Focused Organizational Analysis of Hôtel-Dieu Grace Hospital, Windsor & Windsor Regional Hospital

Final Report

June 2002

HayGroup

Table of Contents

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Executive Summary

Report and Executive Summary

This report presents a summary of the findings of the focused review of the Windsor hospitals, commissioned by the Ontario Ministry of Health and Long-Term Care (MOHLTC). It outlines the recommended actions to be taken by the hospitals and the MOHLTC to allow the Windsor hospitals to address their financial challenges and to proceed with implementation of the restructuring plan. The executive summary highlights selected findings of the review and should be read in conjunction with the full report. A table showing the identified cost savings opportunities and a list of all of the recommendations of the review are presented in Section 12.0 of the full report. The findings of this report and the recommendations contained therein are key inputs to the negotiations between the hospitals and the MOHLTC on the development of financial and operational recovery plans.

Restructuring of Windsor Hospitals Began in 1994

The Hôtel-Dieu Grace Hospital (HDGH) and the Windsor Regional Hospital (WRH) have been in the process of restructuring since 1994 and have been coping with major organizational changes. The hospitals have completed organizational mergers of four large community hospitals, significant consolidations and relocations of services, construction/renovations of facilities and replacement and standardization of equipment over the past eight years. In many instances the Windsor hospitals were forced to deal with the challenges of restructuring in advance of the rest of the province and prior to the establishment of MOHLTC policies designed to support restructuring.

Current Financial Challenges for Windsor Hospitals

At the initiation of this study, HDGH projected an operating deficit for 2001/02 of $17.3 million (on an annual MOHLTC base allocation of $114.8 million) and a working capital deficit of $24.0 million. WRH projected an operating deficit of $4.8 million (on an annual MOHLTC base allocation of $97.0 million) and a working capital deficit of $25.1 million. The hospitals have requested MOHLTC assistance in addressing these financial issues.

MOHLTC Commissioned Focused Review of Windsor Hospitals

The MOHLTC has been working with the hospitals to better understand the issues faced by the hospitals and the steps that will be required of the hospitals to:

- Implement HSRC directions in a timely and cost-effective manner
- Achieve a positive financial position

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As part of this process, the MOHLTC has commissioned this focused review of the HDGH and WRH.

Overall Review Objective

The overall objective of the focused review (as described in the Request for Proposal) has been to:

"Identify issues and assess the causes of the current operational and financial pressures at HDGH and the WRH as they pertain to the hospitals' ability to move forward with restructuring, consistent with Health Services Restructuring Commission (HSRC) direction and MOHLTC approvals in a timely and cost-effective manner."

"The consultants will do a high-level analysis of HDGH's and WRH's operations to identify the causes of the hospitals' current operational and financial difficulties and assess the steps currently being taken by the hospitals to address them. In this process, the consultants will:

- Identify the key factors contributing to the operating deficits and working funds erosion;
- Identify opportunities for improvement in the operating and working funds to achieve a positive financial position;
- Identify opportunities to improve operational productivity and utilization management."

Recovery Plans

Following completion of the focused review, and building on its findings, the Windsor hospitals will each work with the MOHLTC to develop recovery plans to address gaps between MOHLTC funding and other revenues, and actual expenditures, that will remain even after implementation of the recommendations of the review.

Windsor Hospital Environment

There are factors identified during the review that have influenced the decisions of the Windsor hospitals Boards and management regarding planning for hospital services in Windsor. These factors include:

- Proximity of Windsor to Detroit and the resulting impact on recruitment and retention of health care professionals.
- Below average health status of residents of Essex County, and associated higher than average need for health care services
- Very low proportion of Essex County hospital expenditures used for non-acute services
- High rate of population growth in Windsor and the surrounding communities

CONFIDENTIAL DRAFT

- High rate of reliance of Essex County residents on local hospitals for a wide range of services
- Low numbers per population (compared to other Ontario communities) for both physicians and nurses

Some of these factors are unique to Windsor and may impact the ability of the Windsor hospitals to provide efficient and cost-effective care and have contributed to the financial difficulties now faced by the hospitals.

Summary of HDGH Financial Situation

HDGH is in critical financial condition. Since the beginning of 1994/95 the hospital's working funds position has gone from bad ($1.2 million deficit) to worse ($46.1 million deficit). HDGH requires substantial overdraft funds to continue its day to day operations. HDGH cash is currently provided by:

The Hospital's 2002/03 Business Plan submission shows a projected operating deficit of $25.5 million, a trend that will see the hospital run out of available cash and credit well before the end of the year. The deficit gap has been growing since 1999/00. At the same time, MOHLTC percentage of revenue has been increasing steadily to over 86% in 2001/02.

Restructuring has contributed significantly to the accumulated shortfall. Although HDGH has been reimbursed $8.3 million for approved restructuring costs, HDGH still appears to be out of pocket over $25 million for unfunded costs related to restructuring.

There have been significant difficulties related to medical staff recruitment and retention. There is an apparent shortage of physicians at the hospital. One symptom of the distress is seen in the tremendous increase in medical staff remuneration for medical administration and on-call coverage. HDGH medical administration and on-call coverage costs have increased by $4.6 million, an 18-fold increase since 1998/99.

At March 31, 2002 HDGH had the following debt load:

- $5.0 million line of credit
- $9.0 million MOHLTC operating advance
- $6.855 million Creutzfeldt-Jakob disease advance
- Long Term Debt of $5.8 million
- $2.2 million capital lease (expires December 2002)
- Capital fund advance of $20.8 million.

CONFIDENTIAL DRAFT

At present the hospital has stopped all deferrable capital spending. Recent capital spending has contributed to the hospital's current cash problems. HDGH appears to have spent more than prudent on its capital equipment, given its financial position.

Summary of WRH Financial Situation

WRH is also in critical financial condition. Since the beginning of 1995/96 the hospital's working funds position has gone from bad ($1.7 million) to worse ($28.0 million deficit). WRH also requires substantial overdraft funds to continue its day to day operations.

The Hospital's 2002/03 Business Plan submission shows a projected operating deficit of $8.8 million. The Hospital has since updated its estimate for 2002/03 to a projected deficit of $15.1 million. The hospital will run out of available cash and credit by September 2002. At March 31, 2002, WRH cash was provided by:

- Bank advance of $15.0 million
- Bank Loan of $2.1 million
- Promissory Notes payable to WRH Foundation of $5.3 million

The deficit gap would have started in 1999/00, except that one-time funding averted a deficit in 2000/01. However, current projections show the deficit increasing. At the same time, MOHLTC % of revenue has not changed significantly, remaining at about 81%.

Restructuring has contributed significantly to the accumulated shortfall. Although WRH has been reimbursed $5.1 million for approved restructuring costs, and has received $2.9 million in working capital assistance, WRH still appears to be out of pocket over $21 million for unfunded costs related to restructuring.

WRH medical administration and on-call coverage costs have increased by $2.3 million, a 9-fold increase since 1998/99.

WRH operates 15 other vote programs that together account for 4.5% of the Hospital's total operating expenses. This is a higher than average number of other vote programs for a community hospital resulting in the need to absorb more unfunded overhead.

Malden Park Continuing Care Centre is beginning to place a significant drain on the hospital's finances.

- Malden Park is in the second year of a three year plan to reduce its operating costs in line with reduced funding.

CONFIDENTIAL DRAFT

- Malden Park is expected to generate cumulative operating losses of $3.2 million over the next three years.

WRH does not believe it can operate Malden Park at the $107 per diem provincial funding level. At that level, Malden Park will generate a $2.5 million annual operating deficit.

WRH is supported by the WRH Foundation that has assets of $16 million. WRH is counting on the Foundation to use that money to help to finance the remaining $117 million of capital development at the Metropolitan and Western Campuses. According to WRH, HSRC construction costs can be covered by Foundation Funds "providing [the] hospital operates with balanced budget to meet capital needs not covered by HSRC orders and funding".

Cost per Equivalent Weighted Case

The Ontario Joint Policy and Planning Committee has developed a formula to calculate the expected cost per equivalent weighted case (EWC) for most Ontario hospitals. Each hospital's actual cost per EWC is compared with its expected cost per EWC to calculate its performance. Performance is measured in terms of the percent by which the actual cost is above or below the expected cost.

WRH has consistently had actual costs 15% higher than expected. HDGH had actual costs below or equal to expected until 1998/99, when actual costs were 5% above expected costs. There has been continued deterioration in performance from 1999/00 (5% above expected) to 2000/01 (27% above expected). This is evidence of large increases in costs without corresponding increases in patient care workload. Given that workload did not increase in 2001/02, while costs did, we expect that neither the HDGH nor WRH performance for 2001/02 will improve.

Clinical Efficiency Savings Opportunities

A key element of any acute care hospital's attempt to reduce expenditures is the identification of opportunities to reduce use of inpatient beds by shifting inpatient care to ambulatory care, by reducing in-process delays, and by discharging or transferring patients who no longer require acute care. In order to estimate the opportunities to reduce the use of inpatient days, we compared the clinical efficiency (use of ambulatory procedures and inpatient length of stay) of the Windsor hospitals to peer Ontario hospitals. The initial targets for both hospitals were derived from "best quartile" performance of other Ontario hospitals. This is the length of stay where one quarter of the hospitals have a shorter average

CONFIDENTIAL DRAFT

length of stay (for the same type and age of patient) and three quarters of the hospitals have longer average lengths of stay.

Based on adjustments to the initial targets to take into account:

- Improvements in length of stay performance made in 2001/02, and
- The challenges faced by the Windsor hospitals (e.g. physician and nursing shortages, low availability of non-acute services),

the clinical efficiency cost savings targets were reduced to $3.5 million for HDGH and $2.5 million for WRH.

Improved clinical efficiency will allow reduced use of inpatient beds while maintaining patient volumes.

Operational Productivity

Pressures to manage operating costs are challenging hospitals to find new ways of doing things, while at the same time demanding that service quality be maintained and even improved. Service delivery is composed of three integrated components, as follows:

- Human Resources – staffing, organization, competencies, training and education
- Technology - "tools" used in delivering services (information systems, equipment, etc.)
- Process - methods and organization of how services are delivered.

The objective of the operational productivity analysis was to identify at a high level potential opportunities where the Windsor hospitals could improve their efficiency and cost effectiveness within selected functional centres and services.

Based on this analysis of departmental performance, WRH would have spent about $5.0 million less in 2001/02 had all functional centres achieved at least median productivity. Operating expenses would have been about $10.1 million less in 2001/02 had all functional centres achieved best quartile productivity. We suggest that a reasonable estimate of the WRH productivity savings potential would be $6.38 million.

Similarly, HDGH would have spent about $10.9 million less in 2001/02 had all functional centres achieved at least median productivity. Operating expenses would have been about $16.1 million less in 2001/02 had all functional centres achieved best quartile productivity. Using these figures, we suggest that a

CONFIDENTIAL DRAFT

reasonable estimate of the HDGH productivity savings potential would be $13.5 million.

Both Hospitals are in the midst of a long-term redevelopment that involves significant renovation of existing space. Such development activity causes much disruption to normal operating processes. This disruption compromises each hospital's ability to achieve full productivity potential. Until the redevelopment activities are complete, we recommend that reduced productivity targets be used, resulting in short-term cost savings opportunities of $877,000 for WRH and $7,774,000 for HDGH.

Opportunities related to potential savings from improvements in productivity in the shared laboratory service were also identified.

Capital Redevelopment Projects

Each hospital is undergoing a massive transformation to provide a different range of clinical services while consolidating activity to close the Grace site. Redevelopment at each site depends on completion of prior steps at another site. Renovations work requires significant staging of activity and relocation of existing services during construction. Both organizations have managed the projects well. There are no issues related to the management of the physical work involved in these capital redevelopment projects.

For the most part, construction has proceeded without undue delay once started. However there have been significant delays in starting on various phases. The Metropolitan Campus expansion, in particular was delayed more than 3 years. Poor soil conditions were discovered after initial planning was completed, forcing the project to a halt while additional funds were secured to finance the work.

The OB/Psych transfer transition has been extended, the closure of the Grace Site delayed, and the conversion of the Western campus delayed by years as a result of these problems that were beyond the control of the hospitals. These phase delays have had an impact on project cost, overall project timing, and operations.

HDGH Redevelopment Project Cash Flow

HDGH is in a very difficult position. The Hospital borrowed $20.8 million from its capital fund in order to maintain its daily operations. At this point, the Hospital has no more cash to continue with its capital development pending the repayment of the $20.8 million by the operating fund. The Hospital will need all of that money to help to pay for its portion of the remaining capital redevelopment costs. We recommend that HDGH review and consider modifications to its plans for Phases 5 and 6 of the redevelopment project to ensure

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that the Grace site can be closed as soon as possible, and at a cost not to exceed available MOHLTC and local capital funds. This will reduce the hospital's cost of operations, which might allow it to achieve surpluses and start retiring its debt.

Medical Staff Organization

We believe that there are opportunities for the Windsor hospitals to jointly address the medical staff issues associated with physician shortages that impede efficient operation and successful implementation of the HSRC directions. Joint activity is required with respect to:

- Establishment of city-wide call groups for all specialties
- Rationalization of emergency call and identification of mid- to long-term strategies to move away from a subspecialty call system
- Identification of further opportunities for clinical service rationalization, where low volumes at one site make coverage difficult and are below critical mass requirements
- Joint credentialling across the three Essex County hospitals
- A coordinated and non-competitive approach to physician recruitment
- Development of, and monitoring of adherence to, common clinical protocols
- Common utilization management and reporting
- Preparation for the increased teaching role of the Windsor hospitals

The history of competition between the hospitals and the slow progress in increasing cooperation and coordinating medical staff initiatives requires a more formal and structured approach, such as can be obtained with a single medical staff.

Consequently, we recommend that a joint MAC be established for the Windsor hospitals, to provide joint leadership of the medical and dental staff. Under this model, there should be a single chief of the major programs (e.g., single chief of medicine, single chief of surgery, etc.) responsible for the program at both hospitals.

WRH Decision-Making

For the most part WRH has been fiscally conservative in its decision-making and so there is little to say about the processes or the outcomes. We do believe that there are opportunities for WRH to reduce expenditures and to contribute towards financial recovery, and these opportunities are identified in this report.

CONFIDENTIAL DRAFT

It is important that the WRH Board and management maintain their fiscally conservative approach even as they proceed through the operationally difficult Metropolitan campus construction.

HDGH "Ramping Up"

The current financial situation of the HDGH is almost entirely attributable to the costs of restructuring and redevelopment and the Hospital's decisions to incur these costs in the magnitude that they were incurred. One key decision has been to incur additional operating costs by increasing staffing for the redeveloped facilities far in advance of the expanded workload actually occurring. HDGH has described this as "ramping up", and it has been a conscious strategy employed to ensure that the hospital will be prepared to respond to new demands immediately upon opening new and redeveloped facilities. There was a sense of urgency at HDGH to fulfill the HSRC directives. The HDGH ramping up should be differentiated from increases in staffing in conjunction with increased workload; the HDGH ramping up involved increases in staffing long before the arrival of the increased workload, and has resulted in reduced productivity across the hospital.

The HDGH Board and management have consistently worked towards ensuring that HDGH could provide the volume of service directed by the HSRC to be available in 2003. However well intentioned, the long-term focus on ensuring that the redeveloped physical infrastructure would be in place, and that the medical and other staff would be ready, has taken precedence over the more immediate focus on the hospital's operating position. Whether opening new facilities or operating ongoing services, all hospitals have a responsibility to operate within their means.

The hospital Board and administration have addressed a range of challenges of preparing and moving into new facilities, but by adding staff, they have created a more difficult problem. We recommend that the Board of HDGH should stop all hiring pending the development of the recovery plan. HDGH should also proceed as quickly as possible to fulfill the MOHLTC requirements for Post Construction Operating Plan (PCOP) submissions, and develop a plan to deploy staff to those departments where service volume increases are anticipated and where associated PCOP funding will be available.

Coordination of Windsor Hospital Restructuring

The HSRC recommended that a Joint Executive Committee (JEC) be established to support hospital restructuring in Essex County. We believe that the Essex County JEC has strayed far from the

CONFIDENTIAL DRAFT

original role envisioned by the HSRC. The expansion of membership has helped to turn it into an effective communications vehicle regarding health system issues in Essex County but has weakened its focus on implementation of the hospital restructuring plan in Essex county. There is a need to refocus a smaller group on addressing the considerable challenges of implementing hospital restructuring.

We believe that there should be regular (e.g. quarterly) joint meetings of the executive committees of the Windsor hospitals and that these meetings be used to address conflict and ensure coordination between the two hospitals. The joint meetings of the two executive committees can also be used to identify further opportunities for coordination of activity and opportunities to reduce administrative duplication.

Consider Models for Administrative Overlap

Other Ontario communities have established overlapping administrative positions (e.g. single Vice-President Finance for the two London hospitals) or a single administration for two hospitals (Sault Area Hospitals). This has been done while maintaining separate governance for the individual hospitals. While we are not prepared to make a formal recommendation that the Windsor hospitals pursue either of these models, we do believe that they should be considered as the executive committees examine ways to enhance the joint decision making and problem solving between the hospitals.

Implementation Steering Committee

For the purposes of implementation and oversight of the recovery plan developed as a result of this review, there should be an implementation steering committee. This can be an extension of the steering committee for the study and should include Board representatives, CEOs, Chiefs of Staff, Chief Nursing Officers, and the CFOs, as well as MOHLTC representatives.

CONFIDENTIAL DRAFT

1.0 Introduction

1.1 Background

Hôtel-Dieu Grace Hospital and Windsor Regional Hospital are the two acute care hospitals in Windsor that provide a broad range of regional/tertiary programs, secondary/primary care and long term care services. Almost all hospital-based services are provided locally with the exception of transplant surgery, specialized oncology services/surgery for children, and tertiary mental health services.

Hôtel-Dieu Grace Hospital

Hôtel-Dieu Grace Hospital (HDGH) is the result of an alliance, effective April 1, 1994 and believed to be the first such agreement of this scope ever signed in Canada. Consequently, three facilities, The Salvation Army Grace Hospital, Hôtel Dieu of St. Joseph Hospital and Villa Maria, operate under one corporate structure, one Board, one Chief Executive Officer and one Medical Advisory Committee. The hospitals will eventually operate at one site on Ouellette Avenue in downtown Windsor, resulting in the closure of the Grace site.

HDGH provides the following range of services:

- 24 hour Emergency Services
- Ambulatory Care/Day Procedures (Outpatient Services)
- Base Hospital E.M.S. Program
- Cardiology (Regional Cardiac Interventional Services and related Outpatient Services)
- Critical Care
- Comprehensive Diagnostic Imaging (including MRI, CAT and Angiography)
- General Medicine
- General Surgery
- Laboratory Medicine
- Acute Adult Regional Mental Health (Acute Inpatient and Outpatient Services)
- Nephrology (Renal Dialysis including Satellite Self-Care)
- Neurosciences (Neurosurgery and Neurology)
- Nuclear Medicine

CONFIDENTIAL DRAFT

- Ophthalmology
- Orthopedics
- Pastoral Services
- Pediatrics
- General Short Term Rehabilitation Services (Inpatient and Outpatient)
- Regional Trauma
- Vascular and Thoracic Surgery
- Volunteer Services

Windsor Regional Hospital

Windsor Regional Hospital (WRH) is independently governed and legislated under the Public Hospitals Act. WRH was formed on December 1, 1994 through the amalgamation of the Metropolitan General Hospital and Windsor Western Hospital Centre Inc. The hospital-based programs and services are provided from two principal campuses, specifically the Metropolitan (Met) Campus situated in the east end of Windsor and the Western Campus situated in the west end of Windsor. In addition, the detoxification centre for men and women is situated off-campus as is the residential treatment facility for discharged tertiary mental health patients. The Malden Park Continuing Care Centre and the Regional Children's Centre are located at the Western Campus. The Windsor Regional Cancer Centre is located at the Metropolitan Campus.

WRH provides a range of services including:

- 24 – hour Emergency (Met Campus)
- Cardiac Rehabilitation / Regional Co-ordination centre (Met Campus)
- Cardiology (Met Campus)
- Complex Continuing Care (Western Campus)
- Comprehensive Diagnostic and Therapeutic support services including Clinical Laboratory, CT, Nuclear Medicine, Cardiac Diagnostics, Physiotherapy, Occupational Therapy, Speech Therapy, Audiology, Pastoral Care, Volunteer Services etc. (Met and Western Campuses)
- Critical Care (Met Campus)
- Day Hospital (Western Campus)

CONFIDENTIAL DRAFT

- General Medicine (Met Campus)
- General Surgery (Met and Western Campuses)
- Medical Day Care, Day Surgery and Ambulatory Care clinics (Met and Western Campuses)
- NICU (at Grace Site)
- Obstetrical care (Met Campus and Grace Site)
- Oncology (Met Campus)
- Palliative Care (Met and Western Campuses)
- Paediatric Day Surgery (Met and Western Campuses)
- Regional Burn / Plastics, including micro-vascular surgery (Met Campus)
- Regional HIV care/treatment (Met Campus)
- Regional Tertiary Mental Health (Western Campus and Off-Site location)
- Regional Rehabilitation (Western Campus)
- Related "Other Vote" programs for: AIDS anonymous testing, addiction services, geriatric assessment, children's remedial speech & pre-school services and acquired brain injury program (Met, Western Campuses and Off-Site locations)
- Respiratory Rehabilitation (Western Campus)

HDGH and WRH provide community hospital services to the population of Essex County and the adjoining counties of Kent and Lambton. Their own individual Boards of Trustees govern HDGH and WRH. They each have their own management structure. Each hospital has its own medical staff.

1.2 HSRC Directions

In February 1998 the Health Services Restructuring Commission (HSRC) issued the Essex County Health Services Restructuring Report covering the Hôtel-Dieu Grace Hospital and the Windsor Regional Hospital.

The HSRC directed that:

- A Joint Executive Committee be established to implement the Essex County restructuring plan
- The HDGH provide acute beds, short term rehabilitation beds, and acute mental health beds

CONFIDENTIAL
DRAFT

- The WRH provide acute beds, complex continuing care beds, regional and long-term rehabilitation beds, and longer-term mental health beds
- The hospitals develop a plan to maximize the efficiency of the delivery of administrative, support and diagnostic services

The HSRC operating cost model concluded that the net operating expense for each Windsor hospital after restructuring (excluding growth) would be:

- HDGH $81,557,587 (a reduction of 26.3%)
- WRH $106,037,988 (an increase of 4.3%)

Joint Executive Committee

By direction of the HSRC, a new level of collaboration was inaugurated with the establishment of the Joint Executive Committee in September 1998. The committee includes representatives from the three hospitals in Windsor/Essex County (including Leamington District Hospital), as well as representatives from the Windsor Regional Cancer Centre, the Community Care Access Centre, the Canadian Mental Health Association, the Essex, Kent, Lambton District Health Council and the Essex County Medical Society. This committee is implementing the directives of the Restructuring Commission.

The HSRC provided restructuring directions for various program enhancements, transfers and consolidations and capital reinvestments at the hospitals. The Ministry of Health and Long-Term Care (MOHLTC) is working closely with the two hospitals to address HSRC directions.

Program Transfers

The two Hospitals have begun to effect program transfers in accordance with HSRC directives. The "transition phase" of the transfers began on January 22 2000 with the implementation of the following arrangements:

- Obstetrics/NICU services located at the HDGH Grace Site – Windsor Regional Hospital provides management and direct patient care services for patients treated at the Grace Site.
- Sexual Assault Treatment program located at the HDGH Grace Site – Windsor Regional Hospital provides management and direct patient care services for patients treated at the Grace Site.
- Acute Mental Health services located at the WRH Western Campuses - Hôtel- Dieu Grace Hospital provides management

CONFIDENTIAL

and direct patient care services for patients treated at the Western Campuses.

Additionally, both Hospitals have begun to implement an "integrated hospitals laboratory service" as directed by the Health Services Restructuring Commission whereby services have been rationalized between WRH and HDGH (as well as with Leamington District Memorial Hospital) and accommodated in "interim" laboratory facilities.

The Hôtel-Dieu Grace Hospital and the Windsor Regional Hospital have been in the process of restructuring since 1994 and have been coping with major organizational changes. The hospitals have completed organizational mergers of four large community hospitals, significant consolidations and relocations of services, construction/renovations of facilities and replacement and standardization of equipment over the past eight years. In many instances the Windsor hospitals were forced to deal with the challenges of restructuring in advance of the rest of the province and prior to the establishment of MOHLTC policies designed to support restructuring.

1.3 Focused Review Objectives

Operating and Working Capital Deficits

For fiscal year 2001/2002, the HDGH projected operating deficit at the initiation of this study, was $17.3 million (with an annual MOHLTC base allocation of $114.8 million) and a working capital deficit of $24.0 million. For fiscal year 2001/2002, the WRH projected operating deficit at the initiation of this study was $4.8 million (with an annual MOHLTC base allocation of $97.0 million) and a working capital deficit of $25.1 million. The hospitals have requested MOHLTC assistance in addressing these financial issues.

As a result the MOHLTC has been working with the hospitals to better understand the issues faced by the hospitals and the steps that will be required of the hospitals to:

- Implement HSRC directions in a timely and cost-effective manner
- Achieve a positive financial position

As part of this process, the MOHLTC has commissioned this focused review of the HDGH and WRH.

CONFIDENTIAL

Overall Objective to Assess Causes of Operational and Financial Pressures in Windsor Hospitals

The overall objective of the focused review (as described in the Request for Proposal) has been to:

"Identify issues and assess the causes of the current operational and financial pressures at HDGH and the WRH as they pertain to the hospitals' ability to move forward with restructuring, consistent with HSRC direction and MOHLTC approvals in a timely and cost-effective manner."

High Level Review

The review has been focused, both in terms of the allocated time to complete the project, and in terms of the level of detailed investigation and complementary analysis completed. The project Request for Proposal stated that:

"The consultants will do a high-level analysis of HDGH's and WRH's operations to identify the causes of the hospitals' current operational and financial difficulties and assess the steps currently being taken by the hospitals to address them. In this process, the consultants will:

- Identify the key factors contributing to the operating deficits and working funds erosion;
- Identify opportunities for improvement in the operating and working funds to achieve a positive financial position;
- Identify opportunities to improve operational productivity and utilization management."

Specific Objectives

Specific objectives established for the review include

1. Review and assessment of the hospitals' planning and decision-making processes
2. Review and assessment of the hospitals' financial positions
3. Identification of the impact of restructuring on the hospitals' operations and the hospitals' strategies to address these impacts
4. Review and assessment of the hospitals' ability to deliver their redevelopment projects consistent within HSRC directions and MOHLTC approvals.

1.4 Report Contents

This report presents a summary of the findings of the review, and the recommended actions to be taken by the hospitals and the MOHLTC to allow the Windsor hospitals to address their financial

CONFIDENTIAL DRAFT

challenges and to proceed with implementation of the restructuring plan.

The subsequent chapters of this report evaluate the Essex County environment, the financial history and management, capital redevelopment, decision-making processes, and cost savings opportunities, of the Windsor hospitals.

Following review of the draft report by the project Steering Committee, the consultants, with input from the MOHLTC, have assisted the Windsor hospitals with the development of an implementation plan. This final report for the review includes the findings, recommendations, and the draft implementation plan.

1.5 Peer Hospitals for Comparisons

Where detailed data was required for analyses, the Steering Committee identified 8 community and 2 teaching hospitals to be used for comparisons. All of the selected community hospitals are multi-site hospitals, which are involved in, or planning, major redevelopment projects. The two teaching hospitals are single site facilities. The peer hospitals are:

Community hospitals (all multi-site):

- William Osler (Brampton/Etobicoke)
- Trillium Health Centre
- Lakeridge Health (Oshawa General)
- Peterborough Regional
- North York General
- Humber River Regional (Toronto)
- Sudbury Regional Hospital
- Halton Healthcare (Oakville Trafalgar)

Teaching hospitals (single site)

- Kingston General
- St. Joseph's Hamilton

The volume of inpatient cases, inpatient days, "qualifying" ambulatory procedure (SDS) cases, inpatient RIWs, and actual length of stay for fiscal year 2000/01 for the peer hospitals are shown in the following exhibit. Later in this report where

CONFIDENTIAL DRAFT

references are made to peer hospitals or to the communities served by the peer hospitals, the references apply to these hospitals and the counties in which they are located.

Exhibit 1.1
2001 Acute Care Volumes for Windsor and Selected Peer Hospitals

Hospital	Inpatient Cases	Inpatient Days	SDS Cases	Inpatient RIW	Actual LOS
Oakville Trafalgar	13,997	79,190	13,091	16,715	5.66
Peterborough RHC	15,215	88,353	14,866	20,870	5.81
Hotel Dieu Grace, Windsor	**15,795**	**117,712**	**14,824**	**23,692**	**7.45**
Oshawa General Hospital	17,986	112,432	21,072	24,451	6.25
Windsor Regional Hospital	**20,488**	**93,717**	**12,479**	**22,162**	**4.57**
Kingston General, Hotel Dieu	20,701	159,640	13,576	38,340	7.71
St. Joseph's (Hamilton)	21,063	140,203	18,260	33,059	6.66
Sudbury Regional	23,589	153,231	22,711	33,873	6.50
North York General Hospital	25,761	146,138	26,511	32,553	5.67
Trillium Health Centre	27,289	155,965	26,253	36,251	5.72
Humber River Regional Hospital	29,729	184,722	33,045	39,928	6.21
William Osler	38,370	214,548	32,166	44,547	5.59
Sample, excluding Windsor	240,771	1,478,308	220,897	328,855	6.14

CONFIDENTIAL
DRAFT

2.0 Windsor Hospital Activity Trends

2.1 Acute Activity Volume Trends

Appendix A presents the changes in acute activity (beds, days, occupancy, length of stay) in the Windsor hospitals from 1998/99 to 2001/2002, and the plan for 2002/03. The data are shown for both hospitals combined, and then separately for HDGH and for WRH. Changes observed, from 1998/99 to 2001/02, include:

- There has been an increase in medical beds (9 beds) with a further 6 bed increase planned for 2001/02. While there has been a small increase in the number of medical inpatients, the increased bed capacity (and the reduced length of stay) has been used to reduce the average occupancy of the medical beds from 101% to 94%. In 2001/02 the average occupancy of the medical beds was 91% at HDGH and 97% at WRH.
- There has been a reduction in surgical beds (46 beds) with a 12-bed increase planned for 2001/02. While the surgical LOS has dropped by 0.5 days, there has also been a drop in the number of surgical inpatients. The average occupancy of the surgical beds has increased from 83% in 1998/99 to 95% in 2001/02. Surgical LOS dropped by 1.3 days at HDGH and increased by 0.3 days at WRH.
- The number of paediatric beds has stayed constant, but there has been a decrease in the number of paediatric inpatients. Average occupancy of the paediatric beds has dropped from 72% to 64%.
- There has been a 3-bed reduction in the number of ICU beds, but 5 more beds (at HDGH) are to be added in 2002/03. The average occupancy of the ICU beds has dropped from 81% to 64%.
- The number of acute mental health beds has dropped by 28 beds. Mental health bed occupancy has increased from 85% to 86%. Length of stay for mental health patients has decreased by 1.1 days and there were 441 fewer mental health inpatients in 2001/02.
- Overall, the number of acute care beds has decreased from 668 in 1998/99 to 597 in 2001/02. 25 more acute care beds are to be added in 2002/03. While there are fewer beds, the

CONFIDENTIAL DRAFT

reduction in overall length of stay of 1.1 days has allowed more patients to be admitted in 2001/02. With the exception of a drop in activity at WRH in 1999/2000, the overall occupancy of the Windsor hospitals has been 87 to 88%.

