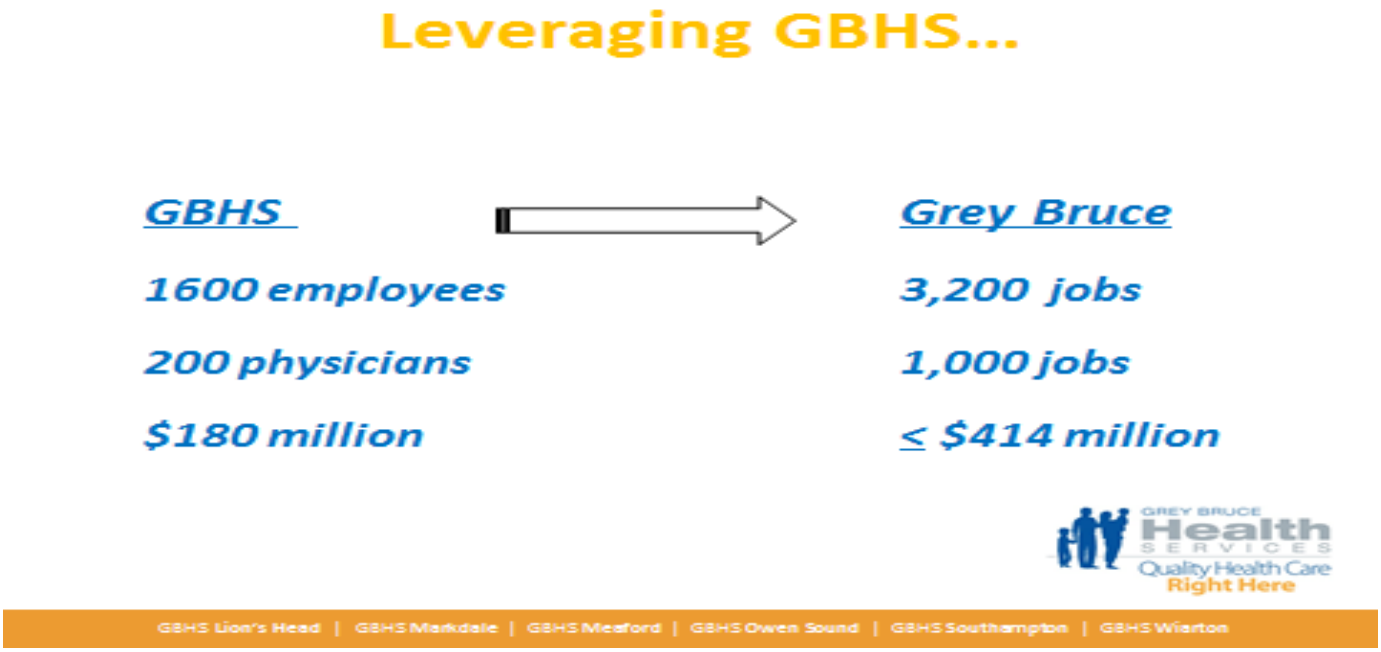
Leveraging Health Services…

- 1 hospital job supports 2 other jobs
- $1 hospital = $2.30 additional business activity

GREY BRUCE Health SERVICES Quality Health Care Right Here

GBHS Lion's Head | GBHS Markdale | GBHS Meaford | GBHS Owen Sound | GBHS Southampton | GBHS Wiarton

Source: American Hospital Association 2010



APPENDIX 3

The Grey Bruce Difference

The Communities of Grey and Bruce Counties

GBHS is an integrated multi-site public hospital organization providing a range of acute care and community-based services and programs. Its hospitals in Owen Sound, Southampton, Markdale, Meaford, Wiarton and Lion's Head (see Map 1) and its Withdrawal Management & Addictions Services facility in Owen Sound serve an immediate permanent population of about 106,000 people in northern Grey and Bruce counties. In addition, the hospitals serve thousands of seasonal residents and about 2 million short stay visitors annually. The Owen Sound Regional Hospital serves as the secondary care centre for all of Bruce and Grey Counties; a largely rural region with an overall population of 160,000 and a population density of 18.5 person/sq.km.

The growth in regional population has been slow to stagnant in recent years, overall, and is expected to grow at a rate of less than 1% over the next ten years. Over half of the region's employment is in manufacturing, and about a quarter is in primary industries, in particular agriculture. Employment in these areas is expected to decline. Continued increases in tourism, seasonal residents and retirees (TSR) are expected to generate considerable job growth. It is projected that there will be an employment shift from the primary manufacturing industries to the TSR employment opportunities. Gains in the TSR economic base employment are not expected to fully offset projected job losses in agriculture and manufacturing.