- The average occupancy rate for HDGH has remained constant at approximately 86%. The average occupancy rate for WRH is 89%. The average occupancy rate for both medical and surgical patients is higher at the WRH than at HDGH.
- Plans for 2002/03 are for a further increase in inpatient case volume and a small reduction in the average occupancy rate.

Overall, the acute care inpatient trends for the Windsor hospitals look very similar to the trends for other Ontario hospitals over the same period. While there has been a reduction in acute care beds, there has also been a reduction in length of stay, allowing the same number of inpatients to be accommodated in fewer beds. On average, Ontario hospitals have seen increases in average occupancy rates, but the rates for the Windsor hospitals have been relatively constant.

2.2 Non-Acute Inpatient Activity Trends

Appendix A also shows the trends in inpatient rehabilitation and complex continuing care (CCC) activity in the Windsor hospitals.

The number of designated rehabilitation beds has increased from 32 in 1998/99 to 60 in 2001/02, with the addition of short-term rehab beds at HDGH and an increase of 4 beds at WRH. The average length of stay for rehab patients in these beds has dropped by 48%.

While the number of complex continuing care beds in the Windsor hospitals has remained the same (75 at WRH), the average length of stay for the patients in these beds has dropped from 197 days in 1998/99 to 96 days in 2001/02.

2.3 Ambulatory Activity Volume Trends

The following exhibits show the trends in ambulatory care activity from 1998/99 to 2001/02 (projected) for HDGH and WRH.

CONFIDENTIAL DRAFT

Exhibit 2.1
HDGH Ambulatory Care Activity Trends

	Unit	1998/99	1999/00	2000/01	2001/02	Change
Emergency Services	Visits	49,096	47,997	48,466	50,696	3.3%
Day/Night Care						
Surgical & Endoscopy	Cases	19,977	15,703	16,364	19,843	-0.7%
Mental Health	Visits	1,115	1,159	3,595	5,232	369.2%
Renal Dialysis	Visits	16,562	17,968	18,972	19,486	17.7%
Other Day/Night Care	Visits	5,502	5,687	4,422	4,348	-21.0%
Clinics	Visits	46,863	51,392	47,455	50,341	7.4%
TOTAL	Cases	19,977	15,703	16,364	19,843	-0.7%
	Visits	139,115	144,014	142,284	150,761	8.4%

Exhibit 2.2
WRH Ambulatory Care Activity Trends

	Unit	1998/99	1999/00	2000/01	2001/02	Change
Emergency Services	Visits	49,654	51,141	50,862	54,000	8.8%
Day/Night Care						
Surgical & Endoscopy	Cases	13,658	13,858	17,980	19,113	39.9%
Mental Health	Visits	7,718	8,589	1,281	2,338	-69.7%
Other Day/Night Care	Visits	684	2,996	3,973	4,500	557.9%
Clinics	Visits	64,679	64,866	56,077	66,552	2.9%
TOTAL	Cases	13,658	13,858	17,980	19,113	39.9%
	Visits	136,393	141,450	130,173	146,503	7.4%

The overall volume of emergency room visits has increased by 6%, surgical and endoscopy cases by 16%, renal dialysis visits by 18%, other day/night care visits by 43%, and other clinic visits by 5%. Mental health visits appear to have decreased by 14%, but this is an artifact of the change in reporting of these visits by HDGH in 2000/01 (now counted under "other votes"). The consultants were advised that there had been no reduction in the actual volume of mental health clinic visits.

2.4 Current and Proposed Program Distribution

HDGH Lead Programs

The HSRC identified roles as "lead" hospital for specific programs for each of the Windsor hospitals. For HDGH, the lead programs (all located at the Ouellette site) are as follows:

- Neuro/Trauma
- Cardiovascular/Thoracic
- Acute Mental Health
- Cardiology
- Ophthalmology
- Renal Dialysis

CONFIDENTIAL

- Cardiac Catheterization
- Emergency Services
- Orthopedics

WRH Lead Programs

For WRH, the lead programs are:

- Women's Health
- Obstetrics and NICU
- Pediatrics
- Oncology
- Burn and Plastics
- Emergency Services
- Long Term Care
- Geriatrics
- Complex Continuing Care
- Regional/Special Rehab
- Tertiary Mental Health
- Host Hospital for Cancer Centre

HSRC Recommended Division of Activity by Program

The HSRC identified the anticipated division of hospital activity (as measured by RIW weighted cases) between the two hospitals. Exhibit 2.3 shows the current (2000/01) distribution of RIW weighted cases, by MOHLTC program cluster category, for the major programs. For the purposes of this analysis, the services physically located at one hospital, but managed and staffed by the other hospital (e.g. obstetrics, neonatology, and gynaecology at the Grace site, mental health at the Western site) are assigned to the hospital who have assumed the operational responsibility for the service.

Deviation from HSRC Planned Division of Programs

For most programs the current division of responsibility between the two hospitals is very close to that recommended by the HSRC. The programs with current distribution most different from the HSRC plans are:

- Cardiology (greater proportion at WRH than planned)
- Pulmonary (greater proportion at WRH than planned)
- Orthopaedics (greater proportion at WRH than planned)
- Trauma (greater proportion at WRH than planned)

Paediatric activity is not shown separately, but the HSRC directed that all of the paediatric service should be provided at the WRH.

CONFIDENTIAL DRAFT

Exhibit 2.3
Actual and HSRC Proposed Distribution of
Windsor Hospital Activity by Program

Program (PCC)	Total RIW	Actual % 2000/2001		Proposed % HSRC 2003		Change in RIW for HSRC %	
		HDGH	WRH	HDGH	WRH	HDGH	WRH
General Surgery	5,199	59%	41%	58%	42%	(51)	51
Cardiology	4,821	46%	54%	66%	34%	944	(944)
Psychiatry	4,652	90%	10%	100%	0%	465	(465)
Obstetrics	3,433	0%	100%	0%	100%	0	0
Pulmonary	3,325	52%	48%	75%	25%	749	(749)
Orthopaedics	3,264	64%	36%	73%	27%	306	(306)
Trauma	2,723	68%	32%	100%	0%	873	(873)
Neonatology	2,721	0%	100%	0%	100%	0	0
Oncology	2,378	30%	70%	30%	70%	1	(1)
Gastro/Hepatobiliary	2,078	50%	50%	50%	50%	6	(6)
Neurology	2,017	67%	33%	64%	36%	(63)	63
Cardio/ Thoracic	1,328	79%	21%	90%	10%	146	(146)
Gynaecology	1,308	0%	100%	10%	90%	131	(131)
Urology	1,232	32%	68%	44%	56%	153	(153)
General Medicine	1,160	56%	44%	49%	51%	(83)	83
Vascular Surgery	944	79%	21%	90%	10%	101	(101)
Neurosurgery	832	99%	1%	100%	0%	12	(12)
Endocrinology	809	60%	40%	51%	49%	(76)	76
Nephrology	390	75%	25%	100%	0%	98	(98)
Other	1,243	43%	57%				
Total	45,854	51%	49%	58%	40%	3,714	(3,714)

CONFIDENTIAL DRAFT

3.0 Windsor Hospital Environment

This section of the report describes (and attempts to confirm) some of the factors identified during the review that have influenced the decisions of the Windsor hospitals Boards and management regarding planning for hospital services in Windsor. Some of these factors are unique to Windsor and may impact the ability of the Windsor hospitals to provide efficient and cost-effective care.

Essex County is located on a peninsula in southernmost Ontario. The City of Windsor is 192 kilometers southwest of London and is surrounded by Lakes Erie and St. Clair. Essex County is 1,861 square kilometres in area and has a population of approximately 350,000. The City of Windsor is home to several major automotive and manufacturing plants.

The Detroit River separates Windsor from Detroit, Michigan. The proximity of Windsor to Detroit (less than 1 mile), and the large concentration of sophisticated (and aggressively recruiting) hospital systems in the Detroit area has been identified as a significant challenge for the recruitment and retention of physicians, nursing, and allied health professionals in Windsor.

3.1 Health Status and Per Capita Funding

All of the Windsor hospital representatives interviewed for this review referred to the under-funding of hospital services in Essex County. The belief that the Windsor hospitals are under-funded (compared to the provincial average) has impacted planning and decision making and focused the attention of most stakeholders on the MOHLTC (as the funding agency) as the primary solution to the financial challenges the Windsor hospitals face.

While it is beyond the scope of this review to conduct a full analysis of the adequacy of hospital funding in Essex County, because of the importance of this issue to the Windsor hospitals we have reviewed the existing studies and data, and comment on their conclusions.

Population Health Status

The Essex, Kent, Lambton District Health Council (EKL DHC) assessed a variety of health status indicators for Windsor-Essex community as part of their Health System Monitoring Report, published in February 2001. They found that:

- District residents reported higher than average prevalence of long term disabilities and chronic conditions;

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- District residents have higher than average rates of mortality, premature mortality and potential years of life lost;
- Circulatory diseases are leading causes of death and potential years of life lost, throughout the District.
- Lower rates of inpatient rehabilitation utilization throughout the District and wide variations within the District in separations and days/1,000 population.

Birch Study Found Essex Need for Hospital Services 17% Above Provincial Average

The District Health Council and the Windsor/Essex Hospitals sponsored a research project, by Dr. Steven Birch of the Centre for Health Economics and Policy Analysis at McMaster University in 2000. This study, "A Needs-Based Approach to Calculating the Health Care Resource Requirements for Essex County", concluded that based on the characteristics of the population, and their needs for health care, per capita use of Essex county hospitals should be 17% above the provincial average.

The study used hospital bed days per population as the measure of hospital utilization and the standardized mortality ratio (SMR) as the primary measure of relative need for hospital care. The SMR values used for Essex County were based on 1991 to 1995 mortality records. All condition SMR values for both males and females were above the Ontario average (and statistically significantly different from the average).

Adjustment for the age and gender of the Essex County population alone generated an expectation of per capita use of hospitals 11% above the provincial average. The additional 6% expected use (in response to need) of hospital services was based on the adjustment to expected hospital bed days using the SMR values.

Using hospital bed days as the measure of hospital utilization is problematic. Effectively, the methodology assumes that the major factor that impacts patient length of stay is patient need. No adjustments are made for delays in discharge (ALC days), variation in the use of ambulatory services as a substitute for inpatient care, or variation in effectiveness of utilization management initiatives. A better measure of hospital utilization would be the Resource Intensity Weights (RIWs). We do not know, and cannot evaluate within the scope of this study, whether the results of the assessment of need for hospital services would be significantly different if RIWs were used as the utilization measure instead of patient days.

CONFIDENTIAL DRAFT

However, the Birch study did show that Essex County residents do, on average, fair more poorly than the average Ontario resident with respect to a number of indicators of population health status.

International Joint Commission Study

In December 2001, a study was published in the journal Environmental Health Perspectives that examined mortality, morbidity, and congenital anomalies in the Windsor area.[1] The study found "consistently elevated rates of mortality, morbidity as hospitalization, and congenital anomalies" in Windsor for conditions that might be linked to pollution.

DHC Report

In March 2002 the EKL DHC published a summary report, "Impact of Windsor/Essex Residents Health Status on Hospital Services". This report concluded that:

"It is evident that the health status of Essex residents is generally worse (in some cases markedly so) than the provincial average. Therefore logically, one would predict that the utilization of local hospital resources would be higher than the provincial norms, and this is in fact the case".

JPPC Volumes Model

The Joint Policy and Planning Committee (JPPC) Volumes Committee reported that in 1999/2000 the per capita use of hospital services by residents of Essex County (measured by RIW weighted cases), after adjustment for population age and gender, was 5% higher than the provincial average. The JPPC also determined that the additional need (measured using the "MARI" index) for hospital inpatient and ambulatory procedure care for Essex residents meant that actual utilization was 3% below expected. The results of the JPPC Volumes Model analyses for Essex County, and for the other communities where the peer hospitals for this review are located, are shown in the following table.

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[1] Gilbertson M, Brophy J. "Community Health Profile of Windsor, Ontario, Canada: Anatomy of a Great Lakes Area of Concern", Environmental Health Perspectives, Vol. 109, Suppl. 6, December 2001.

Exhibit 3.1
JPPC 1999/2000 Volumes Model Analysis of Medical/Surgical Utilization by Community

Community Description	Actual Wtd. Cases	Expected, Based on Age/Sex	% Actual Above Expected (Age/Sex Only)	MARI Index	Expected, Based on Age/Sex and MARI Index	% Actual Above Expected (Age/Sex and MARI)
Hamilton	58,274	47,087	24%	1.18	55,443	5%
Sudbury	25,055	20,950	20%	1.29	27,022	-7%
Oshawa	18,927	17,263	10%	1.18	20,436	-7%
Essex County	**51,175**	**48,724**	**5%**	**1.09**	**52,977**	**-3%**
Kingston	19,629	19,432	1%	1.01	19,708	0%
Peterborough	20,050	20,147	0%	0.96	19,373	3%
Brampton	27,930	29,728	-6%	1.00	29,672	-6%
Etobicoke	46,134	49,273	-6%	1.01	49,805	-7%
North York	80,394	88,694	-9%	0.94	83,139	-3%
Oakville	15,345	17,265	-11%	0.90	15,457	-1%
Mississauga	53,351	66,164	-19%	0.97	64,325	-17%

The range in comparison of actual to expected RIW weighted cases is from 17% below expected for Mississauga to 5% above expected for Hamilton.

The Birch study criticized the JPPC methodology as not being sufficiently sensitive to the higher needs for health care of Essex County residents.

Updated Birch Study Analyses

In 2000/01, the Vice-President of Finance of the HDGH obtained updated population and hospital funding data (for 1997/98) and compared the average provincial per capita hospital funding with the Essex County per capita hospital funding. This analysis included adjustments for the higher costs of teaching and specialty hospitals and adjustments for outflow of residents of Essex County to hospitals outside the county (lack of these adjustments had been a criticism of the original Birch study).

After applying the age and gender, and needs adjustments identified in the Birch study, the updated analysis suggested that there was a $66 million shortfall in hospital funding in Essex County, if the provincial average per capita rate was used as the target. This analysis was based on total hospital funding, including funding for ambulatory and outpatient activity.

Difficult to Reconcile Birch Study and JPPC Results

Initially we found it difficult to reconcile the results of this analysis with the JPPC data. The JPPC data suggests that the per capita use of inpatient and ambulatory surgery (as measured by RIW weighted cases) by Essex County residents is higher than the

CONFIDENTIAL DRAFT

provincial average. The costs per equivalent RIW weighted case of the two Windsor hospitals are both higher than expected (as determined by the JPPC Rates Model). It did not make sense that higher utilization, coupled with higher unit costs could result lower per capita expenditures.

Birch Study Looked at Total Hospital Funding, JPPC at Acute Care Costs

However, the explanation for the difference in the results appears to be related to the scope of hospital services included in each of the analyses. The Birch study and the subsequent update by HDGH look at total hospital funding per population. The JPPC models look at inpatient (acute and chronic) and ambulatory procedure costs per population.

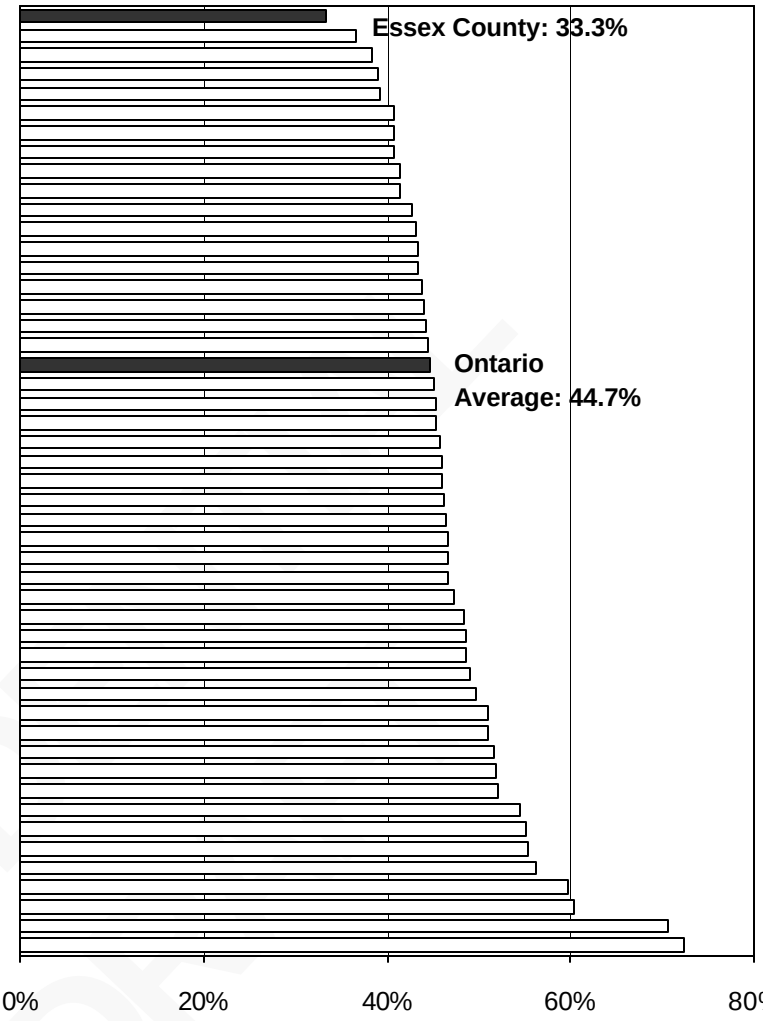
Variation in % of Hospital Costs Used for Non-Acute Care

Exhibit 3.2 shows the percent of total hospital expenditures used for non-acute services in each Ontario county. On average, in 2000/01, 44.7% of Ontario hospital expenditures were used for non-acute care.[2] However, a much lower percentage of the total hospital expenditures in Essex County were used for non-acute care.

CONFIDENTIAL DRAFT

[2] Source: 2000/01 OCDM Data. For purposes of this analysis, acute care includes newborns and adult acute inpatients, plus qualifying day surgery. Non-acute includes all ER, outpatient, and chronic, respite, rehabilitation, and palliative inpatient care.

Exhibit 3.2
Percent of Total Hospital Expenditures for County Hospitals Spent on Non-Acute Services



Essex County Has Lowest % of Hospital Costs for Non-Acute Care

Only 33.3% of total hospital expenditures for the hospitals in Essex County were used for non-acute care. The percent of Essex County hospital expenditures for outpatient activity was the third lowest of all counties. The percent of Essex County hospital expenditures for non-acute inpatient care was sixth lowest of all counties.

The following exhibit shows the percent distribution of hospital expenditures by county for the counties in which the peer hospitals for this review are located. Essex County has the highest percentage of hospital expenditures consumed by acute, newborn, and day surgery.

Exhibit 3.3
Percent Distribution of Hospital Expenditures by County by Type of Care

County	% Outpatient	% Non-Acute Inpatient	% Acute, Newborn, Day Surgery
Durham	35.3%	11.5%	53.3%
Toronto	32.4%	13.7%	53.9%
Ontario Average	32.6%	12.2%	55.3%
Peel	35.7%	8.8%	55.5%
Halton	32.5%	11.4%	56.1%
Peterborough	31.4%	10.0%	58.6%
Frontenac	31.7%	9.1%	59.2%
Hamilton-Wentwort	30.9%	9.8%	59.3%
Sudbury (R.M.)	29.0%	7.5%	63.5%
Essex	26.6%	6.7%	66.7%

Essex County Acute Care Expenditures Above Provincial Average (As is Need)

Based on these analyses we conclude that the Essex County per capita expenditures for acute care services (as measured by the JPPC formulae) are unlikely to be below the provincial average (when adjustments are made for teaching). Adjustments for the higher need of Essex County residents (based on health status measures) justify higher per capita expenditures for both acute care (per the JPPC MARI index) and total hospital services (per the Birch study).

Essex County Total Hospital Expenditures below Provincial Average

However, the Essex County per capita expenditures for all hospital services (including non-acute and ambulatory) are well below the provincial average, because two thirds of the expenditures are for acute care (the highest proportion of any county in the province). This must be taken into account when establishing clinical efficiency and operational productivity targets for the Windsor hospitals, since it means that the non-acute care infrastructure to complement acute care services is under-developed, compared to peer hospitals.

Per Capita Utilization of Other Health Care Services

We also attempted to assess the capacity and utilization of non-hospital health care services in Essex County. Only limited comparative information is available from MOHLTC databases. The following exhibit shows the number of long-term care (nursing home and home for the aged) resident days per population aged over 65 for Essex County and the counties in which the peer hospitals are located. The number of LTC beds per population aged over 65 for Essex County is below the provincial average.

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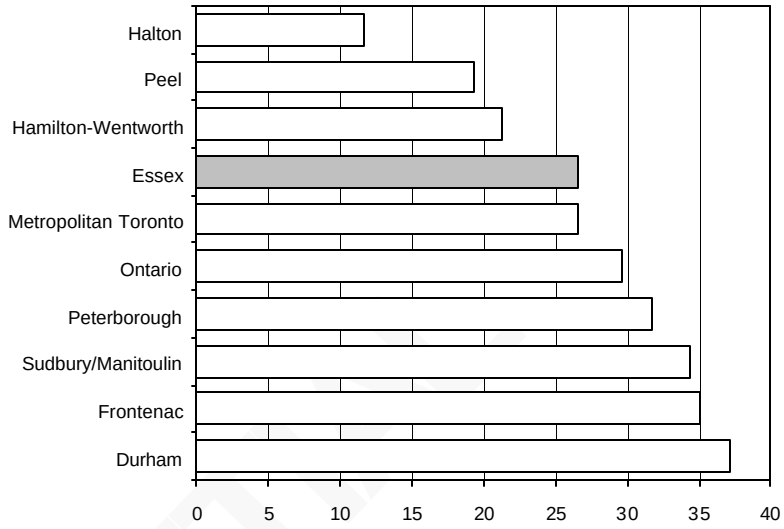
Exhibit 3.4
1998/99 Long-Term Care Days per Resident over 65 Year Old by Peer County



The following data was provided by the MOHLTC Southwest Region team, and includes data for only the counties within the Southwest region.

Exhibit 3.5
LTC Beds and CCAC Budget per Population Over 65 for Southwest Region Counties

County	2001 Population	Popn. > 65	% 65 +	LTC Beds	Beds per 1,000 > 65+	CCAC Budget 2001	CCAC $ per 65+
Perth	75,562	10,790	14.3%	685	63	$ 8,102,947	$ 751
Elgin	85,529	11,254	13.2%	655	58	$ 8,861,835	$ 787
Huron	61,212	10,358	16.9%	601	58	$ 8,256,441	$ 797
Oxford	103,279	14,793	14.3%	753	51	$ 11,898,173	$ 804
Chatham-Kent	112,845	16,176	14.3%	818	51	$ 13,696,202	$ 847
Middlesex	414,042	52,405	12.7%	2522	48	$ 40,446,708	$ 772
Grey Bruce	157,728	26,885	17.0%	1,275	47	$ 21,087,430	$ 784
Essex	383,712	49,254	12.8%	2011	41	$ 39,498,893	$ 802
Lambton	131,280	20,293	15.5%	762	38	$ 14,518,886	$ 715

In 2001, Essex County had the 2nd lowest ratio in the Southwest of long-term care beds per population aged 65 and older and the 3rd highest CCAC budget per population aged 65 and older.

This data does not reflect the impact of the new nursing home beds built (or planned) since 1998/99. Currently there are 16 facilities providing 2,153 long-term care beds in the Windsor/Essex County

area. By 2004, this will increase to 19 facilities providing 2,581 beds (and increase of 428 beds, or 20%).

3.2 Population Growth and Patient Residence

Population Growth

Growth in the population served will increase the demand for hospital services. In high growth communities, delays in implementation of HSRC-directed redevelopment projects, particularly those that include increases in hospital capacity to accommodate growth, will cause greater stress than in low growth communities.

The official MOHLTC population data by county, based on the 2001 Census, is not yet available. As an alternative, we acquired Statistics Canada population data for 1997 to 2001 (incorporating the 2001 Census results) for "Census Metropolitan Areas" (CMAs). A CMA is an area consisting of one or more adjacent municipalities situated around a major urban core, with a population of at least 100,000. The following exhibit shows the percent growth in population for each CMA.

CONFIDENTIAL DRAFT

Exhibit 3.6
Percent Growth in Population for Census Metropolitan Areas from 1997 to 2001 Census

Statistics Canada Census Metropolitan Area	1997	2001	Growth from 97 to 01
Calgary (Alberta)	873	972	11.3%
Toronto (Ontario)	4,499	4,881	8.5%
Oshawa (Ontario)	282	305	8.3%
Windsor (Ontario)	**292**	**314**	**7.6%**
Kitchener (Ontario)	402	432	7.4%
Edmonton (Alberta)	897	957	6.6%
Ottawa–Hull (Ontario–Quebec)	1,046	1,107	5.9%
Vancouver (British Columbia)	1,968	2,079	5.7%
Hamilton (Ontario)	650	681	4.6%
Halifax (Nova Scotia)	345	359	4.0%
London (Ontario)	413	426	3.2%
Montréal (Quebec)	3,409	3,512	3.0%
Sherbrooke (Quebec)	151	155	2.4%
St. Catharines–Niagara (Ontario)	386	393	2.0%
Saskatoon (Saskatchewan)	228	231	1.3%
Québec (Quebec)	685	693	1.1%
Winnipeg (Manitoba)	678	685	1.0%
Victoria (British Columbia)	318	319	0.4%
Saint John (New Brunswick)	128	128	0.2%
St. John's (Newfoundland)	177	176	-0.2%
Trois-Rivières (Quebec)	142	142	-0.5%
Regina (Saskatchewan)	199	198	-0.5%
Chicoutimi–Jonquière (Quebec)	163	159	-2.5%
Thunder Bay (Ontario)	129	125	-3.0%
Sudbury (Ontario)	164	157	-4.4%

The Windsor CMA is one of the fastest growing urban centres in Canada.

Residence of Windsor Hospital Inpatients

Most of the Windsor hospital inpatients come from the City of Windsor (65.8% for WRH, 69.4% for HDGH). Approximately 30% of Windsor hospital inpatients live in Essex County, but outside the City of Windsor (32.5% for WRH, 28.2% for HDGH).

Very few inpatients live outside Essex County (1.8% for WRH, 2.5% for HDGH). This means that the utilization of Windsor hospitals is highly dependent on the local community. It also means that the opportunity to "repatriate" care for non-residents (i.e.

promoting provision of hospital care for non-residents in hospitals located where they live) as a cost reduction strategy is very limited.

Although data was not available to confirm this, prior studies have shown that Essex County is highly self-sufficient for hospital services, with low number of residents seeking care outside the hospitals located within the county. We do not know how many Essex County residents are travelling to the U.S. for their hospital care.

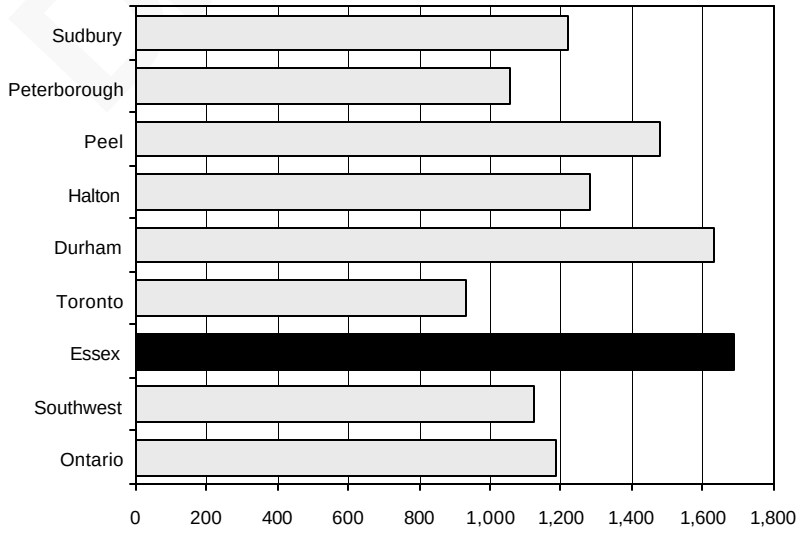
3.3 Essex County Health Care Workforce

Physician Workforce

Availability of physicians (both primary care and specialists) was identified both as a factor influencing the reliance of the Essex County population on the Windsor hospitals and as a factor influencing operational decisions and costs.

We obtained data from the Ontario Physician Human Resource Data Centre (OPHRDC) report "Physicians in Ontario - 2000" to compare the physician workforce in Essex County with physicians in the communities of the selected peer hospitals, the Southwest average, and the overall Ontario average. While the Regional Physician Human Resources Planning Committee (a subcommittee of the Essex County JEC) has rejected the OPHRDC as inaccurate, it is still considered to be the best source for comparative physician supply data in Ontario.

Exhibit 3.7
Average Population per Primary Care Physician for Counties of Peer Community Hospitals



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This data shows that in 2000, Essex County had the highest ratio of population per primary care physician of all of the communities examined.

The Essex County communities shown in the following table have been designated by the MOHLTC as under-serviced for general/family practitioners. In southern Ontario, there are 82 communities designated as under-serviced, requiring a total 0f 427 physicians.

Exhibit 3.8
Essex County Communities Designated as Under-Serviced for General/Family Practitioners (April, 2002)

Community	Designated GPs	Vacancies	% Vacancy
Amherstburg	13	5	38%
Essex	11	5	45%
Harrow	6	3	50%
Kingsville	26	4	15%
Lakeshore	13	11	85%
Windsor	164	19	12%
Total	233	47	20%

The "Regional Physician Human Resources Planning for Windsor and Essex County" report prepared in April 2001 by the Regional Physician Human Resources Planning Committee identified a shortfall of 136 family practitioners for Essex County. This calculation was based on application of a methodology developed by Dr. Peter Coyte and published in Canadian Family Physician in 1997.[3]

The average population per specialist physician in Essex County is above the Ontario average, but below the GTA average. The lower number of specialist physicians in the GTA must be viewed in conjunction with the high number of specialist physicians in Toronto and Hamilton, where many GTA residents seek their hospital care.

The Regional Physician Human Resources Planning Committee identified a need for an additional 114 specialists in Essex County

[3] Coyte, P.C., Catz, M., Stricker, M., "Distribution of Family Physicians in Ontario. Where are there too few or too many family physicians and general practitioners?" Canadian Family Physician. 1997; 43: 667-83, 773.

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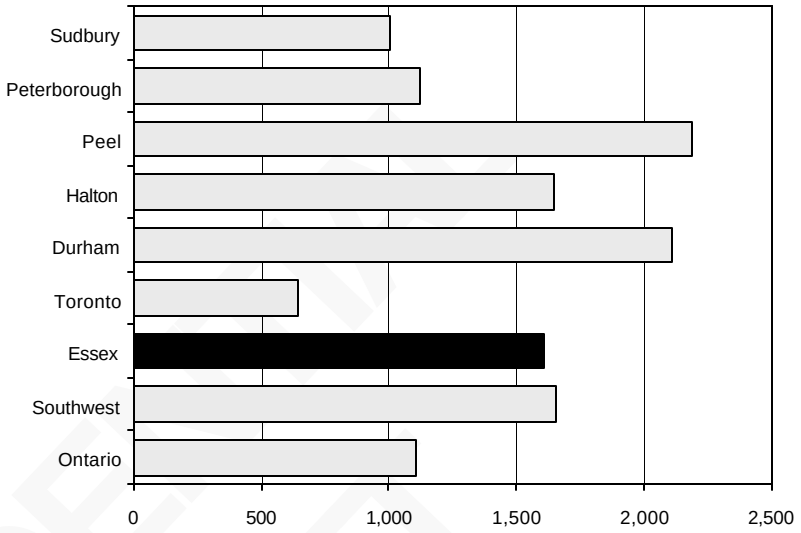
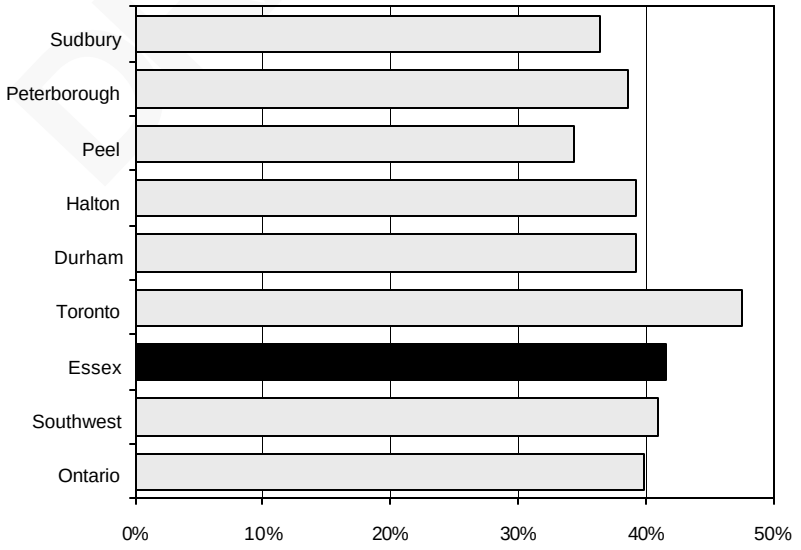
(based on application of population to physician ratios proposed in 1988). They also estimated that the cost to the Essex County hospitals of adding the 114 specialists would be approximately $75 million (a 29% increase in the total costs of the Essex County hospitals).

Exhibit 3.9
Average Population per Specialist Physician



More than 40% of primary care physicians in Essex County are 50 years and older (slightly above the Ontario average rate).

Exhibit 3.10
% Of Primary Care Physicians 50 years and older



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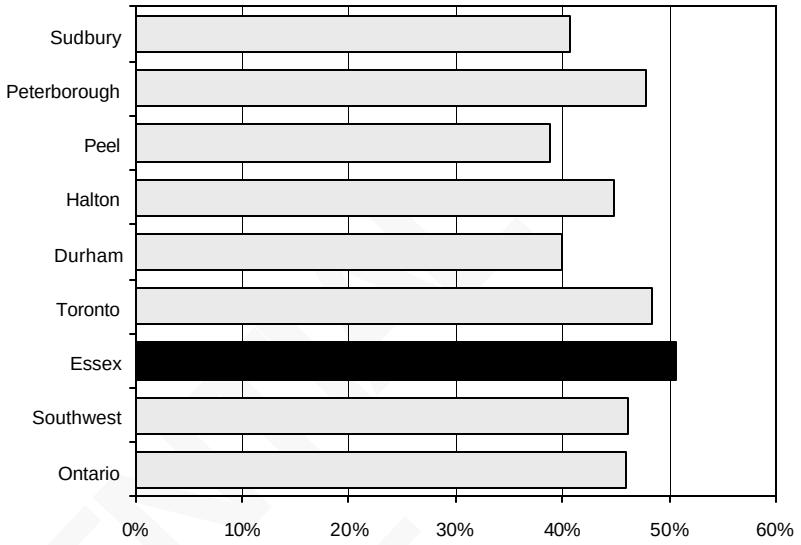
More than 50% of specialist physicians in Essex County are 50 years and older (above the Ontario average rate and the rate for all of the other communities examined).

Exhibit 3.11
% Of Specialist Physicians 50 years and older



The shortage of primary care physicians in Essex County could lead to increased reliance of the population on the hospitals for care that would be provided in the community in other cities. Analysis of the 2000/01 inpatient CIHI data for the Windsor hospitals and the peer hospitals shows that there is a high rate of admissions of patients who may not require hospitalization (and are assigned to MNRH CMGs) in Windsor hospitals.

Exhibit 3.12
% Of Inpatient Cases in
"May Not Require Hospitalization" (MNRH) CMGs

Hospital	% MNRH Cases
Oshawa General Hospital	7.9%
Hotel Dieu Grace, Windsor	**7.4%**
Windsor Regional Hospital	**7.2%**
Sudbury Regional	7.1%
William Osler	6.3%
Humber River Regional Hospital	6.1%
Oakville Trafalgar	5.1%
Kingston General, Hotel Dieu	5.1%
St. Joseph's (Hamilton)	4.8%
Peterborough RHC	4.5%
Trillium Health Centre	4.1%
North York General Hospital	4.1%
Total	5.8%

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The MNRH measure is a potential indicator of unavailability of ambulatory and community based services. An associated measure, usually applied to population-based data, is the rate of admission of "avoidable hospitalization conditions". These are patients for whom admission to an acute care hospital might have been avoided if earlier or more consistent access to primary care (or alternative community or hospital ambulatory services) were available. The overall percent of inpatient admissions in 2000/01 that were for avoidable hospitalization conditions was 5.2% for HDGH, above the peer group average of 4.6%, and 3.1% for WRH, the lowest of all of the peer hospitals.

Exhibit 3.13
% Of Inpatient Cases Categorized as "Avoidable Hospitalization Condition"

Hospital	% Avoidable Hospitalization Condition Cases
William Osler	6.4%
Peterborough RHC	6.0%
Humber River	5.4%
Hotel Dieu Grace	**5.2%**
Oakville Trafalgar	5.1%
Oshawa General	5.1%
Kingston General	5.0%
St. Joseph's Hamilton	4.6%
Sudbury Regional	4.5%
North York General	4.3%
Trillium Health Centre	4.0%
Windsor Regional	**3.1%**
Average	4.6%

If the quality or comprehensiveness of primary care in Essex County was compromised by the low number of primary care physicians, we would expect to see consistent high rates of admission of avoidable conditions in both Windsor hospitals. While data is not available to measure this, we were told that Windsor has a very high number of walk-in clinics compared to other Ontario cities of similar size and that this has had an impact on primary care physician practices and on the emergency rooms.

The low numbers of physicians increases the workload of the available primary care physicians, and may reduce their willingness to participate in hospital care. Both Windsor hospitals have established hospitalist programs (with different approaches) to reduce reliance on primary care physicians.

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The above average population per specialist may increase the workload of the existing specialists and may make it more difficult for the hospitals to ensure coverage, particularly with the subspecialist coverage model used in Windsor.

The older average age of the specialists and the workload levels were reported as factors that tend to reduce the support of the medical staff for hospital administrative activities, such as utilization and quality management, and recruitment. While it is happening throughout the province, there is the perception that Windsor physician dissatisfaction is more acute, and that there is an increasing expectation of enhanced compensation for both administrative and clinical activities.

Nursing Workforce

The MOHLTC has provided data, from the College of Nurses, showing the number of nurses per 100,000 population in Essex County and the province as a whole.

In Essex County, there were 553 RNs per 100,000 population, 26% below the provincial average of 744.

There were 201 RPNs per 100,000 population in Essex County, 8% below the provincial average of 219.

The proximity of Detroit increases the nursing recruitment and retention challenge. It is unknown how many nurses live in Windsor but work in Detroit, but the College of Nurses has reported that there are 1,240 Canadian nurses working in Michigan.

The challenge of recruitment and retention of nurses was reported as a key consideration in decisions at both Windsor hospitals, e.g.:

- "Ramping up" at HDGH (increasing staffing in anticipation of future workload)
- Retention of RPNs not required at the Met Campus, in anticipation of future needs at the Western campus, at WRH

Michigan Senate Bill 178

A proposed bill in the Michigan Senate, supported by the Governor, would amend the Public Health Code to allow an individual licensed to practice a health professional in the Ontario to obtain a Michigan license under certain conditions:

- The individual must substantially meet the requirements for licensure under the Public Health Code.

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- The individual must be licensed in Ontario and standards for licensure in Ontario must be substantially equivalent to those in Michigan.
- Ontario must grant reciprocal licensure to individuals licensed to practice the health profession in Michigan.

The analysis of the bill conducted by the Michigan Office of Policy and Legislative Affairs concluded that "The bill will make little difference in health professional licensing in Michigan. Thousands of Canadian health professionals are already licensed in Michigan. Public Act 256 of 2000 has generated only 221 temporary licenses, and only 3 or 4 new applications are being received each month."[4]

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[4] http://www.cis.state.mi.us/opla/sbana/01sbana/sba178.htm

4.0 Financial History - Hôtel-Dieu Grace Hospital

4.1 Summary of Financial Situation

HDGH is in critical financial condition.

Since the beginning of 1994/95 the hospital's working funds position has gone from bad ($1.2 million deficit) to worse ($46.1 million deficit, taking into account the inter-fund borrowing of $20.8 million).

HDGH requires substantial overdraft funds to continue its day to day operations.

The Hospital's 2002/03 Business Plan submission shows a projected operating deficit of $25.5 million, a trend that will see the hospital run out of available cash and credit well before the end of the year.

Since 1993/94:

- Operating deficits used $19.6 million
- Capital activity used $10.0 million
- Restructuring used $6.8 million
- Parking contributed $3.1 million.
- Changes in working capital items contributed $35.1 million

HDGH cash is currently provided by:

- MOHLTC advance of $15.9 million
- Capital Fund advance of $20.8 million

The deficit gap has been growing since 1999/00. At the same time, MOHLTC percentage of revenue has been increasing steadily to over 86%.

Restructuring has contributed significantly to the accumulated shortfall. Although HDGH has been reimbursed $8.3 million for approved restructuring costs, HDGH still appears to be out of pocket over $25 million for unfunded costs related to restructuring.

There have been significant issues related to medical staff recruitment and retention. One symptom of the distress is seen in the tremendous increase in medical staff remuneration for medical

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administration and on-call coverage. HDGH medical administration and on-call coverage costs have increased by $4.6 million, an 18-fold increase since 1998/99.

Service Volumes provide a mixed picture:

- Inpatient volumes have declined since 1998/99 (separations down 10.3%, patient days down 7.3%)
- Outpatient volumes have increased 8.4% since 1998/99
- HDGH has not yet shown expected growth.

The Average Cost per FTE has increased 9.6% ($4,497) since 1998/99 ($24.05 to $26.36 per hour).

FTE have increased by 254.6 (19.5%, but this figure includes a net 50 FTE impact from the OB/Psych Program staffing transfer. Without that impact, HDGH would have recorded an increase of 15.7%). Increases in staffing are observed in all areas of hospital operations.

At March 31, 2002 HDGH had the following debt load:

- $5.0 million line of credit
- $9.0 million MOHLTC operating advance
- $6.855 million Creutzfeldt-Jakob disease advance
- Long Term Debt of $5.8 million
- $2.2 million capital lease (expires Dec, 2002)
- Capital fund advance of $20.8 million.

At present the hospital has stopped all deferrable capital spending.

Recent capital spending has contributed to the hospital's current cash problems. HDGH appears to have spent more than prudent on its capital equipment, given its financial position.

The financial situation is discussed in greater detail in the following sections.

4.2 Changes in Financial Position

Background

Hôtel-Dieu Grace Hospital was formed through an Alliance Agreement effective April 1, 1994 between the Governing Council of the Salvation Army in Canada and The Religious Hospitallers of Hôtel-Dieu of St. Joseph of the Diocese of London. The Hospital is operated by The Religious Hospitallers of St. Joseph Health

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Centre of Windsor under the corporate structure of The Religious Hospitallers of Hôtel-Dieu of St. Joseph of the Diocese of London. Under the Alliance Agreement, the net assets of the predecessor hospitals were made available to and put under the control of Hôtel-Dieu Grace Hospital for the delivery of programs and services.

The Hospital's auditors have noted that Hôtel-Dieu Grace Hospital does not record its obligation for sick leave benefits upon termination of employment as an accrued liability for employees with a sick bank benefit plan. Although most employee groups have moved to a different type of sick leave plan, service workers represented by CAW still use such a plan.

Canadian generally accepted accounting principles require that this amount be accrued in the financial statements as a liability. The Auditors do note the impact each year. At March 31, 2001, the net effect of recording the accumulated benefits as a liability would have been to decrease the opening general fund balance by $3,509,000 and increase revenue over expense for the year by $847,000.[5] The Hospital has continued to expense these benefits as incurred since formally recognizing the liability would trigger an expense when the hospital is already in a significant deficit position.

Working Funds

Working funds are calculated by netting current assets against current liabilities. A positive answer is good. The review of the change in working funds bridges the period from March 31, 1994 through January 31, 2002. The January 31, 2002 results are unaudited, provided directly by the hospital for this review in a consistent format with the audited financial statements.

The balance sheet comparison is shown in Exhibit 4.1. Since the beginning of 1994/95 the hospital's working funds position has gone from bad ($1.2 million deficit) to worse ($46.1 million deficit, taking into account the inter-fund borrowing of $20.8 million). Current Assets have actually increased by $1.9 million. At the same time, current liabilities have increased by $46.8 million, driven primarily by moneys owed to the capital fund ($20.8 million) and MOHLTC operating advances ($16.4 million). It is possible that a mid-year balance sheet may provide an imperfect comparison. However, the picture going forward appears to be substantially

[5] Hotel-Dieu Grace Hospital Audited Financial Statements, March 31, 2001, Note 14.

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correct: ***HDGH requires substantial overdraft or MOHLTC advance funds to continue its day to day operations***.

In fact, the Hospital is projecting the financial situation to worsen in the coming year. The Hospital's 2002/03 Business Plan submission shows a projected operating deficit of $25.5 million, a trend that will see the hospital run out of available cash and credit well before the end of the year. This amount far exceeds the Hospital's current $5 million operating line, and is a trend that is not sustainable. MOHLTC has agreed to provide an advance of $15.9 million in April, 2002. May and October, 2002 will be difficult months for cash flow since there are three pays in each of those months.

Exhibit 4.1
HDGH Consolidated Balance Sheet at January 31, 2002 (in thousands of dollars).[6]

ASSETS	General Fund $	Capital Fund $	Jan 31, 2002 $	General Fund $	Capital Fund $	March 31, 2001 $	March 31, 1994 $
Current							
Cash	2,777		2,777	2,284	3	2,287	959
Short term investments	93	13	106	3,544	15,568	19,112	
Accounts receivable			-			-	
Ministry of Health			-	2,428		2,428	6,311
Insurers,patients and sundry	5,576		5,576	5,838		5,838	2,846
Inventory	1,041		1,041	951		951	1,262
Prepaid Expenses	1,171		1,171	949		949	402
Other current assets	6,110		6,110		76	76	-
Due from operating fund		20,821	20,821		4,505	4,505	3,069
	16,768	20,834	37,602	15,994	20,152	36,146	14,849
Property, plant and equipment							
Land and improvements	5,546		5,546	6,245		6,245	7,120
Buildings	36,977	9,316	46,293	36,177	9,191	45,368	51,202
Equipment	81,582		81,582	78,341		78,341	39,017
Construction in progress	69,269		69,269	38,760		38,760	107
	193,374	9,316	202,690	159,523	9,191	168,714	97,446
Less accumulated amortization	78,879	2,407	81,286	69,775	2,014	71,789	45,322
	114,495	6,909	121,404	89,748	7,177	96,925	52,124
Assets held for Capital Purposes							15,529
Total Assets	131,263	27,743	159,006	105,742	27,329	133,071	82,502

[6] Sources: HDGH Internal Financial Statements at January 31, 2002; HDGH Audited Financial Statements, March 31, 1995.

LIABILITIES AND EQUITY	General Fund $	Capital Fund $	Jan 31, 2002 $	General Fund $	Capital Fund $	March 31, 2001 $	March 31, 1994 $
Current liabilities							
Line of Credit			-			-	
Accounts payable	8,967		8,967	6,644		6,079	3,515
Accrued payroll	2,657		2,657	3,925		2,483	2,758
Accrued post retirement benefits	477		477	477		477	
Accrued vacation pay	5,301		5,301	5,378		5,377	4,952
Accrued retroactive pay	2,467		2,467	46		46	198
Employee deductions payable	451		451			1,442	358
Due to capital fund	20,821		20,821	4,505		4,505	3,069
Other accrued liabilities	805		805	862		862	746
Deferred Provincial Funding	16,441		16,441	15,304		566	-
Deferred Revenue	531		531	665		665	-
Deferred Grants	-		-			15,304	-
Current portion of term loan		221	221		221	221	250
Current portion of capital lease	3,749		3,749	3,869		3,869	218
	62,667	221	62,888	41,675	221	41,896	16,064
Long-term liabilities							
Obligation under capital lease	-		-	2,185		2,185	381
Accrued post retirement benefits	1,696		1,696	708		708	
Term loan		5,898	5,898		6,082	6,082	436
Total liabilities	64,363	6,119	70,482	44,568	6,303	50,871	16,881
Deferred capital contributions	66,735		66,735	46,292		46,292	6,760
Fund balances							
Invested in capital assets	44,011	790	44,801	37,402	874	38,276	43,332
Capital		20,834	20,834		20,152	20,152	15,529
Unrestricted	(43,846)		(43,846)	(22,520)		(22,520)	
Total fund balances	165	21,624	21,789	14,882	21,026	35,908	58,861
Total Liabilities and Fund Balances	131,263	27,743	159,006	105,742	27,329	133,071	82,502

Exhibit 4.2 shows the changes from 1993/94 (the year before the merger) to 2001/02. Operating deficits contributed $19.6 million to the decline in the hospital's position. Changes in working capital items contributed $35.1 million. Capital activity, including both regular equipment renewal and building activity consumed $10.0 million. Restructuring consumed $6.8 million, and parking contributed $3.1 million. The closing cash position of $2.8 million significantly is comprised of $15.9 million MOHLTC cash advance, and $20.8 million advance from the capital fund.

Parking has been highlighted in this analysis since hospitals differ in their approach to reporting parking revenues. Although the MOHLTC does not fund capital or operating costs related to parking facilities, some hospitals do include net parking revenues in their operating results. Other hospitals, HDGH included, take the

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position that parking revenues should not support hospital operations. HDGH applies parking revenues to repayment of capital debt for the parking garage and to its own capital needs. As a result of this accounting approach, HDGH reports a higher operating deficit (or smaller operating surplus) than if parking were included in operations.

Exhibit 4.2[7]
HDGH Statement of Cash Flows 1994/95 through January 31, 2002 (in thousands of dollars)

Opening Cash		*$ 959*
Impact of Hospital Operations		*(19,600)*
Surplus (Deficit) from Operations & Votes	(16,302)	
Deficit from Mold Remediation	(1,155)	
Future Cost of Employee Benefits	(2,483)	
Adj. to MOH prior year allocation	340	
Parking		*3,120*
Additions to Parking	(8,015)	
Term loan (Parking Garage)	7,000	
Parking income	3,018	
Repayment of term loan(Parking Garage)	(783)	
Amortization parking building	1,900	
Restructuring		*(6,754)*
MoHLTC Net	(2,978)	
Prior Years	(3,776)	
Change in Working Capital Items		*35,095*
AP,AR, Other Current Assets	1,489	
Cash advances MoHLTC	15,855	
Advance from Capital Fund	17,751	
Impact of Capital Activity		*(10,043)*
Additions to building & c.i.p.	(77,407)	
Additions to equipment	(30,253)	
Additions to equipment under lease	(11,396)	
Additions to capital fund fixed assets	(1,229)	
Deferred contributions - capital assets	59,712	
Amortization of Equipment	35,070	
Capital fund incomes	10,377	
(Gain)/loss on disposal of capital assets	227	
Repayment of Capital lease and notes	(6,870)	
Capital lease obligation	11,726	
Closing Cash		*$ 2,777*

4.3 Hospital Operating Results

[7] Sources: HDGH Internal Financial Statements at January 31, 2002; HDGH Audited Financial Statements, March 31, 1995.

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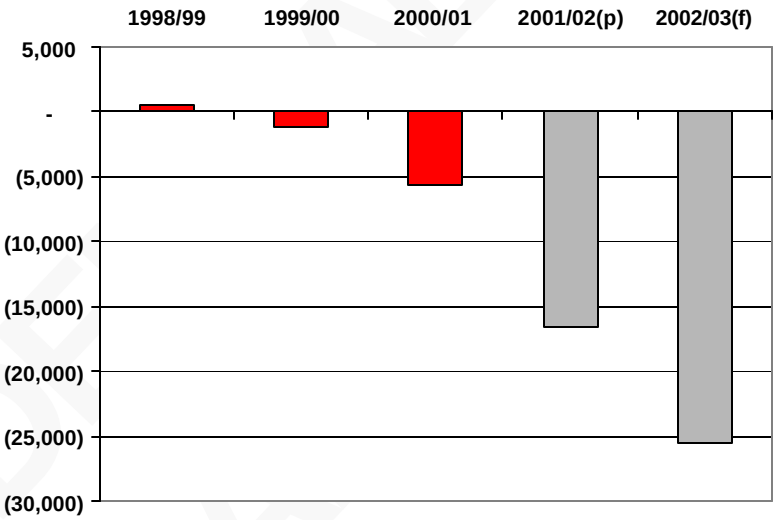
In 1998/99 HDGH recorded a small operating surplus of $551,000 (0.5% of revenue). 1999/00 saw the beginning of recent operating deficits with a deficit of $1.3 million (1.1% of revenue), and by 2000/01 the operating deficit had increased to $5.7 million (4.3% of revenue). Operating results continue to worsen with an operating deficit of $16 million projected for 2001/02,[8] and a much worse operating deficit of $25.5 million for 2002/03.[9] These results are seen in Exhibit 4.3.

Exhibit 4.3[10]
Operating Surplus (Deficit) 1998/99 through 2002/03 (in thousands of dollars)



Operating surplus (deficit) is a product of revenues and expenses. How have revenues and expenses changed over that period? Exhibit 4.4 shows total revenue and total expenses together. It is clear from this view that revenues and expenses tracked closely through 1999/00. From there expenses continue a fairly straight growth path, with a growing gap between revenues and expenses.

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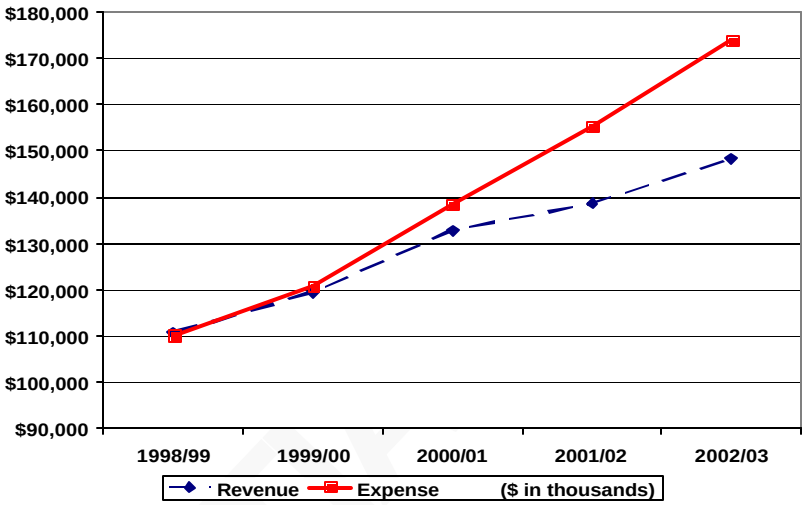
[8] HDGH current projection for year-end 2001/02.

[9] 2002/03 Business Plan Submission.

[10] Actual results for 1998/99 and 1999/00 from 2001/02 operating plan; 2000/01 actual from 2001/02 Q2 report; 2002/03 from Business Plan Submission.

Exhibit 4.4[11]
Operating Revenues and Expenses 1998/99 through 2002/03(forecast) in thousands of dollars



4.4 Operating Revenues

Over this period, non-MOHLTC revenue of about $18 - $19 million increased by 6.1%%, finishing at $18.8 million. MOHLTC revenue increased steadily to $116.6 million in 2001/02 (including Other Votes and restructuring). Exhibit 4.6 shows operating revenues over this period. As a result of these changes, MOHLTC revenue has increased from 84.0% of total revenue in 1998/99 to 86.4% as forecast for 2001/02.

[11] Actual results for 1998/99 and 1999/00 from 2001/02 operating plan; 2000/01 actual from 2001/02 Q2 report; 2002/03 from Business Plan Submission.

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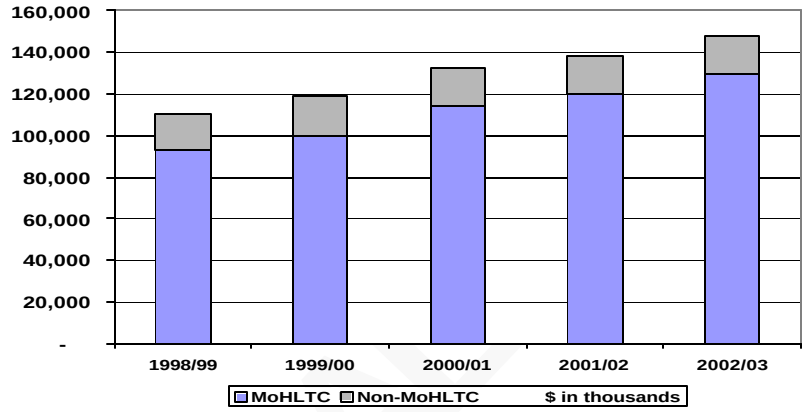
Exhibit 4.5[12]
Operating Revenues 1998/99 through 2002/03(forecast)
(in thousands of dollars)



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[12] Actual results for 1998/99 and 1999/00 from 2001/02 operating plan; 2000/01 actual from 2001/02 Q2 report; 2001/02 and 2002/03 from 2001/02 Q3 report.

4.5 Ministry Base and One-Time Funding

The Ministry of Health provides general funding to hospitals in two categories: Base funding allocation which represents funding that will continue (unless changed); and one-time funding that, by its name, only occurs once. Hospitals also receive other funding for specific programs through other votes of the legislature. These other votes will be discussed later in the report.

Base Funding Allocation

Over the period 1998/99 through 2001/02 the MOHLTC Base Allocation will have increased by $28.9 million, a 34% increase to $114.8 million. Specific changes, as shown in Exhibit 4.6, included:

- **Adjustments** – The net impact of general base adjustments over the period has been an increase of $17,193,288 to the HDGH base allocation.
- **Priority Clinical Programs** – These programs are funded primarily on patient volumes. As volume increases, the base funding is increased. Many of these programs also have one-time funding components where adjustments are made based on actual volumes attained. HDGH base funding has increased $3,376,284 over the period to support priority clinical programs.
- **Rehabilitation** – Base Funding adjustments related to new rehabilitation beds totaled $2,504,920.
- **Nursing** – Base allocation increases totalling $1,427,926 were received in 1999/00 for general and maternal/newborn nursing staffing.
- **Emergency Services** – HDGH base allocation was increased $2,692,368 to provide additional resources to improve ER access.
- **Other Specific Programs/Services** – Base allocation increases totaling $691,644 were received for MRI and sexual assault programs.

One-time Funding

Over the period 1998/99 through 2001/02 one-time funding to HDGH represented about 7% - 10% of total MOHLTC base and one-time funding. Specific items as shown in Exhibit 4.7 have included:

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- **General Adjustments** for financial pressures and growth provided $14,278,398.
- Net one-time funding for **Priority Clinical Programs** was a reduction of $1,046,742. It appears that HDGH has routinely achieved the volume requirements for priority program funding.
- **Program Transfers and Restructuring** funding of $12,289,288 was provided on a one-time basis to support program transfers and recognized restructuring costs.
- The MOHLTC provided hospitals with additional one-time funding in 1998/99 and 1999/00 to allow hospitals to open additional inpatient acute beds during periods of peak demand to improve access to **emergency departments**. This, and other support for emergency services resulted in HDGH receiving $2,165,875 over the period.
- The MOHLTC has also provided $9,186,759 over the period for a range of other specific initiatives, including Nursing HR Strategies, Hospital On Call Compensation, Sexual Assault, Y2K, and Federal Medical Equipment. Funding received under the Y2K and Federal Medical equipment initiatives was directed to equipment acquisition and did not contribute to operating revenues.