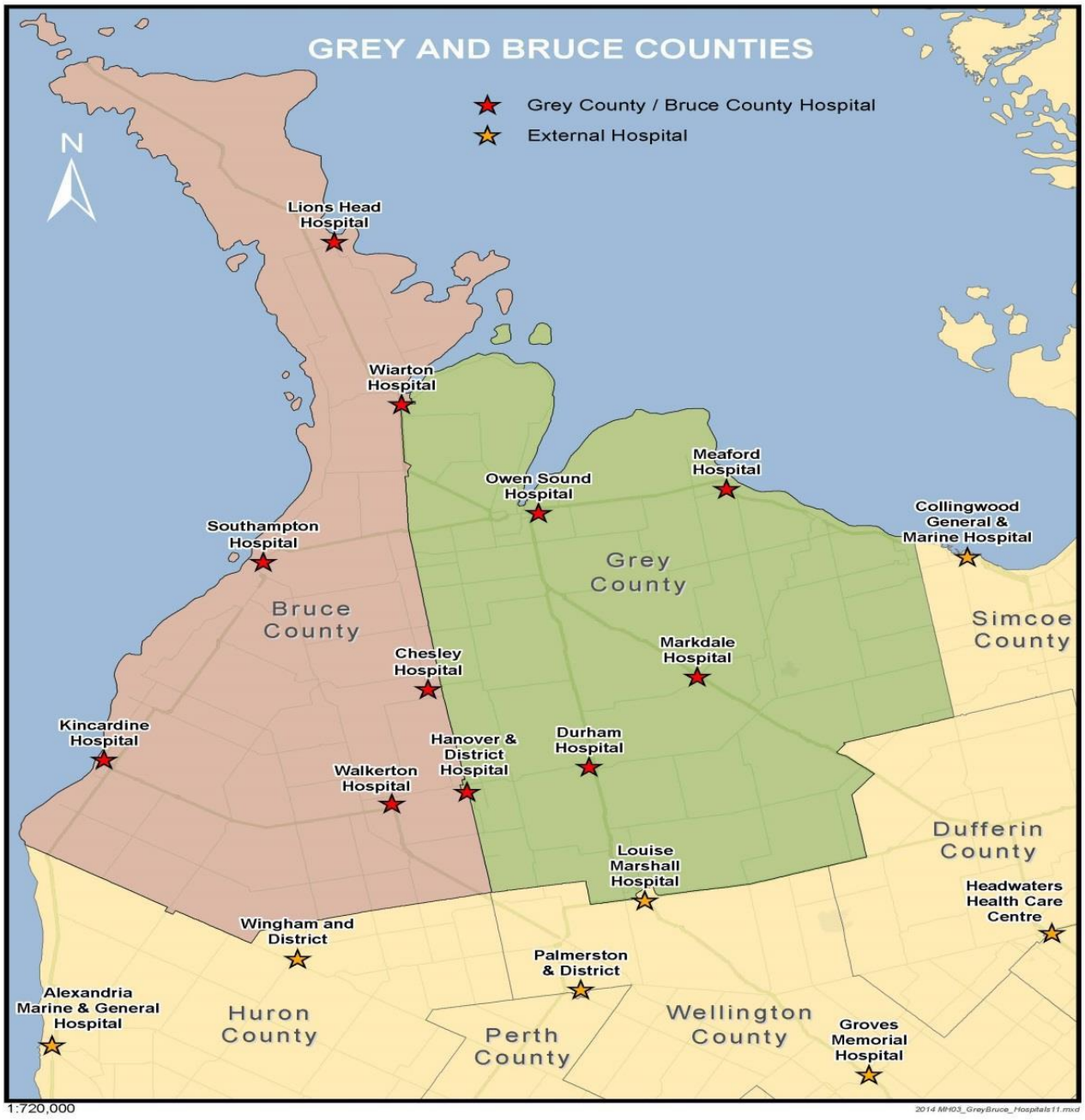
Rural is not Simply the Absence of Urban

Whether defined by population density, access to services or proximity to larger urban centres, the Grey Bruce region is decidedly rural. Over 50% of the population lives in a rural setting, compared to 15% for Ontario as a whole. Rural does not simply mean "not urban". Rural communities are unique in the characteristics and values they embody. These factors include:

- 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 therefore should have considerable bearing on public policy decisions around the provision of community-based health care services for rural communities.

Map 1: Hospitals in and serving Grey and Bruce Counties



Map Courtesy of Grey County Planning Department

Health Status in Rural Areas

According to Statistics Canada, in Ontario, as across Canada, health status of rural residents has been found to be lower than residents in urban areas. For example, rural areas tend to have: higher mortality rates; a proportionately older population; a higher proportion of residents having and reporting fair/poor health; and significantly greater proportion of residents aged 20-64 years reporting being overweight.

Young children, adolescents and seniors are often over-represented 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, in particular, 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 widely expressed by many rural residents nationwide, and certainly in Grey and Bruce Counties.

"Declines in geographic access are also directly linked to equity of access, as socio-economic status has been inversely correlated to the distance travelled to receive care – poorer patients make fewer longer journeys and have a higher incidence of chronic disease prevalence" World Health Organization 2008

Most rural health researchers agree that the distance to health care providers and facilities is increasing for rural residents as physicians and hospitals become more concentrated in urban and urban fringe areas. Grey Bruce has experienced its share of the impact of centralization of care, yet has managed to sustain a strong integrated hospital-based rural health care system.

Health Status in Bruce Grey

Demographics and health status data show that this region typifies the characteristics and general trends found in rural areas nationwide. The data also shows that in many respects the health status of Bruce Grey residents is significantly lower than the average or median values for rural Ontario and Canada as a whole. According to Statistics Canada and Public Health data, 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 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 Mennonite and Amish population and two First Nations territories, which present unique health care challenges
- An age-standardized death rate that is significantly higher than Ontario
- 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 hospitalization due to unintentional injury 50% higher than for Ontario; the main contributors being falls, motor vehicle accidents, and poisoning
- A death rate from motor vehicle collisions more than 30% higher than both the provincial and national averages
- A rate of overweight and obesity significantly higher than that for Ontario and Canada
- A high and increasing rate of reported mood disorders
- Post-secondary educational attainment is lower than the provincial average
- Rates of smoking is higher than the provincial average