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Exhibit 4.6[13]
HDGH Base Funding Allocation 1998/99 through 2001/02

	1998/99	1999/00	2000/01	2001/02
Opening Allocation	$ 83,138,963	$ 85,898,246	$ 89,089,979	$ 108,002,473
Adjustments				
Adjustment(reduction)		$ 858,982	$ 1,986,900	$ 2,169,400
Growth			$ 378,006	
Operating Pressures			$ 9,100,000	$ 2,700,000
Subtotal Adjustments		*$ 858,982*	*$ 11,464,906*	*$ 4,869,400*
Priority Clinical Programs				
Cardiovascular Programs		$ 20,125		
ESRD Services	$ 1,424,283	$ 234,700	$ 250,132	$ 112,449
Orthopaedic Implants	$ 135,600		$ 36,995	
Trauma Program	$ 1,102,000			$ 60,000
Subtotal Priority Programs	*$ 2,661,883*	*$ 254,825*	*$ 287,127*	*$ 172,449*
Nursing				
Additional Funding - Nursing		$ 1,150,742		
Maternal-Newborn Nursing		$ 277,184		
Subtotal Nursing		*$ 1,427,926*		
Program Transfers & Restructuring				
Transition Funding			$ 3,641,959	
Rehabilitation Beds			$ 2,239,660	$ 265,260
Subtotal Restructuring			$ 5,881,619	$ 265,260
Emergency Services				
ER Initiatives			$ 1,237,198	$ 1,455,170
Subtotal Emergency			$ 1,237,198	$ 1,455,170
Other Specific Programs/Services				
MRI	$ 97,400	$ 650,000		
Sexual Assault Treatment Centres			$ 41,644	
Subtotal Other Programs		$ 650,000	$ 41,644	
Final Base Allocation	$ 85,898,246	$ 89,089,979	$ 108,002,473	$ 114,764,752

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[13] Source: MOHLTC Deputy's Template

Exhibit 4.7[14]
HDGH One-time Funding 1998/99 through 2001/02

	1998/99	1999/00	2000/01	2001/02(p)
Adjustments				
Financial/Operating Pressures	$ 1,500,000	$ 2,464,942	$ 2,700,000	
Growth		$ 378,006		
Other Funding	$ 2,776	$ 1,040,250	$ 700,000	$ 6,995,200
Subtotal Adjustments		*$ 3,883,198*	*$ 3,400,000*	*$ 6,995,200*
Priority Clinical Programs				
Cardiac Programs	$ (12,000)	$ (204,000)	$ 264,325	$ 367,725
ESRD Services	$ 134,245	$ (378,245)		$ 204,972
Orthopedic Implants	$ 38,500	$ 16,600		$ 2,645
Trauma Program	$ 435,000	$ (300,000)	$ 150,000	$ 225,000
Settlements - Prior Years			$ 101,975	
Subtotal Adjustments	*$ 595,745*	*$ (865,645)*	*$ 516,300*	*$ 800,342*
Program Transfers & Restructuring				
Transition - Restructuring Funding		$ 2,733,891		
Transition Funding	$ 998,837	$ 908,068		$ 771,044
Restructuring Costs - NET	$ 2,490,987	$ 767,563	$ 1,675,581	$ 1,943,317
Subtotal Restructuring	*$ 3,489,824*	*$ 4,409,522*	*$ 1,675,581*	*$ 2,714,361*
Emergency Services				
Emergency Services	$ 1,125,760	$ 940,115	$ 50,000	$ 50,000
Subtotal Emergency	*$ 1,125,760*	*$ 940,115*	*$ 50,000*	*$ 50,000*
Other Specific Programs/Services				
Nursing Training	$ 5,625			
Nursing HR Strategies			$ 41,667	$ 500,000
Hospital On Call (HOCC)			$ 266,292	$ 599,000
Sexual Assault		$ 41,644		
Y2K	$ 3,098,728	$ 1,038,231		
Federal Medical Equipment			$ 2,063,615	$ 1,531,957
Subtotal Other Programs	*$ 3,104,353*	*$ 1,079,875*	*$ 2,371,574*	*$ 2,630,957*
TOTAL ONE TIME FUNDING	**$ 9,818,458**	**$ 9,447,065**	**$ 8,013,455**	**$ 13,190,860**

4.6 Restructuring Expense & Reimbursement

The MOHLTC implemented a program to provide reimbursement for 85% of eligible restructuring costs commencing with restructuring costs incurred in fiscal 1995/96. HDGH has not fared well with its attempts to gain funding recognition for several significant cost items. These have been repeatedly submitted as restructuring expenses and the submissions have been rejected. There are two main areas of contention:

- The Windsor hospitals incurred severance costs in excess of the original restructuring reimbursement guidelines, but consistent with the parameters in the Metro Agreement.

[14] Source: MOHLTC Deputy's Template

HDGH has applied repeatedly for recognition of the $439,296 that they feel would have been funded had they incurred their costs after the Metro Settlement.

- The hospital has included $6.2 million for the relocation, renovation and decommissioning costs related to the reorganization of services that impacts the HDGH and Grace sites on its restructuring submissions, but they have been rejected since they appear to be capital costs. There appears to be no specific funding mechanism for this category of costs. As a result, they (like the severance costs above) contribute to the overall operating deficit and working capital deficit positions.

Exhibit 4.8 shows the full history of HDGH application for approval of restructuring expense and MOHLTC reimbursement for HDGH.

Exhibit 4.8[15]
HDGH Restructuring Expense & Reimbursement 1995/96 Through 2000/01
(in thousands of dollars)

	Costs per Hospital	Rejected: Capped Severance	Rejected: Grace Consolidation & Renovations	Approved Costs	Reimbursement
1995/96	2,423,113			1,927,870	1,638,689
1996/97	3,789,364		558,765	2,613,787	2,221,719
1997/98	3,377,681	439,296	555,578	2,341,048	2,012,862
1998/99	5,519,888	439,296	4,639,996	924,227	786,688
1999/00	7,134,015	439,296	4,542,725	1,761,272	1,497,081
2000/01	8,642,678	439,296	6,226,281	2,136,256	1,815,817
Total				11,704,460	9,972,856

Unfortunately for HDGH, the Windsor hospitals began their restructuring in 1994/95, and incurred one-time operating costs that pre-dated the restructuring reimbursement program. HDGH has provided a schedule of unreimbursed costs it considers to be related to restructuring. These are shown in Exhibit 4.9. Of the permanent costs:

- Wage Harmonization is quite valid, and not elsewhere addressed.

Of the temporary costs:

[15] Source: MOHLTC Reimbursement of Restructuring Costs Forms

- Prior years severance costs greater than the cap were discussed earlier.
- Grace Site inefficiency details at least part of the contribution to multi-site inefficiency that is a recognized factor. Multi-site inefficiency will be discussed at greater length later in the report.
- Excess capacity (Grace) is based on the premise that HDGH must maintain vacated space at the Grace Site pending closure of the site after the Metropolitan Site redevelopment. There is no evidence that the MOHLTC reduced the hospital's funding at the transfer. Unless significant unfunded facilities expansion took place to enable the consolidation, there is no additional cost. Truly, it is frustrating to know that this excess capacity is wasting close to $1 million per year, but it is not an *additional* cost of operating.

Exhibit 4.9[16]
HDGH Restructuring Expense & Reimbursement
(in thousands of dollars)

	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	To date
Permanent costs:									
1 Wage harmonization	0.92	0.92	0.92	0.93	0.95	0.97	0.99	1.01	7.61
Total permanent costs	0.92	0.92	0.92	0.93	0.95	0.97	0.99	1.01	7.61
Temporary costs									
1 Severance per prior years > Cap		0.15	0.24						0.39
2 Benefits on excess severance		0.02	0.03						0.05
3 Payout of Sick Banks - Union Negotiations							1.13		1.13
4 Grace Site inefficiency (staffing)		2.19	2.30	2.43	2.55	2.69	2.83	2.97	17.96
8 Grace Site "Excess Capacity"		0.91	0.91	0.91	0.91	0.91	0.91	0.91	6.36
Total temporary costs	-	3.26	3.49	3.33	3.46	3.60	4.87	3.88	25.89
Total Annual Restructuring Costs	0.92	4.18	4.40	4.27	4.41	4.57	5.86	4.89	33.50

Over the period 1995/96 through 2001/02 HDGH has, according to its figures accumulated $33.5 million in unfunded costs related to restructuring. Even setting aside the excess capacity costs, the hospital still appears to be out of pocket over $27 million over that period. Note that it is not possible to make an unqualified statement, since the MOHLTC has provided hospitals with large amounts of one-time and base funding using various descriptions such as "financial pressures" or "operating pressures." It is not known if the amounts received by HDGH in these categories were significantly different from what other hospitals received.

[16] Source: HDGH.

4.7 Hospital Revenue Generation

As noted earlier, HDGH generates about $18.8 million in annual revenue from non-MOHLTC sources. The revenue history is shown by major category over the period 1998/99 through 2001/02 in Exhibit 4.10. The results show an overall 6.1% increase over the period. Note that prior to 1998/99 HDGH did not track amortization of grants and donations for equipment separately. The change in that category reflects the increased capture of relevant amounts. Other specific changes of note will be discussed in the following sections.

Exhibit 4.10[17]
Non-MOHLTC Revenue 1998/99 through 2001/02 and % Change from 1998/99
(in thousands of dollars)

	1998/99	1999/00	2000/01	2001/02(p)	% Change
Patient Revenue from Other Payors	$ 8,433	$ 9,545	$ 9,370	$ 9,080	7.7%
Differential Revenue	$ 7,380	$ 6,705	$ 6,072	$ 5,920	-19.8%
Miscellaneous Revenues/Recoveries	$ 1,664	$ 2,202	$ 2,106	$ 2,401	44.3%
Amortization of Grants/Donations	$ 251	$ 1,003	$ 1,097	$ 1,403	459.5%
TOTAL non-MOHLTC REVENUE	$ 17,729	$ 19,456	$ 18,645	$ 18,804	6.1%

Patient Revenue from Other Payors

Exhibit 4.11 shows non-MOHLTC Patient Revenue. After a slight decline in 1999/00 and 2000/01, this category of revenue peaked in 1999/00 but has declined since. The decrease has been largely due to a decline in out of province and WCB revenues.

[17] Source: 1998/99 from 2001/02 Operating Plan (Form 5). Others from 2001/02 Q2 Submission (Form 5).

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Exhibit 4.11[18]
HDGH non-MOHLTC Patient Revenue – 1998/99 - 2001/02
and % Change from 1998/99
(in thousands of dollars)

	1998/99	1999/00	2000/01	2001/02(p)	% Change
Inpatient Revenue	$ 1,111	$ 1,050	$ 1,041	$ 891	-19.8%
Outpatient Revenue - OHIP	$ 4,738	$ 5,482	$ 5,686	$ 5,572	17.6%
All Other Outpatient Revenue	$ 2,585	$ 3,014	$ 2,643	$ 2,617	1.3%
TOTAL	$ 8,433	$ 9,545	$ 9,370	$ 9,080	7.7%

Preferred Accommodation

The experience of HDGH over the past four years (Exhibit 4.10) has been similar to that of other centres. In recent years all Ontario hospitals have raised preferred accommodation rates to maximize this non-MOHLTC revenue source when the MOHLTC reduced base funding levels in 1996/97. Initially, preferred accommodation revenues increased. However, this category of revenue peaked in 1998/99 and has begun to decline, a pattern consistent with most other Ontario Hospitals.

HDGH and WRH try to stay close in rates for preferred accommodation. Current rates at HDGH are $180 for semi-private and $210 - $230 for private.

Miscellaneous Revenues and Recoveries

Changes in Miscellaneous Revenues and Recoveries are shown in Exhibit 4.12. Many of these categories have increased substantially over the years, it is important to note that recoveries, by their nature, are offset by corresponding expense, so the increase does not represent a benefit to the Hospital.

[18] Source: 1998/99 from 2001/02 Operating Plan (Form 5). Others from 2001/02 Q2 Submission (Form 5).

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Exhibit 4.12
Miscellaneous Revenues and Recoveries 1998/99 – 2001/02
and % Change from 1998/99
(in thousands of dollars)

	1998/99	1999/00	2000/01	2001/02(p)	% Change
Non-Pt Food Services	$ 1,079.2	$ 1,223.2	$ 1,292.1	$ 1,380.0	27.9%
Rentals of Equipment	$ 29.7	$ 20.9	$ 23.5	$ 36.0	21.2%
Rental Land and Bldg	$ 10.2	$ 10.2	$ 10.2	$ 10.2	0.0%
Cash Discounts	$ 70.6	$ 115.2	$ 190.8	$ 115.0	62.8%
Net G/L on Disposal	$ 3.3	$ 89.7	$ (13.6)	$ -	
Recoveries (Service)	$ 218.1	$ 270.2	$ 260.3	$ 352.0	61.4%
Recoveries (Comp)	$ 113.8	$ 190.1	$ 205.3	$ 201.0	76.6%
Recoveries (Material)	$ 50.8	$ 72.9	$ 83.1	$ 110.0	116.4%
Other Undistributed	$ 88.7	$ 90.2	$ 42.9	$ 196.8	121.9%
TOTAL	$ 1,664.4	$ 2,082.6	$ 2,094.6	$ 2,401.0	44.3%

4.8 Hospital Operating Expense

A high level summary of hospital operating expenses is shown in Exhibit 4.13. The results are a combination of rate and volume impacts that will be discussed further in a following section. The overall increase in operating expenses was 41.3% for 1998/99 through 2001/02[19]. (Revenue increased by 25.2% over the same period). All of the large categories grew by more than 30%.

Exhibit 4.13[20]
Operating Expense 1998/99 – 2001/02
(in thousands of dollars)

	1998/99	1999/00	2000/01	2001/02(p)	% Change fr 1998/99	% Change fr 2000/01
Salaries and Wages	$ 61,278	$ 64,928	$ 71,977	$ 80,406	31.2%	11.7%
Benefit Contributions	$ 10,550	$ 9,721	$ 11,688	$ 14,473	37.2%	23.8%
Medical Staff Remuneration	$ 4,431	$ 5,741	$ 6,439	$ 8,000	80.5%	24.2%
Supplies and Other	$ 14,664	$ 16,082	$ 18,940	$ 20,547	40.1%	8.5%
Medical /Surgical Supplies	$ 7,477	$ 9,272	$ 10,423	$ 11,832	58.2%	13.5%
Drugs & Medical Gases	$ 4,753	$ 4,873	$ 4,870	$ 5,231	10.1%	7.4%
Bad Debts	$ 205	$ 231	$ 200	$ 190	-7.1%	-4.8%
Interest - short term	$ 186	$ 243	$ 431	$ 220	18.2%	-49.0%
Equipment Amort/Lease	$ 3,555	$ 5,515	$ 8,890	$ 10,482	194.8%	17.9%
TOTAL EXPENSES	$ 107,099	$ 116,606	$ 133,858	$ 151,381	41.3%	13.1%

[19] 2001/02 based on the Hospital's Q3 submission to the MOHLTC.

[20] Sources: 2001/02 Operating Plan (1998/99); 2001/02 Q3 submission to the MOHLTC (1999/00, 2000/01, 2001/02).

Benefit Contributions

Benefit Contributions were 15.0% and 16.2% of salaries in 1999/00 and 2000/01, but increased to 18.0% in 2001/02. They are projected to rise further to 19.8% for 2002/03. A significant factor is the end of the HOOPP holiday. In addition, however, hospitals are seeing significant increases in premium costs for benefits.

Medical Staff Remuneration

Medical staff remuneration has increased 80% from $4.4 million in 1998/99 to $8.0 million in 2001/02[21] as seen in Exhibit 4.13. Reported medical staff remuneration includes amounts paid for medical administration, coverage, and fees for clinical services.

Exhibit 4.14 shows the change in Medical Administrative and Coverage costs. These have risen dramatically over the past four years, although there is some offsetting funding for coverage.

Exhibit 4.14
Increases in Medical Staff Remuneration
Medical Administration and Coverage
($ in thousands)

	1998/99	1999/00	2000/01	2001/02	% Change
Medical Administration & Coverage					
Medical Administration	256	478	665	1,128	
Unattached Patients	-	353	825	930	
Operating Room, On Call	-	-	158	475	
On Call Remuneration	-	-	-	266	
Emergency Room	-	256	1,375	2,083	
Subtotal	***256***	***1,087***	***3,023***	***4,882***	***1811%***
Rec - Unattached Pts		(51)	(332)	(446)	
Rec - Hospital on Call		-	-	(266)	
Rec - Emergency Room		-	(972)	(1,700)	
Net	***256***	***1,036***	***1,718***	***2,470***	***867%***

Hospitals receive offsetting revenues from OHIP for some outpatient diagnostic services. Medical fees for all diagnostic and therapeutic services activity have increased 29% since 1998/99. Medical Fees have risen roughly in line with the increase in OHIP revenue as seen in Exhibit 4.15.

[21] Sources: 2001/02 Operating Plan (1998/99); 2001/02 Q3 submission to the MOHLTC (2001/02).

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Exhibit 4.15
Increases in Medical Staff Remuneration Diagnostic & Therapeutic Services
($ in thousands)

	1998/99	1999/00	2000/01	2001/02	% Change
Diagnostic Services					
Respiratory Therapy	18	7	5	8	
Cardiac Services	597	654	808	854	
Laboratory	735	736	695	916	
Diagnostic Imaging	2,769	3,204	3,538	3,702	
EEG	57	53	46	50	
Subtotal - Diagnostic	***4,176***	***4,654***	***5,092***	***5,530***	***32%***
OHIP Revenues - P only					
Cardiac Services	291	331	349	380	
Diagnostic Imaging	2,169	2,514	2,702	2,801	
EEG	28	25	21	25	
Respiratory	3	-	-	-	
Total "P" Revenues	***2,491***	***2,870***	***3,073***	***3,206***	***29%***

In addition to the medical staff remuneration reported above, the Hospital appears to have similar issues with its other votes for Trauma and Base Hospital. Although other votes typically are managed to break even, the Hospital has had to operate in a deficit to cover medical fees.

Supply Costs

Costs associated with general supplies, medical/surgical supplies and drugs have all increased substantially over the period as seen in Exhibit 4.13. The Change Foundation, in its "Financial Review of 137 Ontario Hospitals 2001," noted that these three categories of spending had come to account for 25% of hospitals' total expenses. Despite the increases observed, HDGH is at 25% for these three categories of expense.

Equipment Costs

Equipment amortization and lease costs have increased almost $7 million ($3.3 million net of grant amortization). This is a significant cost impact that is the direct result of the massive re-equipping of equipment intensive diagnostic & support areas as part of the HSRC directed redevelopment. The hospital will receive additional funding for depreciation on approved new equipment through the PCOP.

Other Vote Programs

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Other Votes account for 1.1% of the Hospital's total operating expenses. Other Vote Programs have not contributed significantly to the operating deficits based on the reported revenues and expenses, although HDGH is projecting a deficit from operation of other votes of $94,177 in 2001/02. The operating deficit is related to Medical Staff Remuneration in excess of funding. The Other Votes are summarized in Exhibit 4.16.

Exhibit 4.16
Other Votes – 2001/02

Other Vote	Revenue	Expense	Net
Trauma Team Leader	95,592	124,062	(28,470)
Base Hospital	446,702	512,409	(65,707)
Community Crisis Centre	1,024,795	1,024,795	-
Municipal Taxes	62,175	62,175	-
	1,629,264	1,723,441	(94,177)

4.9 Service Volumes

The service volume statistics presented in Chapter 2 and Appendix A show that HDGH inpatient volumes have declined only slightly, despite the impact of suspected CJD, and the on-going renovations activity within the hospital.

Exhibit 4.17 shows inpatient activity combining acute and rehabilitation beds. Although the hospital has specific funding for rehabilitation beds, the physical setup currently has these beds sharing space with acute beds on two units. When there are insufficient rehab patients, acute patients use these beds. This combination does not adversely affect acute length of stay, since the rehabilitation length of stay is shorter than the acute length of stay. However, the practice of using rehab beds for acute patients will impact on the Hospital's operating deficit. The ministry funded the 24 rehabilitation beds through the PCOP with a base adjustment predicated on full occupancy. The MOHLTC can be expected to make a one-time cash recovery in 2002/03 for the under utilization of rehabilitation beds in 2001/02 when the hospital operated approximately 7 of the 24 beds for rehabilitation.

Inpatient activity as measured by separations is down 10.3% from 1998/99, while average length of stay has increased slightly. Projected inpatient volumes for 2002/03 are shown also in this exhibit. Inpatient volumes are projected to increase in 2002/03 with an increase of 25 inpatient beds.

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Exhibit 4.17[22]
Acute Inpatient Activity Statistics 1998/99 – 2002/03
And Percentage Change 1998/99 – 2001/02

ACUTE & REHAB	1998/99	1999/00	2000/01	2001/02	Change	2002/03
Avg Beds	359	353	354	356	-0.8%	381
Avg Bassinets	13	-	13	13	0.0%	13
Pt Days, Adult & Ped	113,524	109,793	104,345	105,222	-7.3%	114,996
Pt Days, Neonatal & NB	8,767	8,322	8,917	8,564	-2.3%	8,705
Separations, Adult & Ped	18,430	17,857	17,794	16,533	-10.3%	18,055
Separations, Neo & NB	2,018	1,887	1,748	1,904	-5.6%	1,945
% Occupancy	86.6%	85.2%	80.8%	81.0%	-6.5%	82.7%
Average Length of Stay	6.2	6.1	5.9	6.4	3.3%	6.4

The trends in hospital ambulatory care service volumes are summarized in Exhibit 4.18. These statistics show primarily minor changes since 1998/99 with the exception of the Mental Health day/night care that has transferred from WRH.

Exhibit 4.18[23]
Ambulatory Care Service Volumes 1998/99 through 2002/03
And Percentage Change 1998/99 – 2001/02

	Unit	1998/99	1999/00	2000/01	2001/02	Change	2002/03
Emergency Services	Visits	49,096	47,997	48,466	50,696	3.3%	55,000
Day/Night Care							
Surgical & Endoscopy	Cases	19,977	15,703	16,364	19,843	-0.7%	23,000
Mental Health	Visits	1,115	1,159	3,595	5,232	369.2%	5,000
Renal Dialysis	Visits	16,562	17,968	18,972	19,486	17.7%	22,000
Other Day/Night Care	Visits	5,502	5,687	4,422	4,348	-21.0%	-
Clinics	Visits	46,863	51,392	47,455	50,341	7.4%	65,000
TOTAL	Cases	19,977	15,703	16,364	19,843	-0.7%	23,000
	Visits	139,115	144,014	142,284	150,761	8.4%	170,000

Overall, the service volume statistics show that HDGH has mostly maintained its service volumes through the redevelopment, but they have not yet shown expected growth. It is too early to tell if the projected increases for 2002/03 will materialize.

4.10 Change in Labour Costs

[22] Source: HDGH

[23] Source: HDGH

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Exhibit 4.13 showed that HDGH salary costs have increased by more than 31% since 1998/99; 11.7% in 2001/02 alone. In order to examine this area in more detail, the increase in labour cost is separated into the contribution of increased labour rates and the contribution of the increase in FTE (full time equivalent) staff. This analysis is shown in Exhibit 4.19. Since 1998/99, the average cost per FTE has increased by $4,497 (9.6%). The number of FTE appears to have increased by 254.6 (19.5%), but this figure includes a net 50 FTE impact from the OB/Psych Program staffing transfer. Without that impact, HDGH would have recorded an increase of 15.7%.

Exhibit 4.19[24]
Labour Cost Drivers Summary 1999/00 through 2001/02

	1999/00	2000/01	2001/02
Base F.T.E. (1998/99)	1,306.4	1,306.4	1,306.4
Average Labour Cost per F.T.E.	$ 47,839	$ 50,330	$ 51,403
Change in Avg Labour Cost per F.T.E.	$ 934	$ 2,491	$ 1,073
Salary Increase Due to Rate Increase	$ 1,219,629	$ 3,254,185	$ 1,401,161
F.T.E. Increase	50.3	73.4	130.9
Average Labour Cost per F.T.E.	$ 47,839	$ 50,330	$ 51,403
Salary Increase Due to F.T.E. Increase	$ 2,405,371	$ 3,694,688	$ 6,726,811
Increase due to prior years added F.T.E. receiving higher rate	$ -	$ 125,128	$ 133,028
Total Salary Increase	$ 3,625,000	$ 7,074,000	$ 8,261,000

4.11 Unit Costs

The salary increase in 2000/01 was accentuated by a one time sick bank payout as some categories of staff moved from that sick leave plan. The impact was $1.131 million.

As seen in Exhibit 4.19, the consolidated average hourly wage in 1998/99 was $24.05. In 2001/02 it is 9.6% higher at $26.36. Note that the average wage is a function of wage rates, changes in the mix of categories of staff providing services, changes in seniority levels as recognized in the various wage scales, and year-end labour accruals. Year-end labour accruals are not a significant factor in these years.

[24] Source: HDGH Data. The average labour cost per FTE in 1998/99 was $46,906.

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Exhibit 4.20
Average Hourly Labour Rates 1998/99 through 2001/02
With Percentage Change from 1998/99 to 2001/02[25]

	1998/99	1999/00	2000/01	2001/02	%
Nursing IP	27.23	27.44	28.53	29.24	7.4%
Ambulatory	27.23	27.59	29.26	29.72	9.1%
Diagnostic & Ther	24.37	25.43	26.94	26.96	10.6%
Research			121.73	103.91	
Education	22.73	27.78	28.83	29.08	28.0%
Admin & Support	18.83	19.12	20.47	21.16	12.4%
Other		24.90	26.88	30.10	
Overall Average	24.05	24.53	25.81	26.36	9.6%

4.12 Increase/Decrease in FTE

Overall hours show an increase of 19.5% over the period 1998/99 through 2001/02 with a 9.2% increase in 2001/02 as seen in Exhibit 4.20.

Exhibit 4.21
Total Earned Hours 1998/99 through 2001/02[26]

	1998/99	1999/00	2000/01	2001/02(p)	% Change fr 1998/99	% Change fr 2000/01
Nursing In Patient Services	1,037,857	1,065,018	1,084,035	1,162,533	12.0%	7.2%
Ambulatory Care Services	235,884	256,549	274,586	319,471	35.4%	16.3%
Diagnostic and Therapeutic Services	463,803	495,709	525,493	587,071	26.6%	11.7%
Administrative and Support Services	801,768	811,037	859,995	940,132	17.3%	9.3%
Undistributed Functional Centres	-	407	17,865	4,916		
Research	-	-	55	155		
Education	8,187	16,815	26,653	29,589	261.4%	11.0%
TOTAL IN HOURS	2,547,499	2,645,535	2,788,682	3,043,868	19.5%	9.2%
TOTAL IN F.T.E.S	1,306	1,357	1,430	1,561	19.5%	9.2%

Increases in staffing are observed in all areas of the hospital operations. The OB/Psych program staffing transfer with WRH resulted in a net reduction of about 50 FTE. However, the OB staff hours are still recorded as purchased service hours, so the staffing figures include both the OB and the Mental Health hours. The following exhibits show the contribution by functional centre.

[25] Sources: 2001/02 Operating Plan (1998/99); 2001/02 Q2 submission to the MOHLTC (1999/00, 2000/01), HDGH (2001/02).

[26] Source: HDGH.

Exhibit 4.22
Inpatient Services Earned Hours 1998/99 through 2001/02[27]

	Actual 1998/99	Actual 1999/00	Actual 2000/01	Actual 2001/2002	Change from 1998/99		
					Hours	%	FTE
Nursing Admin,Mgmt,Support	7,995	12,262	14,080	21,668	13,673	171%	7.01
Med/Surg	440,944	443,947	417,663	467,030	26,086	6%	13.38
CCU/ICU	151,538	157,788	153,097	159,029	7,491	5%	3.84
NICU/OB	173,885	171,620	153,475	152,334	(21,551)	-12%	(11.05)
OR/Recovery	127,739	130,952	143,824	147,761	20,022	16%	10.27
Pediatric Services	80,428	79,250	79,863	78,058	(2,370)	-3%	(1.22)
Psychiatry	55,328	69,199	87,185	101,805	46,477	84%	23.83
Rehab			34,848	34,848	34,848		17.87
In - Patient Services Total	1,037,857	1,065,018	1,084,035	1,162,533	124,676	12%	63.94
% Change		2.6%	1.8%	7.2%	12%		
FTE Change		13.93	9.75	40.26	63.94		

Exhibit 4.23
Outpatient Services Earned Hours 1998/99 through 2001/02[28]

	Actual 1998/99	Actual 1999/00	Actual 2000/01	Actual 2001/2002	Change from 1998/99		
					Hours	%	FTE
Emergency	97,805	106,863	106,956	131,885	34,080	35%	17.48
OP Day Surgery (Adult/Childre	54,945	61,349	60,587	61,010	6,065	11%	3.11
Renal	43,785	47,955	51,813	60,053	16,268	37%	8.34
Psy Clinic		1,498	11,994	17,772	17,772		9.11
OB Clinics	14,872	14,453	14,298	14,289	(583)	-4%	(0.30)
Other Ambulatory	24,477	24,431	28,938	34,462	9,985	41%	5.12
Total	235,884	256,549	274,586	319,471	83,587	35%	42.87
% Change		8.8%	7.0%	16.3%	35%		
FTE Change		10.60	9.25	23.02	42.87		

Exhibit 4.24
Diagnostic & Therapeutic Services Earned Hours 1998/99 through 2001/02[29]

	Actual 1998/99	Actual 1999/00	Actual 2000/01	Actual 2001/2002	Change from 1998/99		
					Hours	%	FTE
Lab	133,302	135,243	140,587	158,747	25,445	19%	13.05
Diagnostic Imaging	146,869	172,075	183,464	205,979	59,110	40%	30.31
Other Diagnostics	59,597	61,426	64,531	76,249	16,652	28%	8.54
Rehab, Pharmacy,Therapies	124,035	126,965	136,911	146,096	22,061	18%	11.31
Total	463,803	495,709	525,493	587,071	123,268	27%	63.21
% Change		6.9%	6.0%	11.7%	27%		
FTE Change		16.36	15.27	31.58	63.21		

[27] Source: HDGH.

[28] Source: HDGH.

[29] Source: HDGH.

Exhibit 4.25
Admin & Support Services Earned Hours 1998/99 through 2001/02[30]

	Actual 1998/99	Actual 1999/00	Actual 2000/01	Actual 2001/2002	Change from 1998/99		
					Hours	%	FTE
Administration	19,486	19,513	22,866	21,620	2,134	11%	1.09
QA	3,895	3,874	3,674	5,025	1,130	29%	0.58
Utilization Management/Social	17,133	18,001	17,154	19,430	2,297	13%	1.18
Public Relations	5,604	3,893	4,058	4,085	(1,519)	-27%	(0.78)
Infection Control	1,917	1,955	1,985	1,973	56	3%	0.03
General Accounting	10,289	10,642	11,786	13,215	2,926	28%	1.50
Payroll	9,912	9,908	9,546	9,767	(145)	-1%	(0.07)
Cashier's	18,516	19,281	20,569	22,156	3,640	20%	1.87
Personnel	11,267	11,052	13,447	15,591	4,324	38%	2.22
Employee Health and Safety	7,811	7,710	7,747	7,861	50	1%	0.03
Data Processing	15,691	20,453	23,139	29,168	13,477	86%	6.91
Switchboard and Information	14,433	14,845	18,401	19,102	4,669	32%	2.39
Purchasing	7,858	7,724	5,878	5,780	(2,078)	-26%	(1.07)
Stores and Receiving	18,260	17,354	20,261	21,346	3,086	17%	1.58
Central Supply Room	64,952	63,566	75,847	101,669	36,717	57%	18.83
Print Shop	5,799	5,678	5,879	6,567	768	13%	0.39
Volunteer Services	3,025	3,817	4,949	5,919	2,894	96%	1.48
Housekeeping	188,758	193,159	205,636	218,430	29,672	16%	15.22
Plant Operation	33,628	33,720	37,510	44,139	10,511	31%	5.39
Security	36,963	36,963	38,565	42,852	5,889	16%	3.02
Plant Maintenance	13,788	14,075	13,776	19,102	5,314	39%	2.73
Bio - Medical Engineering	12,696	13,255	13,404	15,098	2,402	19%	1.23
Admitting	49,973	50,793	51,258	51,534	1,561	3%	0.80
Medical Records	91,089	91,113	88,094	97,240	6,151	7%	3.15
Dietary	139,025	138,693	144,566	141,463	2,438	2%	1.25
Total	801,768	811,037	859,995	940,132	138,364	17%	70.96
% Change		1.2%	6.0%	9.3%	17%		
FTE Change		4.75	25.11	41.10	70.96		

4.13 Hospital Debt

The hospital has established an operating line of credit of $5 million. In addition, the MOHLTC has provided an operating advance of $9.0 million. The MOHLTC has also provided an advance of $6.855 million to assist the hospital with the impact of the CJD problem. However, at the current rate, the Hospital will run out of operating cash by the Fall, 2002.

At March 31, 2002 HDGH was carrying a total of $5.8 million in long term debt for the parking garage and supported by parking revenues. The short term portion of this debt is $236,519. Long-term debt consists of:

[30] Source: HDGH.

Exhibit 4.26
HDGH Long Term Debt at March 31, 2002
(in thousands of dollars)

Description	Purpose	Lender	Balance	Annual Payments
Term loan (1998) bearing interest of 6.65% with 10 year term and 20 year amortization.	Parking Garage	Royal Bank of Canada	$ 5,845,312	$ 636,000
TOTAL DEBT			$ 5,845,312	$ 636,000

*Short Term Portion - $236,519.

The Hospital's most significant debt is to itself. Over the years, it has not been unusual to see in the HDGH Audited Financial Statements, "Due to the Capital Fund" as a liability of the operating fund coupled with "Due from the Operating Fund" as an asset of the Capital Fund. Historically, these inter-fund loans have been small and always repaid.

This practice of inter-fund borrowing has landed the Hospital in a very difficult position. As noted earlier, the Hospital borrowed $20.8 million from its capital fund in order to maintain its daily operations. Because of this use of the Hospital's capital funds, the Hospital has no more cash to continue with its capital development pending the repayment of the $20.8 million loan from the operating fund.

Had the operating fund repaid the money before it was needed, there would be no problem, but not only is repayment delayed, there is no obvious way that the operating fund can repay this money in the short term.

This situation highlights why such inter-fund borrowing, even when above board, well documented, and well-intentioned is strongly discouraged. See Chapter 11 for further discussion and recommendations.

4.14 Capital Spending

As seen in Exhibit 4.2, HDGH spent $120.2 million for capital acquisition over the period 1994/95 through 2001/02. Capital activity consumed $10.0 million of the hospital's cash over that period. The Hospital's current overall cash position will seriously impact the hospital's ability to maintain its equipment renewal and its ability to support the major capital redevelopment mandated by the HSRC.

At present the hospital has stopped all deferrable capital spending.

In addition to equipment purchases, the Hospital has a $2.2 million capital lease obligation in 2002/03 as shown in Exhibit 4.28.

Exhibit 4.27
HDGH Capital Leases at March 31, 2002
(in thousands of dollars)

Description	Expiry	Lender	Balance	Annual Payments
Hospital Information System Lease	December-02	IBM Financial	$ 2,184,794	$ 3,012,000
TOTAL CAPITAL LEASES			$ 2,184,794	$ 3,012,000

Fortunately, the Hospital is carrying relatively little long term debt, so there may be some potential to use long term debt as part of the recovery. However, even after eliminating its operating deficit, the Hospital has limited potential to generate operating surpluses and donations. That puts a limit on its ability to carry additional debt.

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5.0 Financial History – Windsor Regional

5.1 Summary of Financial Situation

WRH is in critical financial condition.

Since the beginning of 1995/96 the hospital's working funds position has gone from bad ($1.7 million) to worse ($28.0 million deficit).

WRH requires substantial overdraft funds to continue its day to day operations.

The Hospital's 2002/03 Business Plan submission shows a projected operating deficit of $8.8 million. The Hospital has since updated its estimate for 2002/03 to a projected deficit of $15.1 million. The hospital will run out of available cash and credit by September 2002.

Since 1993/94:

- Operating deficits used $2.0 million
- Capital activity used $18.1 million
- Restructuring used $11.3 million
- Parking contributed $3.7 million.
- Changes in working capital items contributed $32.1 million

At March 31, 2002, WRH cash was provided by:

- Bank advance of $15.0 million
- Bank Loan of $2.1 million
- Promissory Notes payable to WRH Foundation of $5.3 million

The deficit gap would have started in 1999/00, except that one-time funding averted a deficit in 2000/01. However, current projections show the deficit increasing. At the same time, MOHLTC % of revenue has not changed significantly (after correcting for the OB/Psych transfer), remaining at about 81%.

WRH has maintained its preferred accommodation revenue in the face of increasing insurer resistance.

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Restructuring has contributed significantly to the accumulated shortfall. Although WRH has been reimbursed $5.1 million for approved restructuring costs, and has received $2.9 million in working capital assistance, WRH still appears to be out of pocket over $21 million for unfunded costs related to restructuring.

There have been significant issues related to medical staff recruitment and retention. One symptom of the distress is seen in the tremendous increase in Medical Staff Remuneration for medical administration and on-call coverage. WRH medical administration and on-call coverage costs have increased by $2.3 million, a 9-fold increase since 1998/99.

WRH operates 15 other vote programs that together account for 4.5% of the Hospital's total operating expenses. This is a higher than average number of other vote programs for a community hospital resulting in the need to absorb more unfunded overhead.

WRH has not yet completed application for PCOP funding for the new emergency.

Service Volumes provide a mixed picture:

- WRH has maintained its acute inpatient service volumes
- Rehabilitation continues to operate at 96.8% occupancy
- Complex Continuing Care continues to operate at over 90% occupancy
- Emergency volumes are up 8.8%, and overall ambulatory visits are up 7.4%

The Average Cost per FTE has increased 14.1% ($6,205) since 1998/99 ($22.57 to $25.75 per hour).

FTE have increased by 244.1 (17.5%, but this figure includes a net 111 FTE impact from the OB/Psych Program staffing transfer. Without that impact, WRH would have recorded an increase of 9.5%). Increases in staffing are observed in all areas of the hospital operations, but increases in staffing are greater in the nursing and diagnostic and therapy areas of hospital operations. Administrative and support areas are up 5.6%.

Malden Park Continuing Care Centre is beginning to place a significant drain on the hospital's finances.

- Malden Park is in the second year of a three year plan to reduce its operating costs in line with reduced funding.

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- Malden Park is expected to generate cumulative operating losses of $3.2 million over the next three years.

WRH does not believe it can operate Malden Park at the $107 per diem provincial funding level. At that level, Malden Park will generate a $2.5 million annual operating deficit.

WRH is supported by the WRH Foundation that has assets of $16 million. WRH is counting on the Foundation to use that money to help to finance the remaining $117 million of capital development at the Metropolitan and Western Campuses. According to WRH, HSRC construction costs can be covered by Foundation Funds "providing [the] hospital operates with balanced budget to meet capital needs not covered by HSRC orders and funding".

The financial situation is discussed in greater detail in the following sections.

5.2 Changes in Financial Position

Background

Windsor Regional Hospital was formed on December 1, 1994 through the amalgamation of The Metropolitan General Hospital and Windsor Western Hospital Centre, Inc. All assets, liabilities, and equity were transferred to the amalgamated entity at their book value. The first consolidated audited financial statements were produced at March 31, 1996.

Working Funds

Working funds are calculated by netting current assets against current liabilities. A positive answer is good. The review of the change in working funds bridges the period from March 31, 1995 through January 31, 2002. The January 31, 2002 results are unaudited, provided directly by the hospital for this review in a consistent format with the audited financial statements.

The balance sheet comparison is shown in Exhibit 5.1. Since the beginning of 1995/96 the hospital's working funds position has gone from bad ($1.7 million) to worse ($28.0 million deficit). Current Assets have decreased by $1.8 million. At the same time, current liabilities have increased by $27.9 million, driven primarily by a short term bank advance of $15.0 million. It is possible that a mid-year balance sheet may provide an imperfect comparison. However, the picture going forward appears to be substantially correct: ***WRH requires substantial overdraft funds to continue its day to day operations***.

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In fact, the Hospital is projecting the financial situation to worsen in the coming year. The Hospital's 2002/03 Business Plan submission shows a projected operating deficit of $8.8 million, a trend that will see the hospital run out of available cash and credit by September 2002. The Hospital has recently updated its 2002/03 projection to a $15.1 million deficit. This amount far exceeds the Hospital's current $5 million operating line, and is a trend that is not sustainable. MOHLTC has agreed to provide an advance of $16.0 million in April, 2002, converting the bank advance to a MOHLTC advance. May and October, 2002 will be difficult months for cash flow since there are three pays in each of those months.

Exhibit 5.1
WRH Consolidated Balance Sheet at January 31, 2002[31].
(in thousands of dollars)

ASSETS	Jan 31, 2002 $	March 31, 2001 $	March 31, 1995 $
Current			
Cash & short-term investments	**12,069**	**-**	**8,807**
Accounts receivable	**5,749**	**13,712**	**9,890**
Inventory	**1,737**	**1,643**	**1,730**
Prepaid Expenses	**561**	**819**	**192**
Due from related parties	**637**	**848**	**1,894**
Total current assets	**20,753**	**17,022**	**22,513**
Property, plant and equipment, Net	**79,791**	**79,622**	**82,812**
Construction in progress	**41,467**	**34,302**	**-**
Investments	**28,264**	**27,126**	**-**
	149,522	**141,050**	**82,812**
Total Assets	**170,275**	**158,072**	**105,325**

[31] Sources: WRH Internal Financial Statements at January 31, 2002; WRH Audited Financial Statements, March 31, 1996.

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LIABILITIES AND EQUITY	Jan 31, 2002 $	March 31, 2001 $	March 31, 1994 $
Current liabilities			
Bank indebtedness	**15,000**	**9,851**	**-**
Accounts payable	**8,156**	**10,615**	**7,408**
Accrued liabilities	**11,581**	**10,197**	**13,027**
Current portion of long term debt	**-**	**700**	**355**
Ministry of Health - advance	**14,000**	**-**	
Total current liabilities	**48,737**	**31,363**	**20,790**
Long-term liabilities			
Bank loan	**-**	**2,100**	
Notes payable	**5,610**	**5,610**	**1,665**
Accrued benefit obligations	**2,133**	**2,242**	**5,052**
Sick benefits payable	**5,955**	**5,796**	
Deferred revenue - capital grants	**98,805**	**95,724**	**44,517**
Total liabilities	**112,503**	**111,472**	**51,234**
Net Assets	**9,035**	**15,237**	**33,301**
Total liabilities and net assets	**170,275**	**158,072**	**105,325**

Exhibit 5.2 shows that from 1994/95 (the year of the merger) to January 31, 2002, Operating deficits contributed $2.0 million to the decline in the hospital's position. Changes in working capital items contributed $32.1 million. Capital activity, including both regular equipment renewal and building activity consumed $18.1 million. Restructuring consumed $11.3 million, and parking contributed $3.7 million. The closing cash position of $12.1 million significantly is comprised of $14.0 million MOHLTC cash advance, and $15.0 million bank advance.

Parking has been highlighted in this analysis since hospitals differ in their approach to reporting parking revenues. Although the MOHLTC does not fund capital or operating costs related to parking facilities, some hospitals, like WRH, do include net parking revenues in their operating results. Other hospitals take the position that parking revenues should not support hospital operations. As a result of this accounting approach, WRH reports a lower operating deficit (or larger operating surplus) than if parking were not included in operations.

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Exhibit 5.2[32]
WRH Statement of Cash Flows
1995/96 through January 31, 2002
(in thousands of dollars)

Opening Cash		*$ 6,845*
Impact of Hospital Operations		*(1,998)*
Surplus (Deficit)	(1,998)	
Impact of Other Operations		*775*
Malden Park/Riverview	(59)	
Regional Children's Centre	888	
Adjustments	(54)	
Parking		*3,733*
Restructuring		(11,317)
MoHLTC Net	(6,950)	
Prior Years	(4,367)	
Change in Working Capital Items		*32,158*
AP,AR, Other Current Assets	5,858	
Bank Advance	15,000	
Cash advances MoHLTC	14,000	
Bank Loan	(2,800)	
Rounding	100	
Impact of Capital Activity		*(18,127)*
Additions to building & c.i.p.	(60,786)	
Additions to equipment	(42,839)	
Ministry capital grants	41,923	
WRH & WECHF donations	21,289	
Amortization of Equipment	29,013	
Amortization - deferred grants	(11,880)	
(Gain)/loss on disposal	780	
Accounts receivable, capital	(1,819)	
AP, holdbacks, unearned grants	6,192	
Closing Cash		*12,069*

5.3 Hospital Operating Results

In 1998/99 WRH recorded a small operating deficit of $355,000 (0.3% of revenue). 1999/00 saw the deficit worsen to $1.3 million (1.1% of revenue), and by 2001/02 the operating deficit had increased to $9.5 million (6.9% of revenue). Operating results

[32] Sources: WRH Internal Financial Statements at January 31, 2002; WRH Audited Financial Statements, March 31, 1996.

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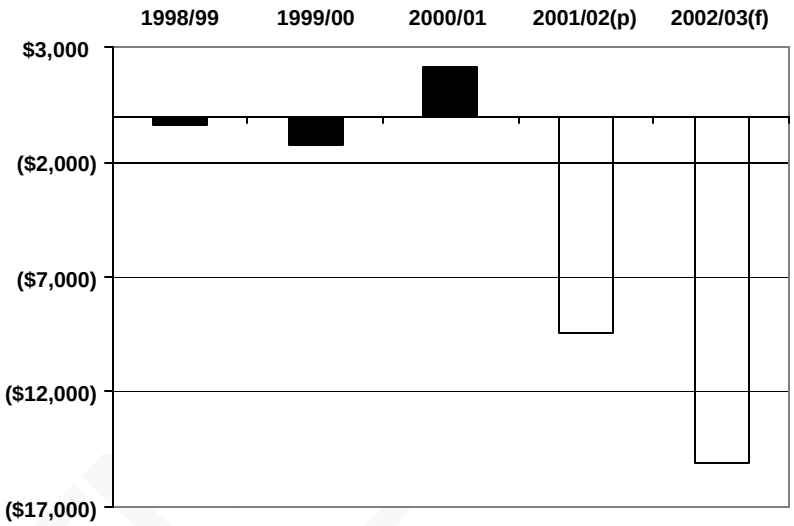
continue to worsen with an operating deficit of $ 15.1 million projected for 2002/03.[33] These results are seen in Exhibit 5.3.

Exhibit 5.3[34]
Operating Surplus (Deficit) 1998/99 through 2002/03
(in thousands of dollars)



Operating surplus (deficit) is a product of revenues and expenses. How have revenues and expenses changed over that period? Exhibit 5.4 shows total revenue and total expenses together. It is clear from this view that revenues and expenses tracked closely through 2000/01. From there, expenses increase without a similar increase in revenues.

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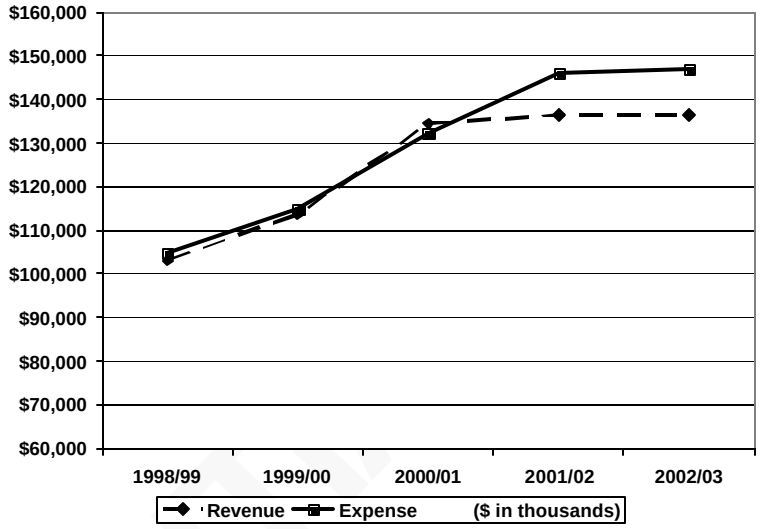
[33] Per WRH.

[34] Actual results for 1998/99 and 1999/00 from 2001/02 operating plan; 2000/01 actual from 2001/02 Q2 report; 2001/02 actual per WRH final estimate provided directly to the consultants; 2002/03 from Business Plan Submission. Adjustments to early years made for reporting consistency.

Exhibit 5.4[35]
Operating Revenues and Expenses 1998/99 through 2002/03(forecast) in thousands of dollars

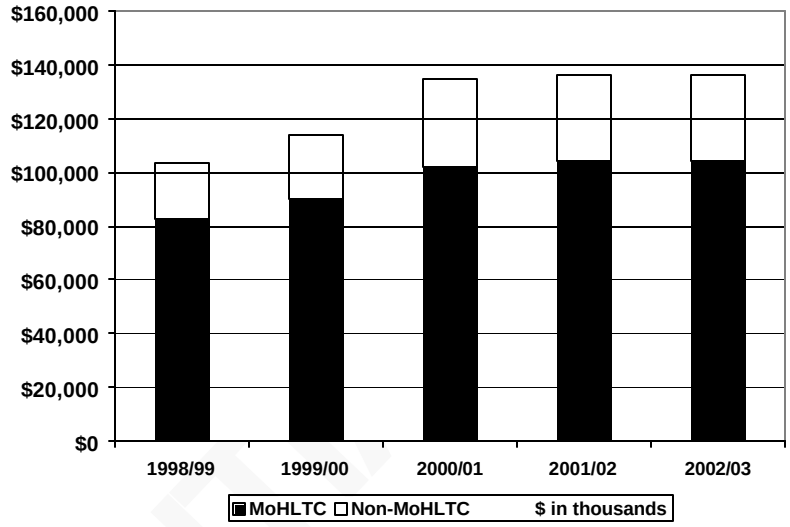


5.4 Operating Revenues

Over this period, non-MOHLTC revenue appeared to grow from $21.1 million to over $32 million. However, for 2000/01 and 2001/02 these revenues include about $6 million in revenues received from HDGH under the program transfer agreement for Obstetrics and Mental Health. MOHLTC revenue increased steadily to $101.7 million in 2000/01 (including Other Votes) and is projected to increase slightly to $104.1 million for 2001/02 and 2002/03. Exhibit 5.6 shows operating revenues over this period. After adjusting for the program transfer revenue, MOHLTC revenue has increased from 80% of total revenue in 1998/99 to 81% as forecast for 2002/03.

[35] Actual results for 1998/99 and 1999/00 from 2001/02 operating plan; 2000/01 actual from 2001/02 Q2 report; 2001/02 actual per WRH final estimate provided directly to the consultants; 2002/03 from Business Plan Submission. Adjustments to early years made for reporting consistency.

Exhibit 5.5[36]
Operating Revenues 1998/99 through 2002/03(forecast)
(in thousands of dollars)



5.5 Ministry Base and One-Time Funding

The Ministry of Health provides general funding to hospitals in two categories: Base funding allocation which represents funding that will continue (unless changed); and one-time funding that, by its name, only occurs once. Hospitals also receive other funding for specific programs through other votes of the legislature. These other votes will be discussed later in the report.

Base Funding Allocation

Over the period 1998/99 through 2001/02 the MOHLTC Base Allocation will have increased by $20.7 million, a 27% increase to $97.0 million. Specific changes, as shown in Exhibit 5.6, included:

- **Adjustments** – The net impact of general base adjustments over the period has been an increase of $9,581,904 to the WRH base allocation.
- **Cancer Program Expansion** - $4,000,000.
- **Program Transfers & Restructuring** – Base Funding adjustments related to this category totaled $4,847,524.

[36] Actual results for 1998/99 and 1999/00 from 2001/02 operating plan; 2000/01 actual from 2001/02 Q2 report; 2001/02 and 2002/03 from 2001/02 Q3 report adjusted for artificial increase due to program transfer arrangement.

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- **Nursing** – Base allocation increases totalling $1,479,140 were received in 1999/00 and 2000/01 for general and maternal/newborn nursing staffing.
- **Emergency Services** – WRH base allocation was increased $1,039,205 to provide additional resources to improve ER access.

Exhibit 5.6[37]
WRH Base Funding Allocation 1998/99 through 2001/02

	1998/99	1999/00	2000/01	2001/02
Opening Allocation	$ 76,073,690	$ 76,301,290	$ 78,398,443	$ 88,347,182
Adjustments				
Adjustment(reduction)		$ 763,013	$ 1,652,800	$ 1,902,400
Other Funding Inc. (Dec.)				$ 4,283,691
Operating Pressures			$ 4,980,000	
Subtotal Adjustments		*$ 763,013*	*$ 6,632,800*	*$ 6,186,091*
Nursing				
Additional Funding - Nursing		$ 994,912		
Maternal-Newborn Nursing		$ 339,228	$ 145,000	
Subtotal Nursing		*$ 1,334,140*	*$ 145,000*	
Program Transfers & Restructuring				
Program Transfers in (out)	$ 227,600			
Transition Funding			$ 688,823	
Acute Care - HRIT			$ 1,234,894	$ 2,058,157
Complex Continuing Care - HRIT			$ 239,267	$ 398,783
Subtotal Restructuring	$ 227,600	$ -	$ 2,162,984	$ 2,456,940
Emergency Services				
ER Initiatives			$ 1,007,955	$ 31,250
Subtotal Emergency			$ 1,007,955	$ 31,250
Final Base Allocation	$ 76,301,290	$ 78,398,443	$ 88,347,182	$ 97,021,463

One-time Funding

Over the period 1998/99 through 2001/02 one-time funding to WRH represented about 7% - 10% of total MOHLTC base and one-time funding. Specific items as shown in Exhibit 5.7 have included:

- **General Adjustments** for financial pressures and growth provided $11,007,245, including working capital assistance of $2.915 million.
- **Restructuring Transition** funding of $1,601,707 was provided.
- The MOHLTC provided hospitals with additional one-time funding in 1998/99 and 1999/00 to allow hospitals to open additional inpatient acute beds during periods of peak demand

[37] Source: MOHLTC Deputy's Template

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to improve access to **emergency departments**. This, and other support for emergency services resulted in WRH receiving $1,608,819 over the period.

- The MOHLTC has also provided $7,428,967 over the period for a range of other specific initiatives, including Hospital On Call Compensation, Y2K, and Federal Medical Equipment. Funding received under the Y2K and Federal Medical equipment initiatives was directed to equipment acquisition and did not contribute to operating revenues.

Exhibit 5.7[38]
WRH One-time Funding 1998/99 through 2001/02

	1998/99	1999/00	2000/01	2001/02(p)
Adjustments				
Financial/Operating Pressures	$ 1,000,000	$ 4,166,801	$ 2,683,000	
Nursing Training	$ 1,800			
Other Funding			$ 760,444	$ 482,000
Subtotal Adjustments		*$ 4,166,801*	*$ 3,443,444*	*$ 482,000*
Priority Clinical Programs				
Cardiac Programs	$ (18,850)			$ (100,000)
ESRD Services	$ 182,780	$ (105,000)		$ 33,277
Settlements - Prior Years			$ (25,900)	$ (57,429)
Subtotal Adjustments	*$ 163,930*	*$ (105,000)*	*$ (25,900)*	*$ (124,152)*
Program Transfers & Restructuring				
Transition Funding	$ 912,884	$ 688,823		
Subtotal Restructuring	*$ 912,884*	*$ 688,823*	*$ -*	*$ -*
Other Clinical Programs				
Nursing Training	$ 1,800			
Nursing HR Strategies			$ 41,667	$ 500,000
C - Section Initiative			$ 27,500	
Sexual Assault		$ 46,102	$ 145,237	$ 145,000
Physician Job Action			$ 1,000,000	
Working Capital Assistance			$ 2,915,000	
Cardiac Rehab Pilot Project			$ 142,500	$ 530,000
Subtotal Adjustments	*$ 1,800*	*$ 46,102*	*$ 4,271,904*	*$ 1,175,000*
Emergency Services				
Emergency Services	$ 947,947	$ 660,872		
Subtotal Emergency	*$ 947,947*	*$ 660,872*	*$ -*	*$ -*
Other Specific Programs/Services				
Hospital On Call Compensation			$ 478,625	$ 895,000
Y2K	$ 2,821,110	$ 955,492		
Federal Medical Equipment			$ 1,688,059	$ 590,681
Subtotal Other Programs	*$ 2,821,110*	*$ 955,492*	*$ 2,166,684*	*$ 1,485,681*
TOTAL ONE TIME FUNDING	**$ 5,849,471**	**$ 6,413,090**	**$ 9,856,132**	**$ 3,018,529**

[38] Source: MOHLTC Deputy's Template

5.6 Restructuring Expense & Reimbursement

The MOHLTC implemented a program to provide reimbursement for 85% of eligible restructuring costs commencing with restructuring costs incurred in fiscal 1995/96. WRH has not fared well with its attempts to gain funding recognition for several significant cost items. These have been repeatedly submitted as restructuring expenses and the submissions have been rejected. There are two main areas of contention:

- The Windsor hospitals incurred severance costs in excess of the original restructuring reimbursement guidelines, but consistent with the parameters in the Metro Agreement. WRH has applied repeatedly for recognition of the $861,824 that they feel would have been funded had they incurred their costs after the Metro Settlement.
- The hospital has included $639,810 for renovation costs, and $3,775,595 for Western Site consolidation costs, but they have been rejected since they appear to be capital costs. There appears to be no specific funding mechanism for this category of costs. As a result, they (like the severance costs above) contribute to the overall operating deficit and working capital deficit positions.

Unfortunately for WRH, the Windsor hospitals began their restructuring in 1994/95, and incurred one-time operating costs that pre-dated the restructuring reimbursement program.

Exhibit 5.8 shows the full history of WRH application for approval of restructuring expense and MOHLTC reimbursement for WRH.

CONFIDENTIAL DRAFT

Exhibit 5.8[39]
WRH Restructuring Expense & Reimbursement 1995/96 Through 2000/01 (in thousands of dollars)

	Costs per Hospital	Rejected: Prior Year Rejected	Rejected: Western Site Costs	Approved Costs	Reimbursement
1995/96	1,468,968			1,195,300	1,016,005
1996/97	1,713,947			1,322,598	1,124,208
1997/98	2,166,968			1,526,636	1,298,035
1998/99	5,028,703		2,466,595	1,076,183	921,921
1999/00	6,964,911	4,211,174	1,309,000	1,314,068	1,116,958
2000/01	2,223,405		1,453,582	760,696	646,591
Total		4,211,174	5,229,177	7,195,481	6,123,718

WRH has provided a schedule of costs it considers to be related to restructuring. These are shown in Exhibit 5.9. Of the permanent costs:

- Wage Harmonization is quite valid, and not elsewhere addressed.
- ER expansion operating costs can and should be addressed through the PCOP process.
- Malden Park seems unrelated and should be addressed separately.

Of the temporary costs:

- Excess capacity (Western) is based on the premise that WRH must maintain vacated space at the Western Site pending the redevelopment of the site after the Metropolitan Site redevelopment. There is no evidence that the MOHLTC reduced the hospital's funding at the transfer. Unless significant unfunded facilities expansion took place to enable the consolidation, there is no additional cost. Truly, it is frustrating to know that this excess capacity is wasting $1 million per year, but it is not an *additional* cost of operating. To the Hospital's credit it should be noted that they have managed to defray some of these costs by leasing some space to the Iler Nursing Home.
- Multi-site inefficiency is a recognized factor. $4.7 million might be the right number, but the items used by the hospital to calculate this amount relate more to unfinished business related to the OBS/Mental Health program transfers than to the

[39] Source: MOHLTC Reimbursement of Restructuring Costs Forms.

general concern of multi-site inefficiency. Multi-site inefficiency will be discussed at greater length later in the report.

- Early merger costs of $4.4 million were incurred in 1994/95 and 1995/96, prior to the MOHLTC Restructuring Reimbursement program. These have not been formally funded by the MOHLTC.
- Renovations related activity of $2.3 million is included. There does not appear to be an effective mechanism for consideration of project management, coordination, or departmental moves related to restructuring.
- Nursing Strategy Implementation is an initiative designed to:
  - Increase the full time ratio of nurses to 70% full time and 30% part time
  - Review and standardize nurse to patient ratios across programs in order to ensure manageable workloads and consistency across groups of nurses
  - Consolidate RN Nursing workforce in acute care patient areas (inpatient and ambulatory), consolidate RPN workforce in continuing complex care and rehabilitation where their level of professional practice autonomy is consistent with the needs of the patients
  - Develop a succession plan for nursing workforce that proactively recruits nurses to offset the impact of upcoming wave of retirements (36% of WRH nurses) in the next 7 years
  - WRH began incurring costs related to this initiative in 2001/02. The overall cost through 2005/06 is projected at $9.2 million. The hospital feels that it is more sensible to incur the costs of working through such a transition than to fix the imbalance through mass layoffs and rehirings. It does seem a stretch to count these as restructuring costs. The fact that the hospital is restructuring provides an outlet for its surplus RPN staff in acute care and Malden Park, but that doesn't make these restructuring costs.
- The Integrated Laboratory Implementation has cost WRH $1.3 million to date, and is expected to cost an additional $2.0 million through 2005/06. These costs are already captured in the Laboratory operating costs. The Hospital feels that other hospitals have received funding to defray some of the transitional cost impact. The April 1998 Essex County lab

CONFIDENTIAL DRAFT

proposal developed by the local hospitals estimated operating savings of 17.4% from the 1997/98 forecast expenditures. According to the MOHLTC, the current plan estimates an increase in costs of 20%. It appears that this element of local restructuring has escalated significantly. Laboratory productivity is discussed in Chapter 8.

- Physician Recruitment/retention is the final category of temporary costs with $3.9 million spent to date and another $5.2 million projected through 2005/06. Both Windsor hospitals are struggling with physician recruitment and retention. These are not restructuring costs, but they do represent significant unfunded expenditures.

Whether or not these costs can be classified as restructuring costs, for the most part they do represent operating expenses beyond the funding provided for routine hospital operation. In several cases the costs represent spending in advance of MOHLTC funding policy. These costs highlight the importance of hospitals having and maintaining a positive working funds balance so that the hospital can, when necessary, get things done in advance of MOHLTC funding.

Over the period 1994/95 through 2001/02 WRH has, according to its figures accumulated $36.4 million in unfunded costs related to restructuring. Even setting aside the costs that are only remotely related to restructuring, the hospital still appears to be out of pocket over $24 million over that period. Note that it is not possible to make an unqualified statement, since the MOHLTC provided hospitals with large amounts of one-time and base funding using various descriptions such as “financial pressures” or “operating pressures.” It is not known if the amounts received by WRH in these categories were significantly different from what other hospitals received. It is clear that WRH did receive $2.9 million in 2000/01 for Working Capital Assistance. Assuming that this amount should relate directly to the erosion of working capital due to restructuring, WRH would still appear to be $21.1 million out of pocket.

CONFIDENTIAL

Exhibit 5.9[40]
WRH Restructuring Expense & Reimbursement 1994/95 Through 2001/02 (in millions of dollars)

	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	To date
Permanent costs:									
1 Wage harmonization	0.70	0.70	0.70	0.70	0.70	0.70	0.70	2.00	6.90
2 ER expansion							0.40	0.40	0.80
3 Malden park per diem subsidy								1.00	1.00
Total permanent costs	0.70	0.70	0.70	0.70	0.70	0.70	1.10	3.40	8.70
Temporary costs									
1 Excess capacity (Western)				1.12	1.35	1.13	1.10	1.03	5.72
2 Multi-site inefficiency							4.70	4.70	9.40
3 Renovations activity							1.00	1.30	2.30
4 Early merger costs	1.10	3.30							4.40
5 Nursing strategy implementation								0.70	0.70
6 Integrated lab implementation							0.50	0.80	1.30
7 Physician recruitment/retention						1.30	1.30	1.30	3.90
8 Program development (LBRP & MH)									-
Total temporary costs	1.10	3.30	-	1.12	1.35	2.43	8.60	9.83	27.72
Total Annual Restructuring Costs	1.80	4.00	0.70	1.82	2.05	3.13	9.70	13.23	36.42

5.7 Hospital Revenue Generation

As noted earlier, WRH generates about $32.2 million in annual revenue from non-MOHLTC sources. The revenue history is shown by major category over the period 1998/99 through 2001/02 in Exhibit 5.10. The results show an overall 55.7% increase over the period. Note that prior to 1998/99 WRH did not track amortization of grants and donations for equipment separately. The change in that category reflects the increased capture of relevant amounts. Other specific changes of note will be discussed in the following sections.

[40] Source: WRH.

CONFIDENTIAL DRAFT

Exhibit 5.10[41]
Non-MOHLTC Revenue 1998/99 through 2001/02 and % Change from 1998/99 (in thousands of dollars)

	1998/99	1999/00	2000/01	2001/02(p)	% Change
Patient Revenue from Other Payors	$ 7,732	$ 8,444	$ 8,925	$ 9,426	21.9%
Differential Revenue	$ 5,473	$ 6,413	$ 6,488	$ 6,511	19.0%
Copayment Revenue	$ 736	$ 637	$ 658	$ 660	-10.4%
Recoveries and Misc. Revenue	$ 6,114	$ 6,648	$ 14,869	$ 13,894	127.3%
Amortization of Grants/Donations	$ 653	$ 1,586	$ 1,856	$ 1,752	
TOTAL non-MOHLTC REVENUE	$ 20,708	$ 23,727	$ 32,796	$ 32,243	55.7%

Patient Revenue from Other Payors

Exhibit 5.11 shows non-MOHLTC Patient Revenue. This broad category of revenue has increased over the period.

Exhibit 5.11[42]
WRH non-MOHLTC Patient Revenue – 1998/99 - 2001/02 and % Change from 1998/99
(in thousands of dollars)

	1998/99	1999/00	2000/01	2001/02(p)	% Change
Inpatient	$ 46	$ -	$ -	$ (65)	
Ambulance	$ 182	$ 201	$ 194	$ 206	13.2%
Outpatient OR	$ 61	$ 185	$ 227	$ 232	280.9%
Outpatient Clinic	$ 171	$ 418	$ 430	$ 395	131.2%
Outpatient Diagnostics	$ 6,395	$ 6,389	$ 6,705	$ 6,560	2.6%
Other Outpatient	$ 877	$ 1,251	$ 1,367	$ 1,417	61.6%
TOTAL	$ 7,732	$ 8,444	$ 8,923	$ 8,746	13.1%

Preferred Accommodation

The experience of WRH in differential revenue for preferred accommodation over the past four years (Exhibit 5.10) has been quite extraordinary. In recent years all Ontario hospitals have raised preferred accommodation rates to maximize this non-MOHLTC revenue source when the MOHLTC reduced base funding levels in 1996/97. For most Ontario hospitals, this category of revenue peaked in 1998/99 and has begun to decline.

[41] Source: 1998/99 from 2001/02 Operating Plan (Form 5). Others from 2001/02 Q2 Submission (Form 5).

[42] Source: 1998/99 from 2001/02 Operating Plan (Form 5). Others from 2001/02 Q2 Submission (Form 5).

HDGH and WRH try to stay close in rates for preferred accommodation. Current rates at WRH are $190 for semi-private and $220 for private.

Miscellaneous Revenues and Recoveries

Changes in Miscellaneous Revenues and Recoveries are shown in Exhibit 5.12. Many of these categories have increased substantially over the years, it is important to note that recoveries, by their nature, are offset by corresponding expense, so the increase does not represent a significant benefit to the Hospital.

Exhibit 5.12
Miscellaneous Revenues and Recoveries 1998/99 – 2001/02
and % Change from 1998/99
(in thousands of dollars)

	1998/99	1999/00	2000/01	2001/02(p)	% Change
Non-Pt Food Services	$ 1,248.6	$ 1,761.3	$ 2,013.7	$ 2,052.2	64.4%
Drug Sales	$ 1,015.6	$ 1,008.9	$ 1,333.0	$ 1,758.1	73.1%
Telephone Rental	$ 20.0	$ 29.4	$ 27.8	$ 21.2	6.0%
Building Rentals	$ 275.9	$ 444.6	$ 389.3	$ 318.3	15.4%
Parking	$ 905.4	$ 1,139.9	$ 1,145.9	$ 1,059.8	17.0%
Cash Discounts	$ 36.3	$ 43.8	$ 40.3	$ 38.1	5.0%
Interest Income	$ 140.1	$ 58.0	$ 228.4	$ 236.1	68.5%
Referred - In Lab	$ 0.1	$ 0.0	$ -	$ 354.4	
TV rental	$ (196.0)	$ (232.0)	$ (207.0)	$ (245.0)	25.0%
Supplies Recoveries	$ 21.6	$ 24.6	$ 26.6	$ 19.1	-11.9%
HDGH OB Program Staff			$ 5,820.0	$ 6,320.0	
Other Recoveries	$ 2,645.4	$ 2,369.6	$ 4,051.0	$ 1,962.0	-25.8%
TOTAL	$ 6,113.2	$ 6,648.0	$ 14,869.0	$ 13,894.3	127.3%

CONFIDENTIAL DRAFT

5.8 Hospital Operating Expense

A high level summary of hospital operating expenses is shown in Exhibit 5.13. The results are a combination of rate and volume impacts that will be discussed further in a following section. The overall increase in operating expenses was 35.0% for 1998/99 through 2001/02.[43] Revenue increased by 30.2% over the same period. All of the large categories except "supplies and other" grew by more than 30%.

Exhibit 5.13[44]
Operating Expense 1998/99 – 2001/02
(in thousands of dollars)

	1998/99	1999/00	2000/01	2001/02(p)	% Change fr 1998/99	% Change fr 2000/01
Salaries and Wages	$ 59,524	$ 65,154	$ 77,059	$ 81,357	36.7%	5.6%
Benefit Contributions	$ 8,799	$ 9,243	$ 11,208	$ 12,762	45.0%	13.9%
Medical Staff Remuneration	$ 4,122	$ 5,121	$ 5,463	$ 6,557	59.1%	20.0%
Supplies and Other	$ 13,517	$ 14,152	$ 15,621	$ 15,307	13.2%	-2.0%
Medical /Surgical Supplies	$ 4,595	$ 4,865	$ 5,654	$ 6,212	35.2%	9.9%
Drugs & Medical Gases	$ 3,906	$ 4,118	$ 4,950	$ 5,384	37.8%	8.8%
Bad Debts	$ 100	$ 100	$ 100	$ 100		
Interest - short term	$ -	$ 332	$ -	$ 200		
Equipment Amort/Lease	$ 4,685	$ 4,590	$ 5,150	$ 6,082	29.8%	18.1%
TOTAL EXPENSES	$ 99,248	$ 107,676	$ 125,205	$ 133,961	35.0%	7.0%

Benefit Contributions

Benefit Contributions were 14.8% of salaries in 1998/99. With the HOOPP Holiday they decreased to 14.2% in 1999/00 and 2000/01. They are projected to increase to 15.7% in 2001/02, with a further increase to 17.1% for 2002/03. A significant factor is the end of the HOOPP holiday. In addition, however, hospitals are seeing significant increases in premium costs for benefits.

Medical Staff Remuneration

Medical staff remuneration has increased 59% from $4.1 million in 1998/99 to $6.6 million in 2001/02[45] as seen in Exhibit 5.13.

[43] 2001/02 based on the Hospital's Q3 submission to the MOHLTC.

[44] Sources: 2001/02 Operating Plan (1998/99); 2001/02 Q3 submission to the MOHLTC (1999/00, 2000/01, 2001/02).

[45] Sources: 2001/02 Operating Plan (1998/99); 2001/02 Q3 submission to the MOHLTC (2001/02).

Reported medical staff remuneration includes amounts paid for medical administration, coverage, and fees for clinical services.

Exhibit 5.14 shows the change in Medical Administrative and Coverage costs. These have risen dramatically over the past four years, although there is some offsetting funding for coverage.

Exhibit 5.14
Increases in Medical Staff Remuneration Medical Administration and Coverage
($ in thousands)

	1998/99	1999/00	2000/01	2001/02	% Change
Medical Administration & Coverage					
Medical Administration	187	300	352	628	
Unattached Patients	-	85	527	369	
HIV Clinic	60	60	60	64	
Hospital on Call	-	-	-	895	
Emergency	-	346	541	589	
Subtotal	***247***	***791***	***1,480***	***2,545***	***931%***
MoHLTC - Unattached Pts	-	-	(500)	-	
MoHLTC - Hospital on Call	-	-	-	(895)	
Net	***247***	***791***	***980***	***1,650***	***569%***

Hospitals receive offsetting revenues from OHIP for some outpatient diagnostic services. Medical fees for all diagnostic and therapeutic services activity have increased 27% since 1998/99. Medical Fees have risen faster than the increase in OHIP revenue as seen in Exhibit 5.15.

CONFIDENTIAL DRAFT

Exhibit 5.15
Increases in Medical Staff Remuneration Diagnostic & Therapeutic Services
($ in thousands)

	1998/99	1999/00	2000/01	2001/02	% Change
Diagnostic Services					
Acute Injuries Rehab & Eval	127	165	172	230	
Cardiac Services	785	1,058	1,047	988	
Lab	611	671	839	993	
Diagnostic Imaging	2,328	2,431	2,416	2,680	
Other	25	7	9	16	
Subtotal - Diagnostic	***3,875***	***4,331***	***4,484***	***4,907***	***27%***
OHIP Revenues - P & T					
Acute Injuries Rehab & Eval	669	812	812	967	
Cardiac Services	1,192	1,334	1,589	1,405	
Diagnostic Imaging	4,894	4,778	4,781	4,962	
Other	1	0	14	23	
TOTAL OHIP P & T Revenue	6,757	6,924	7,197	7,358	
Est 40% Professional	***2,703***	***2,770***	***2,879***	***2,943***	***9%***

Supply Costs

General supplies, medical/surgical supplies and drugs have all increased substantially over the period as seen in Exhibit 5.13. The Change Foundation, in its "Financial Review of 137 Ontario Hospitals 2001," noted that these three categories of spending had come to account for 25% of hospitals' total expenses. Despite the increases observed, WRH is at 20% for these three categories of expense.

Equipment Costs

Equipment amortization and lease costs have increased almost $1.4 million over the period. The hospital will receive additional funding for depreciation on approved new equipment through the PCOP.

Other Vote Programs

WRH operates 15 other vote programs that together account for 4.5% of the Hospital's total operating expenses. Other vote programs have not contributed significantly to the operating deficits based on the reported revenues and expenses. However, WRH operates considerably more other vote programs than most other community hospitals resulting in the need to absorb more unfunded overhead. The other votes are summarized in Exhibit 5.16.

CONFIDENTIAL DRAFT

Exhibit 5.16
WRH Other Votes – 2001/02[46]

Other Vote	Revenue	Expense	Net
Problem Gambling Services	404,588	401,610	2,978
Withdrawal Management Services	922,450	922,450	(0)
Remedial Measures	34,608	22,271	12,336
Anonymous Testing	48,503	60,273	(11,770)
Mental Health Programs	2,025,469	2,013,601	11,868
Infant Hearing Program	264,308	264,308	(0)
Preschool Speech & Language Initiative	283,802	283,802	-
Adult Day Care	361,414	361,414	-
Outpatient Psychiatry Sessional Fees	154,178	153,982	196
Bedside Manor	2,575	8,032	(5,457)
Outreach	140,106	141,924	(1,818)
Workplace Childcare	176,890	217,530	(40,640)
Municipal Taxes	66,375	66,375	-
Central Access	459,424	432,661	26,763
Geriatric Assessment Program	668,854	668,854	-
	6,013,542	6,019,086	(5,544)

5.9 Service Volumes

The service volume statistics presented in Chapter 2 and Appendix A show the following:

- WRH has maintained its acute inpatient service volumes
- Rehabilitation continues to operate at 96.8% occupancy
- Complex Continuing Care continues to operate at over 90% occupancy
- Emergency volumes are up 8.8%, and overall ambulatory visits are up 7.4%
- Day surgery and endoscopy cases appear to be up close to 40%, but about 3,000 IP day surgery cases were not reported in the first year
- Other day/night care visits appear to be up five fold. Although they are increasing, they were not reported separately in earlier years as they would have been included in ambulatory visit totals

Overall, inpatient activity has remained stable while outpatient activity has shown growth over the past four years.

5.10 Change in Labour Costs

Exhibit 5.13 showed that WRH salary costs have increased by 36.7% since 1998/99; 5.6% in 2001/02 alone. In order to

[46] Source: WRH.

CONFIDENTIAL DRAFT

examine this area in more detail, the increase in labour cost is separated into the contribution of increased labour rates and the contribution of the increase in FTE (full time equivalent) staff. This analysis is shown in Exhibit 5.17. Since 1998/99, the average cost per FTE has increased by $6,205 (14.1%) and the number of FTE has increased by 244.1 (17.5%), including 111 FTE added through the Obstetrics Transfer.

Exhibit 5.17[47]
Labour Cost Drivers Summary 1999/00 through 2001/02

	1999/00	2000/01	2001/02
Base F.T.E. (1998/99)	1,393.5	1,393.5	1,393.5
Average Labour Cost per F.T.E.	$ 46,010	$ 48,864	$ 50,212
Change in Avg Labour Cost per F.T.E.	$ 2,004	$ 2,854	$ 1,348
Salary Increase Due to Rate Increase	$ 2,791,918	$ 3,976,467	$ 1,878,848
F.T.E. Increase	29.4	192.1	22.6
Average Labour Cost per F.T.E.	$ 46,010	$ 48,864	$ 50,212
Salary Increase Due to F.T.E. Increase	$ 1,352,599	$ 9,384,339	$ 1,137,264
Increase due to prior years added F.T.E. receiving higher rate	$ -	$ 83,890	$ 298,582
Total Salary Increase	$ 4,144,516	$ 13,444,696	$ 3,314,694

5.11 Unit Costs

As seen in Exhibit 5.18, the consolidated average hourly wage in 1998/99 was $22.57. In 2001/02 it is 14.1% higher at $25.75. Note that the average wage is a function of wage rates, changes in the mix of categories of staff providing services, changes in seniority levels as recognized in the various wage scales, and year-end labour accruals. Year-end labour accruals are not a significant factor in these years.

[47] Source: WRH Data. The average labour cost per FTE in 1998/99 was $4,061 (excluding fringe benefits).

CONFIDENTIAL DRAFT

Exhibit 5.18
Average Hourly Labour Rates 1998/99 through 2001/02 With Percentage Change from 1998/99 to 2001/02[48]

	1998/99	1999/00	2000/01	2001/02	%
Nursing IP	25.05	26.21	23.99	27.57	10.1%
Ambulatory	26.14	25.93	26.13	29.45	12.7%
Diagnostic & Ther	23.13	23.65	23.81	25.31	9.4%
Education	24.18	26.45	25.01	25.60	5.9%
Admin & Support	17.72	19.10	19.61	21.21	19.7%
Other (71920 & 715*)	13.55	21.25	26.53	11.06	-18.3%
OBS 7192031			33.45	30.84	
Restructuring	23.00	20.06	25.00	24.46	6.3%
Overall Average	22.57	23.59	25.06	25.75	14.1%

5.12 Increase/Decrease in FTE

Overall hours show an increase of 17.5% over the period 1998/99 through 2001/02 with a 1.4% increase in 2001/02 as seen in Exhibit 5.19.

Exhibit 5.19
Total Earned Hours 1998/99 through 2001/02[49]

	1998/99	1999/00	2000/01	2001/02(p)	% Change fr 1998/99	% Change fr 2000/01
Nursing In Patient Services	1,083,901	1,134,915	1,204,989	1,211,441	11.8%	0.5%
Ambulatory Care Services	248,524	281,285	280,414	293,129	17.9%	4.5%
Diagnostic and Therapeutic	493,091	492,951	528,339	541,729	9.9%	2.5%
Education	18,542	18,345	24,254	24,928	34.4%	2.8%
Administrative and Support	780,133	754,814	795,165	823,753	5.6%	3.6%
Other (71920 & 715*)	14,939	14,146	51,240	21,857	46.3%	-57.3%
OBS 7192031		-	218,184	213,546		-2.1%
Restructuring	78,167	78,167	46,539	62,907	-19.5%	35.2%
TOTAL IN HOURS	2,717,297	2,774,623	3,149,124	3,193,290	17.5%	1.4%
TOTAL IN F.T.E.S	1,393	1,423	1,615	1,638	17.5%	1.4%

Increases in staffing are observed in all areas of the hospital operations, but increases in staffing are greater in the nursing and diagnostic and therapy areas of hospital operations. Administrative and support areas are up 5.6%. The OB/Psych program staffing transfer with HDGH resulted in a net increase of about 111 FTE. However, the Mental Health staff hours are still recorded, so the staffing figures include both the OB and the Mental Health hours. The following exhibits show the contribution by functional centre.

[48] Sources: 2001/02 Operating Plan (1998/99); 2001/02 Q2 submission to the MOHLTC (1999/00, 2000/01), WRH (2001/02).

[49] Source: WRH.

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Exhibit 5.20
Inpatient Services Earned Hours 1998/99 through 2001/02[50]

Inpatient Services	Actual 1998/99	Actual 1999/00	Actual 2000/01	Actual 2001/2002	Change from 1998/99	%	FTE
Nursing Administration	4,921	1,664	21,306	22,192	17,271	351%	8.86
Medical Inpatient Services	245,321	246,282	276,355	282,049	36,728	15%	18.83
Surgical Inpatient	114,112	115,221	116,208	123,472	9,360	8%	4.80
ICU - Combined Med/Surg	59,866	61,860	59,768	58,147	(1,719)	-3%	(0.88)
ICU - Burn	28,661	30,912	25,275	23,414	(5,247)	-18%	(2.69)
ICU - Coronary Care (Med)	37,054	41,825	37,202	33,517	(3,537)	-10%	(1.81)
Birthing Program	144,564	159,196	172,067	178,702	34,138	24%	17.51
Operating Rooms	116,874	114,765	120,461	121,630	4,756	4%	2.44
Post-Anesthetic Recovery	26,446	26,789	31,226	26,087	(359)	-1%	(0.18)
Acute Psychiatry IP	128,587	131,607	126,881	118,707	(9,880)	-8%	(5.07)
Rehabilitation	62,879	64,454	65,889	62,428	(451)	-1%	(0.23)
Palliative	-	5,758	5,645	10,213	10,213		5.24
Chronic Care	114,616	134,582	146,706	150,885	36,269	32%	18.60
Total	1,083,901	1,134,915	1,204,989	1,211,441	127,540	12%	65.41
% Change		4.7%	6.2%	0.5%	11%		
FTE Change		26.16	35.94	3.31	65.41		
OBS 7192031 (Grace Site)				218,184	213,546		
FTE Change				111.89	(2.38)		

Exhibit 5.21
Outpatient Services Earned Hours 1998/99 through 2001/02[51]

Outpatient Services	Actual 1998/99	Actual 1999/00	Actual 2000/01	Actual 2001/2002	Change from 1998/99	%	FTE
Emergency	110,250	119,140	125,513	142,314	32,064	29%	16.44
Surgical (OR/PARR Excluded)	20,116	33,044	-	-	(20,116)	-100%	(10.32)
Surgical (OR/PARR Included)	50,320	35,966	35,011	35,182	(15,138)	-30%	(7.76)
Endoscopy	-	11,347	12,426	11,550	11,550		5.92
Acute Psychiatric Day/Night	6,409	9,236	-	-	(6,409)	-100%	(3.29)
Addiction Day/Night	-	6,205	6,504	5,254	5,254		2.69
Rehabilitation D/N	14,664	-	-	-	(14,664)	-100%	(7.52)
Social Support D/N	-	12,645	12,085	-	-		-
Clinics	46,765	53,702	88,875	98,829	52,064	111%	26.70
Total	248,524	281,285	280,414	293,129	44,605	18%	22.87
% Change		13.2%	-0.3%	4.5%	18%		
FTE Change		16.80	(0.45)	6.52	22.87		

[50] Source: WRH.

[51] Source: WRH.

Exhibit 5.22
Diagnostic & Therapeutic Services Earned Hours 1998/99 through 2001/02[52]

Diag. and Ther. Services	Actual 1998/99	Actual 1999/00	Actual 2000/01	Actual 2001/2002	Change from 1998/99	%	FTE
Main Lab with Chem/Hem/BB	73,098	68,950	84,155	85,863	12,765	17%	6.55
Anatomical Pathology	10,041	9,873	11,435	22,464	12,423	124%	6.37
Microbiology	13,229	13,446	14,338	3,740	(9,489)	-72%	(4.87)
Tissue Typing	-	2,437	-	-	-		-
Diagnostic Imaging - General	87,556	92,597	91,115	92,925	5,369	6%	2.75
Computed Tomography	-	5,233	5,092	4,589	4,589		2.35
Diagnostic Ultrasound	18,109	17,740	18,497	14,704	(3,405)	-19%	(1.75)
Nuclear Medicine	20,385	22,602	23,191	23,900	3,515	17%	1.80
Cardiac Catheterization Lab	5,188	1,179	-	-	(5,188)	-100%	(2.66)
Magnetic Resonance Imaging	-	-	-	-	-		-
Electrodiagnosis	525	728	722	745	220	42%	0.11
Diagnostic Cardiology	26,083	25,111	26,471	25,492	(591)	-2%	(0.30)
Respiratory Therapy	43,092	46,201	48,435	52,514	9,422	22%	4.83
Pharmacy	51,352	50,194	55,062	64,116	12,764	25%	6.55
Pharmacy Clinical Trials	-	-	1,990	-	-		-
Clinical Nutrition	14,651	10,685	11,054	11,192	(3,459)	-24%	(1.77)
Rehabilitation Services - Adm	-	-	-	1,595	1,595		0.82
Physiotherapy	39,528	40,307	43,749	41,764	2,236	6%	1.15
Occupational Therapy	27,022	28,405	26,271	26,995	(27)	0%	(0.01)
Speech/Language Pathology	6,081	6,294	6,625	14,674	8,593	141%	4.41
Audiology	9,159	8,949	11,961	8,003	(1,156)	-13%	(0.59)
Social Work	23,610	16,023	21,394	19,494	(4,116)	-17%	(2.11)
Psychology	10,424	10,733	12,566	12,236	1,812	17%	0.93
Pastoral Care	9,262	10,240	8,620	8,892	(370)	-4%	(0.19)
Recreation	4,696	5,024	5,596	5,832	1,136	24%	0.58
Total	493,091	492,951	528,339	541,729	48,638	10%	24.94
% Change		0.0%	7.2%	2.5%	10%		
FTE Change		(0.07)	18.15	6.87	24.94		

[52] Source: WRH.

Exhibit 5.23
Admin & Support Services Earned Hours 1998/99 through 2001/02[53]

	Actual 1998/99	Actual 1999/00	Actual 2000/01	Actual 2001/2002	Change from 1998/99		
					Hours	%	FTE
General Administration	42,408	35,549	63,667	49,382	6,974	16%	3.58
Finance	42,218	42,606	41,487	41,008	(1,210)	-3%	(0.62)
Personnel Services	25,889	26,109	25,601	31,582	5,693	22%	2.92
Systems Support	22,785	23,490	32,551	33,784	10,999	48%	5.64
Communications	24,022	18,758	20,375	21,612	(2,410)	-10%	(1.24)
Materiel Management	61,010	61,082	59,484	59,075	(1,935)	-3%	(0.99)
Volunteer Services	3,724	3,796	3,827	3,841	117	3%	0.06
Housekeeping	197,192	187,479	191,307	195,810	(1,382)	-1%	(0.71)
Plant Operations & Maintenance	55,929	35,475	44,659	49,184	(6,745)	-12%	(3.46)
Plant Security	40,613	23,529	12,588	21,143	(19,470)	-48%	(9.98)
Bio-Medical Engineering	4,670	1,958	2,625	3,667	(1,003)	-21%	(0.51)
Registration (Admitting)	50,086	47,357	46,551	48,889	(1,197)	-2%	(0.61)
Patient transport	11,494	12,601	13,052	12,793	1,299	11%	0.67
Health Records	80,485	86,038	86,228	86,205	5,720	7%	2.93
Patient + Non-Patient Food Svces	133,751	148,987	151,163	159,793	26,042	19%	13.35
Total	796,276	754,814	795,165	817,768	21,492	3%	11.02
% Change		-5.2%	5.3%	2.8%	3%		
FTE Change		(21.26)	20.69	11.59	11.02		

5.13 Hospital Debt

The hospital has established an operating line of credit of $5 million. In addition, the MOHLTC has provided an operating advance of $16.0 million. However, at the current rate, the Hospital will run out of operating cash by the Fall, 2002.

At March 31, 2002 WRH was carrying a total of $22.4 million in debt (Exhibit 5.24). The long-term portion of the debt consists of two loans from the WRH Foundation totaling $5.26 million. The short term debt is comprised of $17.1 million of demand installment loans. Since March 31, 2002, the $15 million loan has been replaced by an advance from the MOHLTC.

[53] Source: WRH.

Exhibit 5.24
WRH Debt at March 31, 2002 (in thousands of dollars)

Description	Purpose	Lender	Balance	Annual Principal	Payments Interest
Interest-bearing promissory note issued to Windsor Regional Hospital Foundation payable on demand	Capital	Windsor Regional Hospital Foundation	$ 3,612,354	$ 3,612,354	$ 180,618
Non Interest-bearing promissory note issued to Windsor Regional Hospital Foundation payable on demand.	Capital	Windsor Regional Hospital Foundation	$ 1,651,268	$ 1,651,268	$ -
CIBC - Demand Installment Loan	Bridge Ministry Advances - capital & operating	CIBC	$ 15,000,000	$ 15,000,000	$ 43,750
CIBC - Demand Installment Loan	Capital purchases	CIBC	$ 2,100,000	$ 700,000	$ 28,000
TOTAL DEBT			$ 22,363,622	$ 20,963,622	$ 252,368

5.14 Capital Spending

As seen in Exhibit 5.2, WRH spent $103.6 million for capital acquisition over the period 1995/96 through 2001/02. Capital activity consumed $18.1 million of the hospital's cash over that period. The Hospital's current overall cash position will seriously impact the hospital's ability to maintain its equipment renewal and its ability to support the major capital redevelopment mandated by the HSRC.

The Hospital has no capital lease obligations.

Fortunately, the Hospital is carrying relatively little long term debt, so there may be some potential to use long term debt as part of the recovery. However, even after eliminating its operating deficit, the Hospital has limited potential to generate operating surpluses and donations. That puts a limit on its ability to carry additional debt.

5.15 Malden Park

As seen in Exhibit 5.2, Malden Park Continuing Care Centre has had little cumulative impact on the organization's cash position through January 31, 2002. However, the picture going forward does not look so neutral. Malden Park opened in 1994 with a per diem of $207 based on the then current chronic rates. Changes in the provincial approach to long term care resulted in the rate being red circled by the MOHLTC in 1997. Since then, the MOHLTC has gradually reduced the per diem. The 2002 rate is $125, and

CONFIDENTIAL DRAFT

the rate is scheduled to be reduced further to the provincial standard of $107 on July 1, 2003.

Malden Park is in the second year of a three year plan to reduce its operating costs in line with reduced funding. A key part of this plan is to shift from primarily RPN staffing to health care aide staffing. Although progress is being made, the process is expected to take three years during which Malden Park is expected to generate operating losses of $3.2 million.

WRH has indicated that despite their best efforts at cost reduction, they cannot reduce operating costs sufficiently to achieve a balance result with a $107 per diem. A per diem of $137 would be needed to break even.

The Hospital has projected that Malden Park will generate a $2.5 million annual operating deficit, based on the following assumptions:

- Stable or rising CMI
- Full occupancy maintained
- Western Campus capital redevelopment plan is completed and operations adequately financed.

The Hospital needs to find a solution to this dilemma.

It is recommended that:

(1) The Board of WRH should establish a dialogue with the MOHLTC to develop options for resolving the operating deficit situation at Malden Park Continuing Care Centre.

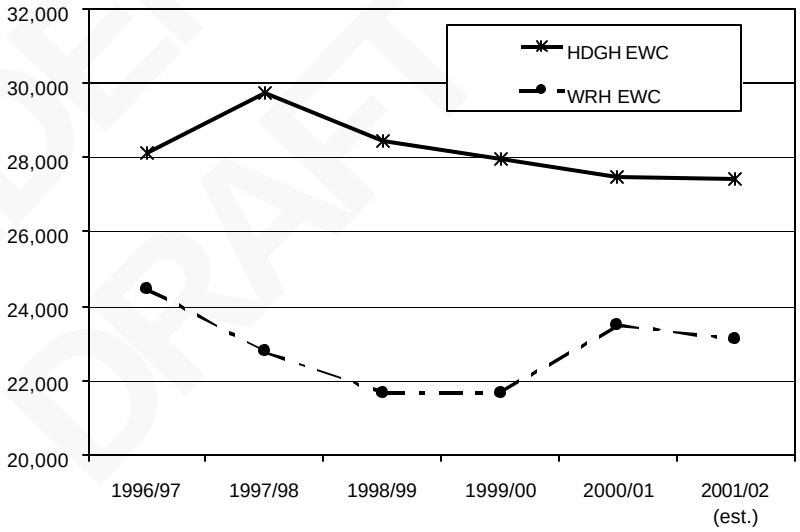
CONFIDENTIAL DRAFT

6.0 Cost per Equivalent Weighted Case

Equivalent Weighted Cases

The primary measure of the relationship between acute care hospital costs and activity in Ontario is the cost per equivalent weighted case (EWC). Weighted cases for inpatient acute care and ambulatory procedures are measured using the Resource Intensity Weights developed by CIHI. For acute care hospitals with complex continuing care beds, the equivalent weighted cases also include cases derived from Resource Utilization Group (RUGs) weighted patient days. Exhibit 6.1 shows the change in EWCs from 1996/97 to 2001/02 for the Windsor hospitals. The 2001/02 value is an estimate based on extrapolation of the third quarter year-to-date volume reported in the Business Planning Briefs prepared by each hospital.

Exhibit 6.1
Equivalent Weighted Case Volume Trend for Windsor Hospitals



The EWC volume for HDGH has decreased each year since 1997/98. The 2001/02 volumes were negatively impacted by the CJD incident. The EWC volume for WRH decreased each year until 1999/2000, but increased in 2000/01. WRH projected a decrease again for 2001/02.

EWC Volumes Don't Reflect Responsibility for Transferred Programs

The EWC volumes shown above reflect the data as reported to CIHI. The weighted cases for the Grace site are reported as HDGH weighted cases, and the inpatient mental health weighted cases for patients at WRH are reported as WRH weighted cases. If the weighted cases are to act as a measure of the patient activity

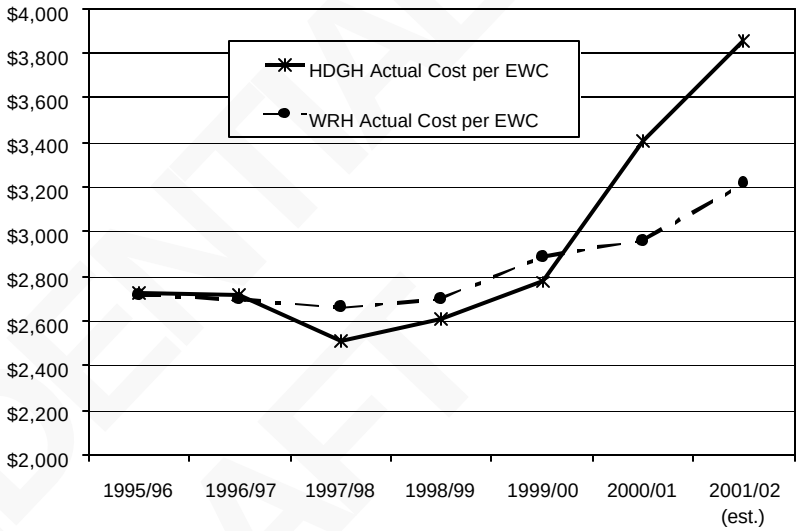
CONFIDENTIAL DRAFT

for which a hospital provides care, then the weighted cases as reported are artificially low for WRH and inflated for HDGH.

Actual Cost per EWC

Exhibit 6.2 shows the trend from 1995/96 to 2001/02 actual cost per equivalent weighted case. The 2001/02 value is an estimate based on the equivalent weighted cases shown above and the percent change projected in hospital costs from 2000/01 to 2001/02.

Exhibit 6.2
Actual Cost per Equivalent Weighted Case Trend for Windsor Hospitals



Business Planning Briefs Underestimate Projected Cost per EWC

In their Business Planning Brief submissions, both hospitals reported that their actual cost per EWC would not increase in 2001/02. We believe that this is unrealistic, given the projected decreases in EWC volumes and the overall increases in expenditures. In their Business Planning Brief submissions, HDGH projected an actual cost per EWC of $3,051 for 2002/03 and WRH projected an actual cost per EWC of $3,000. HDGH projected a 10% increase in EWC for 2002/03, while WRH projected an increase of less than 1%.

In 2000/01 HDGH's actual cost per EWC was third highest of all of Ontario's 70 large community hospitals. WRH's actual cost per EWC was ninth highest.

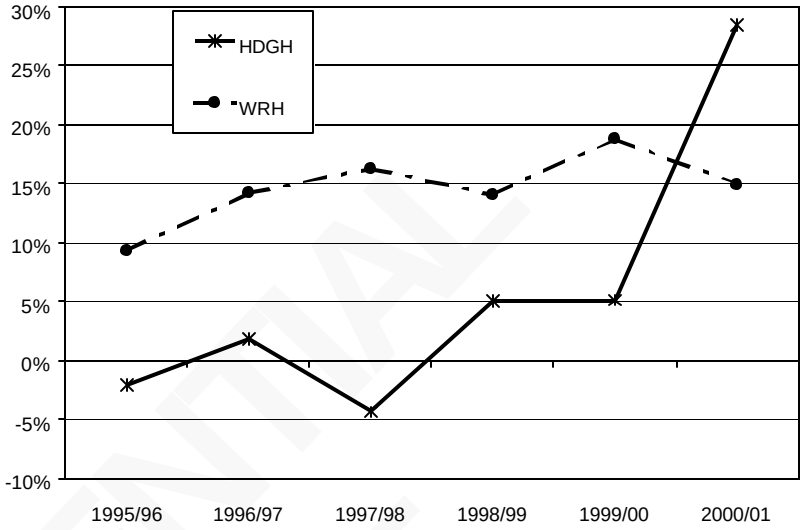
Hospital Cost Performance

The Joint Policy and Planning Committee Rates Sub-Committee has developed a formula to calculate the expected cost per EWC for most Ontario hospitals. Each hospital's actual cost per EWC is compared with its expected cost per EWC to calculate its performance. Performance is measured in terms of the percent by

CONFIDENTIAL DRAFT

which the actual cost is above or below the expected cost. Exhibit 3.3 shows the trend in performance for the Windsor hospitals.

Exhibit 6.3
Trend in Windsor Hospital Performance
Actual CPEWC above/below Expected CPEWC



Performance for 2001/02 cannot be calculated because expected cost per EWC has not been determined. WRH has consistently had actual costs 15% higher than expected. HDGH had actual costs below or equal to expected until 1998/99, when actual costs were 5% above expected costs. There has been continued deterioration in performance from 1999/00 (5% above expected) to 2000/01 (27% above expected). This is evidence of large increases in costs without corresponding increases in patient care workload. Given that workload did not increase in 2001/02, while costs did, we expect that neither the HDGH nor WRH performance for 2001/02 will improve.

Impact of Multi-Site Factor on Expected Cost Calculations

There are six adjustment factors in the JPPC Rates Model to calculate the expected cost per equivalent weighted case. These are factors that are considered to impact hospital costs and are beyond the control of hospital management.

The JPPC Rates Sub-Committee is continually working to refine the Rates Model. One potential modification that has been identified as a high priority is the investigation of the impact of operating multiple sites on hospital costs.

To help assess the impact of operating multiple sites on the Windsor hospitals, we have simulated the changes to the JPPC Rates Model if an adjustment factor for multi-site status was

CONFIDENTIAL

added. The following table shows the impact of addition of a simple multi-site flag as an adjustment factor to the Rates Model. It is based on the JPPC Rates Model published in October 2001. The Rates Model has been subsequently updated, but the data has not yet been released.

Exhibit 6.4
Impact of Addition of Multi-Site Factor on JPPC Rates Model (1999/2000 Provincial Data)

Parameter	JPPC Rates Model			
	As Published (October 2001) w/2 Mergers		With Multi-Site Factor (Acute Sites Only)	
Adjusted R-Squared	**70.8%**		**79.5%**	
	Coefficient	Signif.	Coefficient	Signif.
(Constant)	$ 2,231	0.000	$ 2,142	0.000
Size Factor	$ 1,189,470	0.000	$ 1,413,583	0.000
Non-Neonate Tertiary	$ 16	0.000	$ 12	0.000
Neonate Tertiary	$ 58	0.021	$ 74	0.000
Teaching	$ 1,199	0.001	$ 1,307	0.000
Isolation Flag	$ 136	**0.242**	$ 65	**0.497**
Chronic Flag	$ 370	0.000	$ 428	0.000
Multi-Site Flag	NA	NA	**$ 272**	0.000
Number of Outliers	6 (4 teaching)		8 (4 teaching)	

Addition of a multi-site flag would substantially improve the ability of the resulting models to explain variation in hospital costs in Ontario in 1999/2000. The adjusted R^2 would increase from 70.8% to approximately 80%. Using the model would generate a multi-site factor with a coefficient of $272. This means that, all other factors being equal, a multi-site organization would be expected to be $272 per equivalent weighted case more expensive than a single site organization. The statistical significance of the multi-site factor confirms that Ontario hospitals operating on multiple sites are experiencing higher unit costs.

Implications for Windsor Hospitals

If the JPPC expected cost formula included a multi-site factor, the expected cost for each of the Windsor hospitals would increase by $3.5 million (based on the 1999/2000 data). The increase is approximately the same for both hospitals, even though HDGH has more equivalent weighted cases, because of the interaction of the multi-site factor with the other factors. This interaction (and the reduction in the base rate) is why the estimated increase in expected cost is not equal to $272 multiplied times the number of EWCs for each hospital.

CONFIDENTIAL

7.0 Clinical Efficiency and Utilization Management

Identifying Clinical Efficiencies

A key element of any acute care hospital's attempt to reduce expenditures is the identification of opportunities to reduce use of inpatient beds by shifting inpatient care to ambulatory care, by reducing in-process delays, and by discharging or transferring patients who no longer require acute care. In order to estimate the opportunities to reduce the use of inpatient days, we compared the clinical efficiency (use of ambulatory procedures and inpatient length of stay) of the Windsor hospitals to peer Ontario hospitals. The analyses are based on the methodologies used for the CIHI/HayGroup annual benchmarking database study. Both Windsor hospitals are participants in the CIHI/HayGroup study and receive benchmark performance data as a result.

Re-Assignment of Data

The CIHI data for 2000/2001 for the Windsor hospitals assigns inpatient separation data on the basis of the location of the beds. Discharges from beds at an HDGH site are recorded in the HDGH CIHI data (including obstetrics, neonates, gynaecology, and paediatrics at the Grace site, staffed and managed by WRH staff). Discharges from beds at a WRH site are recorded in the WRH CIHI data (including the mental health beds staffed and managed by HDGH staff).

For purposes of analysis we have re-assigned the data to reflect the responsibility for staffing and management of the beds:

- All obstetrics, neonates, and inpatient gynaecology data for patients at HDGH has been re-assigned to WRH
- All mental health data for patients at WRH has been re-assigned to HDGH

The mismatch between the CIHI data hospital identification and the organization actually responsible for the patients means that the CIHI data provided to the MOHLTC and used for performance assessment and JPPC funding formula calculations do not accurately reflect the activity volumes of each Windsor hospital. This will have an impact on the assignment of weighted cases, and potentially funding allocations for the Windsor hospitals. In 2000/01, we estimate that the misallocation of the activity caused the WRH expected cost per equivalent weighted case to be $20 lower than it would have been if WRH had received credit for the Grace site tertiary activity in the JPPC funding formula. The

CONFIDENTIAL DRAFT

corollary is that the HDGH expected cost per equivalent weighted case was $15 higher because it received credit for the Grace site tertiary activity. The following table shows the percent of inpatient weighted cases that are considered tertiary for the Windsor hospitals and the peer hospitals. The column "Previous % Tertiary" shows the tertiary measure prior to reassignment of activity to reflect the Windsor hospital program transfers.

Exhibit 7.1
Distribution of Inpatient Weighted Cases by Level of Care

Hospital	IP Weighted Cases			%	Previous
	Primary	Secondary	Tertiary	Tertiary	% Tertiary
William Osler	13,301	24,614	6,632	14.9%	14.9%
Oakville Trafalgar	5,052	9,020	2,643	15.8%	15.8%
North York General Hospital	9,209	17,319	6,025	18.5%	18.5%
Windsor Regional Hospital	**7,224**	**10,547**	**4,391**	**19.8%**	**17.5%**
Peterborough RHC	4,865	11,510	4,495	21.5%	21.5%
Humber River Regional Hospital	10,651	20,435	8,842	22.1%	22.1%
Oshawa General Hospital	5,786	12,928	5,738	23.5%	23.5%
Hotel Dieu Grace, Windsor	**3,725**	**13,515**	**6,452**	**27.2%**	**29.0%**
Trillium Health Centre	8,517	17,049	10,685	29.5%	29.5%
Sudbury Regional	7,281	15,360	11,232	33.2%	33.2%
St. Joseph's (Hamilton)	6,127	15,681	11,250	34.0%	34.0%
Kingston General, Hotel Dieu	5,074	15,506	17,759	46.3%	46.3%
Total	86,813	183,484	96,144	26.2%	26.2%

The mismatch of attribution of responsibility for the patients on the CIHI records and the reality of patient care responsibility limits the utility of the CIHI length of stay management reports, since WRH receives reports for discharges from beds controlled by HDGH, and vice versa.

It is recommended that:

(2) The CEOs of the Windsor hospitals should investigate the feasibility of re-assignment of patient abstract records prior to submission to CIHI to better reflect hospital responsibility for management of the patient stays.

Clinical Efficiency Analysis Approach

The clinical efficiency analysis involves the identification of the opportunity to shift inpatient cases to ambulatory procedures (SDS) so that a target percent use of ambulatory care is achieved and the opportunity to reduce length of stay (LOS) to a target LOS. The targets are derived from the distribution of activity from the peer hospitals and would normally be specific to individual CMG/ Complexity/ Age combinations. Thus, each patient record would be assigned to a cell, based on the Case Mix Group, the patient age (using the three CIHI age bands – 0 to 17, 18 to 69,

and 70 and older), and where applicable, to a complexity (Plx) level.

Because the fragmentation of the patient care activity into many cells can lead to very small volumes in individual cells, and artificially large estimates of savings opportunities, targets are not established unless there are at least 30 cases in an individual cell in at least one peer hospital.

7.1 Treatment of "Complexity"

The "Complexity" (Plx) system of further subdividing CMGs on the basis of the patient burden of disease, and anticipated impact on length of stay and care plans, was introduced by CIHI in 1996. The results of the clinical efficiency analyses are dependent on documentation of complexity in the Windsor hospital patient records. The Steering Committee for the review requested that the consultants conduct a sensitivity analysis of the impact of treatment of complexity on the clinical efficiency analyses.

Complexity

Complexity levels are assigned based on comorbid diagnoses, and the possible complexity levels are:

1 – No complexity

2 – Complexity related to chronic conditions

3 – Complexity related to serious illness

4 – Complexity related to life threatening illness

Some types of patients do not have complexity assigned (Obstetrics, Neonates, Mental Health, Trauma) and are given complexity level 9 by default.

Recent analysis has raised concern that the assignment of complexity on CIHI records in some Ontario hospitals may not accurately reflect the true health status of the patients. Exhibit 7.2 shows the 2000/01 distribution of inpatient activity by complexity level for the Windsor hospitals and peer hospitals.

CONFIDENTIAL DRAFT

Exhibit 7.2
Percent Distribution of Inpatient Cases by Complexity Level

Hospital	1 - No Complexity	2 - Chronic Illness	3 - Serious Illness	4 - Life Threatening Illness
Windsor Regional Hospital	**65.4%**	**17.4%**	**9.9%**	**7.3%**
Kingston General, Hotel Dieu	68.1%	15.0%	8.8%	8.1%
St. Joseph's (Hamilton)	68.3%	13.5%	8.8%	9.4%
Humber River Regional Hospital	74.1%	12.9%	7.0%	6.1%
Trillium Health Centre	74.2%	14.3%	7.0%	4.5%
Peterborough RHC	74.4%	13.2%	7.2%	5.2%
Oshawa General Hospital	74.6%	12.5%	7.0%	5.9%
North York General Hospital	75.0%	13.1%	6.7%	5.2%
Hotel Dieu Grace, Windsor	**76.6%**	**11.9%**	**6.6%**	**4.8%**
Oakville Trafalgar	76.8%	14.1%	5.5%	3.5%
William Osler	78.5%	11.7%	5.7%	4.1%
Sudbury Regional	82.5%	10.4%	4.5%	2.6%
Average	74.6%	13.1%	6.9%	5.4%

WRH Patients More Complex Than Patients in Other Hospitals?

This data would suggest that the WRH inpatient population is more complex than the patient population of the peer hospitals (including the two teaching hospitals).

Complexity Influenced by Recording of Comorbid Diagnoses

The complexity and tertiary assignment is influenced by the documentation on the CIHI records of comorbid diagnoses that are considered to influence the patients' length of stay or outcome. It has been suggested that some of the apparent differences in complexity of patient populations between hospitals result from differences in documentation and CIHI record preparation practices.

Variation in Rates of Reporting Comorbid Diagnoses

To test whether there were variations in capture of diagnostic information between the Windsor hospitals and the peer hospitals, that might influence the clinical efficiency analysis results, we examined the average number of comorbid diagnoses recorded on the CIHI abstracts for each hospital. The following exhibit shows the average number of comorbid (Type 1 and 2) diagnoses recorded for each program for each peer hospital. Data is shown for the Windsor hospitals and the selected peer hospitals, as well as mean and median values for all of the teaching and community hospitals in the CIHI/HayGroup annual benchmarking study.

CONFIDENTIAL DRAFT

Exhibit 7.3
Average Number of Type 1 and 2 Diagnoses Per Case for Windsor Hospitals and Peer Hospitals

Corporation	Medicine	Surgery	Pregnancy	Neonates	Mental Health	Total
301 Windsor Regional Hospital	**3.02**	**1.84**	**1.55**	**0.45**	**1.83**	**2.05**
410 St. Joseph's Hospital Hamilton	2.24	1.75	1.61	0.43	1.96	1.63
Teaching Weighted Average	**1.86**	**1.72**	**1.45**	**0.56**	**1.73**	**1.60**
450 Halton Healthcare Services	2.03	1.88	0.92	0.27	1.87	1.60
ACAHO Study Weighted Average	1.76	1.59	1.28	0.46	1.56	1.47
Teaching Hospital Median	**1.77**	**1.52**	**1.52**	**0.45**	**1.89**	**1.45**
090 Lakeridge Health Corporation	1.95	1.50	0.72	0.21	1.41	1.43
302 Hotel Dieu Grace, Windsor	**1.66**	**1.57**	**0.90**	**0.59**	**1.13**	**1.42**
610 Peterborough Regional Health Centre	1.63	1.63	0.83	0.29	1.38	1.41
ACAHO Study Median	**1.66**	**1.48**	**1.09**	**0.32**	**1.53**	**1.36**
230 Humber River Regional Hospital	1.95	1.50	0.90	0.16	1.69	1.33
Community Hospital Median	**1.65**	**1.48**	**0.99**	**0.29**	**1.44**	**1.33**
Community Hospital Weighted Average	**1.67**	**1.39**	**1.11**	**0.36**	**1.43**	**1.33**
080 Kingston General	1.44	1.44	0.90	0.51	1.74	1.30
490 North York General Hospital	1.60	1.13	1.75	0.25	1.55	1.27
270 Trillium Health Centre	1.52	1.57	0.56	0.14	1.22	1.17
140 William Osler Health Centre	1.45	1.18	0.92	0.36	1.31	1.10
390 Hopital regional de Sudbury Regional	1.25	1.01	0.38	0.19	1.15	1.00

Results Suggest Analyses could be impacted by Variation in Documentation of Comorbid Diagnoses

For most programs WRH records the most comorbid diagnoses per patient. For all programs except neonates, the average number of comorbid diagnoses recorded for WRH patients is higher than the average for Canadian teaching hospitals. CIHI will be initiating a re-abstraction study to assess the quality and accuracy of discharge data submitted by Ontario hospitals. WRH should volunteer to participate in this review.

During interviews, some HDGH stakeholders expressed concern that clinical documentation and abstracting at HDGH was not sufficiently comprehensive to ensure that CIHI records accurately described the patient population. HDGH has recently completed an independent audit of their abstract data, which has concluded that there are opportunities to more comprehensively record diagnostic data and increase RIW credit.

CONFIDENTIAL

It is recommended that:

(3) The CEO of WRH should request that CIHI include WRH patient records in the proposed Ontario re-abstraction study.

Decision to Exclude Complexity Measurement from Analyses

Based on this and other analyses, it was decided that the clinical efficiency analyses should not use the complexity assignment. Thus, instead of establishing targets and savings opportunities for each CMG/ Age/ Complexity cell, targets and savings opportunities were examined for CMG/ Age cells only.

7.2 Initial Clinical Efficiency Targets Based on Best Quartile

The initial clinical efficiency targets are based on the Best Quartile (25th percentile) performance (the performance level where ¼ of hospitals [with sufficient volume] are more aggressive, and ¾ are less aggressive). For use of ambulatory procedures, this is the performance level where ¼ of the hospitals have a higher percentage use of ambulatory procedures for the CMG and age combination. For length of stay, this is the performance level where ¼ of the hospitals have a shorter length of stay.

The length of stay targets are based on the total length of stay (including ALC days) for only Typical and Outlier cases combined. No assumptions are made regarding opportunities to reduce length of stay for acute care transfers, deaths, or sign-outs against medical advice. Average length of stay targets are established in conjunction with the assessment of opportunity to shift short stay (3 day stay or less) inpatient cases to ambulatory care, thereby taking into account the longer length of stay of the residual inpatient cases. Length of stay targets for deliveries and newborns are set at a minimum of 2 days.

When clinical efficiency targets are set using only CMG and patient age cells, there are fewer potential cells, and increased likelihood that at least one of the peer hospitals (and the Windsor hospitals) will have sufficient cases to set a target. The following exhibit shows the proportion of inpatient cases at each hospital for which clinical efficiency benchmarks are applied.

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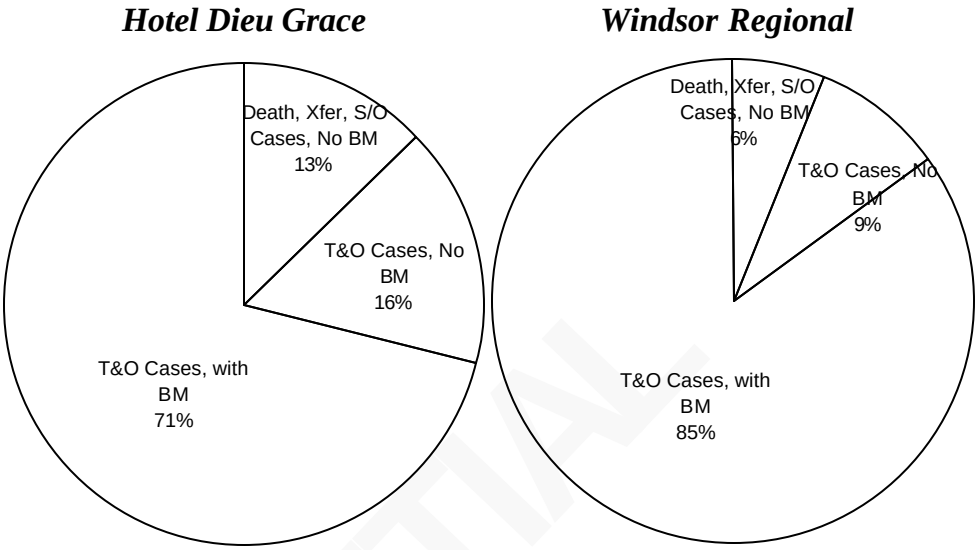
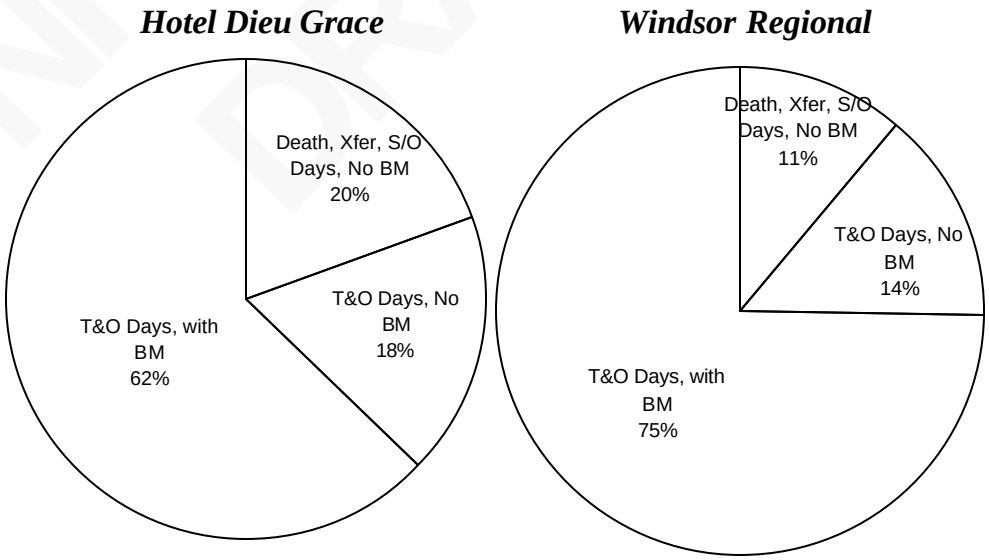
Exhibit 7.4
Proportion of Cases for Which LOS Benchmarks are Applied



Although 71% of inpatient cases at HDGH and 85% at WRH were assessed relative to a target length of stay, a smaller percent of Windsor hospital inpatient days were examined for length of stay reduction opportunities. The following exhibit shows that only 62% of the 2000/01 HDGH inpatient days were included in the length of stay analysis and 75% of WRH inpatient days.

Exhibit 7.5
Proportion of Days in Cases for Which LOS Benchmarks are Applied



Overall, 20% of the HDGH inpatient days are in cases which are either deaths, sign-outs, or transfers. For the HDGH inpatient mental health program (which, for the purpose of this analysis,

includes the beds at both the Hôtel Dieu site and at the WRH campuses) there are many patients admitted at Hôtel Dieu and then transferred to the WRH Western Campus. About one third of all of the patients in the mental health program are transfers, and these cases (and the associated days) are excluded from benchmark application.

Exhibit 7.6
HDGH Inpatient Mental Health Exclusions from Benchmark Application

Inpatient Activity Type	Cases	Days	ALOS
Total Inpatient	2,528	34,184	13.5
Typical/ Outlier	1,670	23,826	14.3
Excluded (Transfer, Sign-Out, Death)	858	10,358	12.1
Percent Excluded	34%	30%	

If, for the purposes of CIHI reporting, the inpatient mental health beds were all treated as HDGH beds, then the transfers from one site to another would be considered to be an internal transfer within HDGH, and these cases would be assessed using the clinical efficiency benchmarks.

The results of the application of the clinical efficiency best quartile targets to the 2000/01 data for the Windsor hospitals and the selected peer hospitals are shown below.

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Exhibit 7.7
% of Total Days to be Saved Using Best Quartile Clinical Efficiency Targets

Hospital	IP Cases	IP Days	SDS Cases	% Days Saved via SDS	% Days Saved via LOS	Total % Days Saved
Hamilton St. Joe's	21,063	140,203	18,260	1.2%	14.5%	15.8%
Hotel Dieu Grace	15,795	117,712	14,824	1.5%	10.6%	12.2%
Humber River	29,729	184,722	33,045	1.0%	11.1%	12.1%
Kingston	20,701	159,640	13,576	1.0%	14.5%	15.5%
North York General	25,761	146,138	26,511	0.7%	10.8%	11.4%
Oakville Trafalgar	13,997	79,190	13,091	1.1%	9.4%	10.4%
Oshawa General	17,986	112,432	21,072	1.3%	10.7%	12.0%
Peterborough RHC	15,215	88,353	14,866	1.0%	6.8%	7.8%
Sudbury Regional	23,589	153,231	22,711	1.6%	14.3%	15.9%
Trillium HC	27,289	155,965	26,253	0.7%	8.6%	9.2%
William Osler	38,370	214,548	32,166	1.2%	13.5%	14.8%
Windsor Regional	20,488	93,717	12,479	2.8%	8.0%	10.8%
Sample Total	269,983	1,645,851	248,854	1.2%	11.5%	12.7%

For the entire sample, shifting from inpatient activity to use of ambulatory procedures could save only 1.2% of the initial actual days. Most of the estimated savings opportunities (11.5% of the initial actual days) come from reductions in inpatient length of stay.

The estimate of the percent of total days that could be saved by achieving the best quartile targets for use of ambulatory procedures ranges from 0.7% at North York General and Trillium Health Centre, to 2.8% at Windsor Regional.

The estimate of the percent of total days that could be saved by achieving the best quartile targets for length of stay ranges from 6.8% at Peterborough Regional Health Centre to 14.5% at either Kingston General or Hamilton St. Joseph's hospitals.

While the overall estimate of days that could be saved is less for Windsor Regional (10.8%) compared to Hôtel-Dieu Grace (12.2%), Windsor Regional has the largest apparent opportunity to reduce use of days by increasing use of ambulatory procedures.

Clinical Efficiency Savings Opportunities by Program

The estimated clinical efficiency opportunities (in terms of potential to save days at the best quartile targets) by program for the Windsor hospitals are shown below.

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Exhibit 7.8
% of Total Days to be Saved at the Windsor Hospitals Using Best Quartile Clinical Efficiency Targets by Program

Program (PCC)	Hotel Dieu			Windsor Regional		
	IP Cases	IP Days	% Days to Save	IP Cases	IP Days	% Days to Save
Psychiatry	2,528	34,184	8.2%	1	1	0.0%
Cardiology	1,760	11,523	9.0%	1,859	11,037	5.8%
General Surgery	1,546	11,030	17.8%	1,294	7,005	24.0%
Pulmonary	1,530	8,639	9.4%	883	6,468	4.4%
Neonatology	0	0	0.0%	4,343	13,785	1.4%
Gastro/Hepatobiliary	1,402	6,959	30.0%	1,116	6,145	21.4%
Oncology	340	3,666	4.2%	847	8,783	7.9%
Obstetrics	0	0	0.0%	4,644	12,252	6.1%
Orthopaedics	1,489	7,020	14.3%	747	4,349	19.2%
Neurology	937	7,643	3.8%	408	3,357	0.5%
Trauma	914	6,843	7.2%	524	3,662	5.3%
General Medicine	598	3,217	15.0%	371	2,270	14.0%
Urology	479	1,887	35.3%	904	3,458	32.3%
Endocrinology	531	2,952	29.1%	274	1,808	7.7%
Gynaecology	0	0	0.0%	1,395	4,746	25.5%
Vascular Surgery	319	2,884	13.6%	67	732	11.5%
Cardio/ Thoracic	268	2,494	16.6%	59	654	17.9%
Neurosurgery	226	2,693	11.4%	10	55	14.5%
Nephrology	181	1,423	5.4%	69	488	9.2%
Haematology	140	764	13.9%	123	732	16.6%
Otolaryngology	307	709	39.7%	280	580	38.7%
Plastic Surgery	29	148	7.1%	91	636	4.4%
Rheumatology	46	413	0.0%	39	359	0.0%
Dermatology	32	233	7.4%	37	192	4.2%
Ophthamology	73	211	29.4%	14	50	12.0%
Not Generally Hospitalized	106	114	0.0%	9	10	0.6%
Dental/Oral Surgery	9	10	85.7%	78	100	63.5%
Rehabilitation	4	52	0.0%	0	0	0.0%
Ungroupable	1	1	0.0%	2	3	0.0%
Grand Total	15,795	117,712	12.2%	20,488	93,717	10.8%

The programs with the largest absolute number of days that could be saved across both hospitals are (in order of decreasing total days):

- Gastro/Hepatobiliary 2,925 days
- Psychiatry 2,793 days
- General Surgery 2,558 days
- Cardiology 1,669 days
- Orthopaedics 1,480 days

The psychiatry savings are shown as a percent of the total psychiatry days, but are calculated by applying the LOS targets to only the subset of psychiatric inpatients that were not transferred between the HDGH and WRH sites.

Low Volume Cells

Only 407 (2.8%) of the total estimated days to save at HDGH are in CMG and Age combinations with fewer than 10 cases. Only 397 (3.9%) of the total estimated days to save at WRH are in CMG and Age combinations with fewer than 10 cases.

Ambulatory Procedure Opportunities

The Case Mix Groups with the greatest opportunity to shift from inpatient to ambulatory procedures are shown below.

Exhibit 7.9
CMGs with Greatest Opportunity to Reduce Use of Inpatient Days at HDGH By Increased Use of Ambulatory Procedures

#	CMG	IP Cases	IP Days	Avg. LOS	SDS Cases	Case Shift to SDS	Days Saved via SDS
294	Esoph/Gastro/Misc Digest Dis	852	3,377	4.0	1,768	96	164
266	Anus & Stomal Proc (Mnrh)	83	210	2.5	181	61	99
317	Laparoscopic Cholecystectomy	158	434	2.7	111	96	96
536	Urinary Obstruction (Mnrh)	125	408	3.3	340	57	90
380	Other Lower Extrem Proc(Mnrh)	118	176	1.5	289	74	88
483	Diabetes	165	1,093	6.6	3	36	77
375	Minor Upper Extremity Proc	178	251	1.4	87	73	73
269	Bilateral Hernia Procedures	150	347	2.3	183	66	66
512	Oth Transureth Proc/Bx(Mnrh)	75	282	3.8	89	40	65
109	Other Ent Infections	38	117	3.1	6	27	60
428	Brst Pr X Bx/Loc Exc No Malig	74	89	1.2	82	54	54
83	Reconstructive Ent Procedures	50	101	2.0	20	29	51
374	Minor Lower Extremity Proc	98	192	2.0	528	40	43
93	Tonsill/Adenoidectomy (Mnrh)	51	57	1.1	122	41	41

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Exhibit 7.10
CMGs with Greatest Opportunity to Reduce Use of Inpatient Days at WRH By Increased Use of Ambulatory Procedures

CMG	IP Cases	IP Days	Avg. LOS	SDS Cases	Case Shift to SDS	Days Saved via SDS
Maj Ut/Adnexal Proc No Malig	862	3,148	3.7	186	216	448
Laparoscopic Cholecystectomy	353	501	1.4	3	275	275
Urinary Obstruction (Mnrh)	243	563	2.3	400	157	219
Oth Transureth Proc/Bx(Mnrh)	204	598	2.9	135	129	203
Esoph/Gastro/Misc Digest Dis	425	2,087	4.9	1,611	102	138
Brst Pr X Bx/Loc Exc No Malig	89	173	1.9	47	71	110
Bilateral Hernia Procedures	162	335	2.1	130	91	91
Anus & Stomal Proc (Mnrh)	61	156	2.6	83	47	82
Reconstructive Ent Procedures	93	181	1.9	106	46	73
Dental Extract/Restore (Mnrh)	78	100	1.3	1,310	64	64
Other Respiratory Diagnoses	60	320	5.3	2	22	48
Red Blood Cell Disorders	97	595	6.1	41	21	42
Diabetes	83	504	6.1	0	22	41
Biliary Tract Disease	151	692	4.6	11	26	38

Laparoscopic Cholecystectomy

Laparoscopic Cholecystectomy (LC) appears near the top of the list for both hospitals. The best quartile targets for provision of LC on an ambulatory basis are 81% for patients aged 18 to 69 and 52% for patients aged 70 and older. At WRH in 2000/01, only 3 of 353 LCs were performed as outpatient surgery, while 111 of 269 LCs at HDGH were done as outpatients.

Laparoscopic vs. Open Cholecystectomy

The 2001 CIHI/HayGroup annual benchmarking study includes a series of quality indicators. One of these indicators is the percent of time that cholecystectomies are performed using a laparoscopic approach for uncomplicated cases. This indicator will be discontinued in next year's study because all of the participating hospitals except 2 have rates above 92% (one of the 2 is HDGH, and it is the only hospital below 85%). In 2000/2001, the HDGH used the laparoscopic approach for 64% of the cholecystectomies performed. If HDGH had used the laparoscopic approach at the same rate as other Canadian hospitals, then 119 open cholecystectomies could have been converted to LC. Open cholecystectomies require an inpatient stay (and greater expense), cause more pain for the patient, and a longer recovery period.[54] We estimate that the 119 open cholecystectomies cost HDGH $200,000 more than if the procedures had been performed laparoscopically.

[54] CIHI (2001). Hospital Report 2001: Acute Care. Ottawa: CIHI, 40.

Given the volume of cholecystectomies done each year (624 in the Windsor hospitals in 2000/01), the unusual patterns of use of inpatient versus outpatient surgery (at WRH) and high volumes of open procedures (at HDGH), standardization of clinical practice should be a priority.

It is recommended that:

(4) The Chiefs of Staff of the Windsor hospitals should initiate a joint project to develop standard clinical protocols for common procedures in the Windsor hospitals.

Length of Stay Reduction Opportunities

The case mix groups with the greatest opportunity for reduction in use of inpatient days are shown below.

Exhibit 7.11
CMGs with Greatest Opportunity to Reduce Use of Inpatient Days at HDGH by Decreased Length of Stay

#	CMG	IP Cases	IP Days	Avg. LOS	Days Saved via LOS	Resulting Avg. LOS
294	Esoph/Gastro/Misc Digest Dis	852	3,377	4.0	1,023	2.9
766	Depress Mood Dis No Ect/Ax3	712	9,737	13.7	769	12.6
253	Major Intestinal/Rectal Proc	142	2,160	15.2	521	11.5
485	Nutrit/Misc Metabolic Disord	328	1,618	4.9	514	3.4
218	Card Cath No Cond Or Los <4	87	641	7.4	306	3.9
365	Back & Neck Proc No Fusion	121	627	5.2	297	2.9
770	Bipolar Mood/Manic No Ect/Ax3	160	2,742	17.1	294	15.3
783	Psychoactive Substance Depend	65	570	8.8	283	4.5
1	Craniotomy Procedures	138	2,105	15.3	257	13.4
777	Schizophren/Psy No Ect/Axis3	370	6,063	16.4	249	15.7
143	Simple Pneumonia & Pleurisy	419	2,736	6.5	246	6.0
325	Pancreas Diseases (Ex Malig)	66	616	9.3	245	5.9
146	Asthma	303	867	2.9	221	2.1

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Exhibit 7.12
CMGs with Greatest Opportunity to Reduce Use of Inpatient Days at WRH by Decreased Length of Stay

#	CMG	IP Cases	IP Days	Avg. LOS	Days Saved via LOS	Resulting Avg. LOS
579	Maj Ut/Adnexal Proc No Malig	862	3,148	3.7	478	3.4
294	Esoph/Gastro/Misc Digest Dis	425	2,087	4.9	408	4.8
251	Gastrostomy & Colostomy Proc	55	1,263	23.0	367	16.3
354	Knee Replacement	157	1,237	7.9	320	5.8
736	Chemotherapy	120	517	4.3	293	1.9
623	Antepartum Dx W Complic Dx	142	562	4.0	219	2.6
602	Caesarean Del W Complic Dx	282	1,482	5.3	205	4.5
281	G.I. Hemorrhage	119	713	6.0	195	4.9
352	Hip Replacement	87	726	8.3	193	6.1
512	Oth Transureth Proc/Bx(Mnrh)	204	598	2.9	188	2.8
325	Pancreas Diseases (Ex Malig)	136	891	6.6	183	5.4
242	Chest Pain	214	586	2.7	178	1.9
255	Less Ext Esoph/Stom/Duod Proc	21	248	11.8	163	4.2

Estimated Value of Reduction in Use of Inpatient Days

The estimated 14,315 inpatient days that could have been saved if HDGH had achieved best quartile performance for use of ambulatory care and length of stay for all CMG and patient age combinations represent 12.2% of the actual inpatient days used in 2000/01. If those days had been eliminated it would not have resulted in a corresponding 12.2% reduction in costs, since many of the days that could be saved are the least expensive days of care, found at the end of the patient's stay. Thus the reduction in costs would be less than 12.2% and there would be an increase in the average intensity and cost of the remaining inpatient days.

Use of RIW Components to Estimate Potential Cost Reduction

To estimate the potential dollar savings associated with the target reduction in use of inpatient days we used the CMG-specific RIW components. For each inpatient case considered as appropriate to shift to ambulatory procedure (based on the best quartile target) we removed the typical inpatient RIW and added the corresponding ambulatory procedure RIW. For each day of stay that could be eliminated (based on the best quartile target) we removed the CIHI "low severity" per diem RIW (if there were ALC days for the cases) or the CIHI "routine/ancillary" per diem RIW values (if the ALC days were less than the target days to save).

The results of this analysis are shown in Exhibit 7.13.

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Exhibit 7.13
Estimate of Cost Savings Due to Reduction in Use of Inpatient Days at Best Quartile Targets

Measure	Hotel Dieu Grace	Windsor Regional
Days Saved	14,315	10,098
% of Total Days	12.2%	10.8%
RIW Saved	2,244	1,885
% of Total RIW	8.4%	7.7%
OCDM Direct $ per RIW	$2,613	$2,226
Estimated $ Savings	$5,863,771	$4,195,526

Estimated Savings of $5.9 M at HDGH, $4.2 M at WRH

The estimated reduction in direct costs in 2000/01 for HDGH, if it had achieved best quartile targets, would have been $5.9 million. The estimated reduction in direct costs in 2000/01 for WRH, if it had achieved best quartile targets, would have been $4.2 million.

7.3 2001/02 Clinical Efficiency

2001/02 YTD Data for Typical Patients Provided

The preceding analyses of clinical efficiency opportunities were based on 2000/01 CIHI data, which is the most current year for which a full year of data is available. The hospitals have identified initiatives to improve clinical efficiency and utilization management that were implemented during the 2001/02 fiscal year. To assess whether lengths of stay for 2001/02 are substantially different from the 2000/01 results, we obtained both 2000/01 and 2001/02 year-to-date summary CIHI data from the hospitals' health records departments. This data was limited to "Typical" patients (as defined by CIHI) and included the CIHI expected length of stay for typical patients. The following exhibit shows a comparison of the 2000/01 and 2001/02 YTD CIHI typical patient for each of the hospitals.

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Exhibit 7.14
Comparison of 2000/01 and 2001/02 YTD Typical Inpatient Length of Stay Performance

Indicator	HDGH*	WRH*
Typical LOS Excl. ALC (2000/01)	5.09	4.81
Typical LOS Excl. ALC (2001/02 YTD)	4.87	4.42
Change in Typical LOS	(0.22)	(0.38)
Percent Over/Under CIHI ELOS (2000/01)	0.2%	-4.7%
Percent Over/Under CIHI ELOS (2001/02 YTD)	-0.9%	-7.0%
Percentage Point Improvement in LOS Performance	1.1%	2.3%

* Activity assigned to hospital according to responsibility for patient records (e.g. Grace obstetrics included in HDGH, WRH inpatient mental health included in WRH).

Both hospitals show an improvement in clinical efficiency performance for typical cases from 2000/01 to 2001/02, with HDGH having moved from about the CIHI expected LOS (ELOS) to almost 1% below, and WRH having moved from 5% below the CIHI ELOS to 7% below.

It should be noted that the CIHI ELOS is based on the average length of stay calculated using national data from a prior calendar year. It includes data from small hospitals (which tend to have longer lengths of stay) and data from outside Ontario (where average lengths of stay are also longer). In 2000/01, there were no regions in Ontario where the average LOS was higher than the CIHI ELOS. Most Ontario hospitals do not use the CIHI ELOS as an absolute target for length of stay, but instead strive to be at least 10% below the CIHI ELOS. The best quartile targets used for this project are equivalent to a length of stay for typical patients 12.5% below the CIHI ELOS.

Based on the improvement in LOS performance for Typical patients from 2000/01 to 2001/02, we estimate that 15% of the target length of stay reduction has already been achieved during fiscal year 2001/02. Thus, the cost savings estimates for clinical efficiency savings have been reduced by 15%:

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- HDGH clinical efficiency savings target: $4,984,000
- WRH clinical efficiency savings target: $3,566,000

7.4 Adjustments to Clinical Efficiency Targets for the Windsor Hospitals

The use of the peer hospital best quartile targets applied to the Windsor hospitals 2000/01 CIHI data suggests that there were opportunities to save $5.0 million and $3.6 million at HDGH and WRH respectively. Upon the conclusion of implementation of the HSRC directions for Windsor, we believe that use of the peer hospital best quartile targets will be appropriate. However, for the purposes of establishing immediate cost reduction targets, there are circumstances that militate against using the full calculated amounts. These circumstances have been described in section 2 of this report and include:

- Shortages of primary care physicians in Essex County
- Shortage of hospital and community-based ambulatory services
- Lower supply of residential long-term care beds
- Disruption due to renovation, new construction, and movement of beds

Revised Clinical Efficiency Cost Savings Targets

As a result of these factors, we propose that the target for cost savings through clinical efficiency be reduced to 70% of the calculated first quartile targets. This would result in clinical efficiency cost savings for each of the Windsor hospitals of:

- $3.49 million for HDGH
- $2.50 million for WRH

or a total of $5.99 million for the Windsor hospitals.

It is recommended that:

(5) The CEO of HDGH should set clinical efficiency targets that will reduce the length of stay of typical patients to 12.5% below the 2000/01 CIHI expected length of stay over the next two years.

(6) The CEO of WRH should set clinical efficiency targets that will reduce the length of stay of typical patients to 12.5% below the 2000/01 CIHI expected length of stay over the next two years.

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Discharge Disposition of Acute Inpatients

The percent distribution of inpatients by discharge disposition is shown for the Windsor hospitals and the peer hospitals. The HDGH has the second highest rate of discharge of inpatients to Home Care and the highest rate (equal to Peterborough) of transfer of inpatients to acute care.

Exhibit 7.15
Percent Distribution of Inpatient Discharges by Discharge Disposition

Hospital	Home	Died	Transfer to Acute	Rehab	Complex Cont. Care	LTC (NH/ HFA)	Home Care	Other
Hotel Dieu Grace	**75.6%**	**3.0%**	**3.6%**	**2.9%**	**0.3%**	**1.6%**	**10.4%**	**2.5%**
Windsor Regional	**83.6%**	**3.3%**	**1.6%**	**0.5%**	**0.9%**	**3.1%**	**6.8%**	**0.2%**
Oakville Trafalgar	83.2%	2.6%	2.6%	3.5%	0.8%	2.5%	4.7%	0.3%
Humber River	85.7%	4.0%	1.2%	2.2%	0.4%	2.6%	3.2%	0.7%
Oshawa General	80.9%	3.8%	2.3%	2.5%	1.5%	1.5%	7.3%	0.4%
North York	83.0%	3.1%	2.2%	2.0%	0.6%	3.1%	5.2%	0.9%
Trillium HC	83.0%	3.5%	2.2%	4.1%	0.6%	1.6%	4.6%	0.4%
Peterborough RHC	68.0%	3.2%	3.6%	1.1%	1.7%	1.9%	20.3%	0.2%
William Osler	85.6%	2.9%	2.3%	1.5%	0.5%	3.8%	3.0%	0.4%
Kingston General	81.3%	4.1%	2.5%	1.3%	0.6%	2.0%	7.0%	1.2%
St. Joseph's (Ham)	83.4%	2.6%	2.5%	1.5%	0.7%	1.8%	6.1%	1.3%
Sudbury Regional	80.2%	3.6%	2.6%	0.4%	0.2%	2.7%	8.7%	1.6%
Average	81.9%	3.3%	2.3%	2.0%	0.7%	2.5%	6.5%	0.8%

HDGH has the 3rd highest rate of transfer of patients to rehabilitation and the 2nd lowest rate of transfer of patients to complex continuing care and to long-term care. WRH has the 2nd lowest rate of transfer of patients to rehabilitation and the 3rd highest rate of transfer of patients to complex continuing care and to long-term care.

Discharge to Inpatient Rehabilitation

Rationalization of inpatient rehabilitation beds has assigned the short-term (general) rehab beds to HDGH, and the long-term (special) rehabilitation beds to WRH. In 2000/01 the numbers of admissions to the HDGH short-term rehabilitation beds were:

- 413 patients from HDGH
- 0 patients from WRH

The number of admissions to the WRH long-term rehabilitation beds were:

- 127 patients from HDGH
- 78 patients from WRH

There does not appear to be equal access to the short-term rehabilitation beds, which should be a citywide resource. This may

impact the acute care length of stay for patients at WRH who might benefit from access to short term rehabilitation. If concern over moving acute care patients between facilities for post-acute rehabilitation is preventing discharge of WRH patients to the HDGH rehabilitation beds, then the Windsor hospitals should consider developing other plans for distribution of the directed total number of rehabilitation beds.

It is recommended that:

(7) The CEOs of the Windsor hospitals should initiate a review of the current distribution of rehabilitation beds to ensure that it best meets the needs of patients requiring rehabilitation care following acute care, and if necessary, develop a revised local plan for rehabilitation beds for consideration by the MOHLTC.

7.5 Utilization Management

1999 Joint Utilization Management Project

In 1999, the MOHLTC funded a joint utilization management project for the Windsor hospitals. There was a belief that there were opportunities to standardize utilization management activities and approaches in the Windsor hospitals and generate efficiencies and improvements in patient care. The main recommendation of the project was that:

"A formal steering committee, be established to:

- Provide oversight and direction in the development and maintenance of a Joint Utilization Management Program;
- Ensure convergence of UM activities within the community;
- Act as a resource to the organizations;
- Establish standards for performance of UM activities;
- Monitor outcomes of the joint program; and
- Ensure a forum to share information and raise UM issues."

The proposed joint utilization management program (JUMP) steering committee was formed from the project steering committee. This committee met during 1999 and 2000 and until mid-2000 reported regularly to the JEC on progress with implementation of the recommendations. The last report to the JEC was at the April 12, 2000 meeting.

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The JUMP steering committee has not met within the last year. Our review of the minutes of the meetings of the committee suggests that the committee was used mainly as an opportunity for each hospital to share information about UM activities within their own organization.

Each hospital has continued to work, somewhat independently, on improving decision support capabilities and monitoring and managing utilization.

During interviews we were told that the joint utilization management program was never fully established because:

- The JUMP steering committee membership was heavily weighted towards Board participation, and UM activities require an operational focus incompatible with the role and expertise of Board members
- Each hospital has the perception that the other hospital has a different (more punitive) approach to working with physicians
- The medical staffs are separate
- There is a perception of incompatibility in organization cultures
- The hospitals are at different stages in development of decision support, pathway development, & information infrastructure
- There is incompatibility between the program management structure at WRH, and the more traditional structure at HDGH

The utilization management coordinators of the three Essex County hospitals have continued to meet on an ongoing basis, to share approaches and experiences.

We saw evidence of enhancement in utilization management effort and in creation of decision support capability at both Windsor hospitals, and improved reporting of performance measures. However, the lack of a true joint UM program has left gaps in both quality and utilization management for those services operated on one hospital's site, but managed by the other.

CIHI reports and data for the Grace site obstetrics, newborn, and gynaecology services are routinely sent to HDGH. CIHI reports and data for the inpatient mental health services located at WRH are routinely sent to WRH. Because in each case the hospital receiving the reports does not have responsibility for management of the direct care staff, their internal UM program does not address issues identified in these services.

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Later in this report we recommend changes in other structures to facilitate increased joint problem-solving by the Windsor hospitals, rather than just improved communications between the hospitals (which has occurred). In conjunction with those recommendations, and as a vehicle to support implementation of plans to achieve the identified clinical efficiency savings, we recommend that the joint utilization management program steering committee be re-established. The role of the JUMP steering committee should be to closely monitor adherence to the implementation plan targets for achievement of the clinical utilization savings targets and to monitor standardized indicators of the performance of both Windsor hospitals. We believe that there are greater opportunities for the Windsor hospitals to learn from each other and synergies that can assist the hospitals in providing cost-effective and efficient care in a difficult health care environment.

It is recommended that:

(8) The CEOs of the Windsor hospitals should re-establish the Windsor Hospitals Joint Utilization Management Steering Committee and assign it responsibility for implementation of a plan to meet the clinical efficiency targets identified in the focused review.

Low ALC Days

One finding from the original JUMP project was that the reported ALC days by the Windsor hospitals were exceptionally low, suggesting either that access to post-acute placement options (e.g. LTC, complex continuing care) was easier in Windsor than elsewhere in the province, or that ALC days were under-reported. The pattern of relatively low ALC rates in the Windsor hospitals has continued. WRH has reported that the percent ALC days at WRH has increased to 3.2% in fiscal year 2001/02.

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Exhibit 7.15
Percent of Acute Care Days Used By Patients Waiting for Discharge Placement (ALC Days) in 2000/01

Hospital	IP Days	ALC Days	% ALC
Windsor Regional	**93,717**	**1,622**	**1.7%**
Hotel Dieu Grace	**117,712**	**4,652**	**4.0%**
Sudbury Regional	153,231	7,886	5.1%
Oakville Trafalgar	79,190	4,103	5.2%
Peterborough RHC	88,353	6,126	6.9%
Kingston	159,640	13,649	8.5%
Trillium HC	155,965	17,144	11.0%
Oshawa General	112,432	12,970	11.5%
Humber River	184,722	21,846	11.8%
Hamilton St. Joe's	140,203	19,100	13.6%
William Osler	214,548	31,584	14.7%
North York General	146,138	24,569	16.8%
Average	1,645,851	165,251	10.0%

LOS Reduction Opportunities Mainly Internal?

The low ALC day rates for the Windsor hospitals suggest that the opportunities to reduce length of stay are more dependent on internal changes, rather than changes in the capacity of post-acute discharge options.

CONFIDENTIAL DRAFT

8.0 Operational Productivity

Pressures to manage operating costs are challenging hospitals to find new ways of doing things, while at the same time demanding that service quality be maintained and even improved. Service delivery is composed of three integrated components, as follows:

- Human Resources – staffing, organization, competencies, training and education
- Technology - "tools" used in delivering services (information systems, equipment, etc.)
- Process - methods and organization of how services are delivered.

The objective of the productivity screen was to identify at a high level potential opportunities where the Windsor hospitals could improve the efficiency and cost effectiveness within selected functional centres and services.

No On-Site Interviews and Observations

On-site reviews and interviews were not conducted in this review. As a result we have not confirmed through on-site observation, interview or analysis the degree and magnitude of improvements in productivity and reductions in cost suggested by the screening.

Performance Comparisons

For purposes of this review it was agreed by the project's Steering Committee that the performance of the Windsor hospitals' functional centres would be compared against a peer group comprised of the following Ontario hospitals:

- Halton Health Services
- Humber River Regional
- Kingston General
- Lakeridge Health Services
- North York General
- Peterborough Regional
- St. Joseph's, Hamilton
- Sudbury Regional
- Trillium Health Centre
- William Osler Health Centre

The peer hospital performance ranges were developed using each hospital's reported 2000/01 data in accordance with the Canadian

CONFIDENTIAL DRAFT

Management Information Systems (MIS) reporting guidelines.[55] The peer data were reviewed, and extraordinary results were removed prior to calculating the performance ranges. Two comparisons of the Windsor Hospitals' functional centres performance were made:

- Comparison based on each Windsor Hospital's 2000/01 performance as reported in the MIS Trial Balance.
- Comparison based on each Windsor Hospital's 2001/02 YTD performance (as of September 31, 2001) as reported to the project team by the hospital.

These two time periods were used for the following reasons to help to identify any areas where data problems might affect one year's results:

- To identify areas where poor productivity in 2000/01 might have been already addressed in 2001/02; and
- To help to identify areas where productivity has significantly worsened in 2001/02.

The comparisons applied productivity (hours per workload or dollars per workload) to 2001/02 workload volumes. Thus, each hospital's calculated potential for both comparisons is based on its most recent workload volumes.

The use of part-year data (2001/02) in these analyses is problematic in that each quarter brings different challenges for a department, so the simple projections used may not be truly representative of year-end performance. Also, for some areas the performance indicator is of the form, "net cost as a percentage of. . . ." These indicator results may be distorted if a department's costs are biased to the beginning or to the end of the year. Despite these concerns, the 2001/02 based comparison does provide useful information to inform the analysis.

[55] While the MIS Guidelines provide a uniform set of reporting guidelines there continues to be vagaries in reporting of workload, staffing and costs among Canadian hospitals. The budget for this project did not allow for reviewing the reporting of comparator hospitals to confirm the accuracy of their data. However, given the number of comparators and the use of the best quartile rather than the 'best practice' performance level, the vagaries in reporting should not have a significant impact on the reasonableness of the performance targets established in this project.

CONFIDENTIAL DRAFT

Where appropriate, the hospitals' 1998/99 and 1999/2000 performance was taken into account.

The performance screening exercise compared each Windsor Hospital's functional centre performance relative to a peer range of performance, as follows:

- Best Quartile Performance Level
- Median Performance Level
- Bottom Quartile Performance Level

The comparison output for each functional centre is a potential savings at that performance level. If the functional centre is already performing at a lower cost than the peer target would suggest, it is assumed that the functional centre would continue to maintain its current productivity and no cost savings are identified.

For some areas the performance indicator is of the form, "net cost as a percentage of. . . ." Potential savings are sometimes identified for such areas even though the current performance is better than the peer performance. This situation occurs since the methodology first reduces the areas upon which the percentage is applied, then the current net cost of the net cost based area is applied to the reduced divisor.

Preliminary Results Reviewed with the Hospitals.

The preliminary results were reviewed with each hospital so that obvious errors/omissions identified in the reported data could be investigated and corrections made as appropriate prior to finalizing the results. Based on the preliminary review of the productivity screening, WRH identified specific areas of concerns related to their reported data:

- Nuclear Medicine workload was unreliable. Nuclear Medicine was excluded.
- Pharmacy workload was unreliable. Pharmacy was excluded.

Issues identified with HDGH data included:

- 2001/02 Housekeeping costs were distorted by early year expenses. The 2000/01 Housekeeping potential was used for both years.
- Pastoral care workload data were unavailable. Pastoral care was excluded.
- Cardiac Catheterization Lab workload appeared to be significantly understated. This functional centre was excluded.

CONFIDENTIAL

The exchange of Obstetrics and Mental Health staffing was already partially represented in the data. For this analysis, however, the data for the inpatient areas were consolidated with the Hospital responsible: Obstetrics and NICU at WRH and Mental Health at HDGH.

It should also be noted that performance screening and recommended productivity targets have been established based on current reporting practices. Any subsequent changes to these reporting practices will require the Hospital to revise corresponding screening and productivity targets accordingly.

Best Quartile Considered to be Reasonable Target for Performance for Functional Centres in Canadian Hospitals

The best quartile (more hours per unit of workload than only 25% of peer hospitals) is considered to be a reasonable expectation of the level of performance for functional centres in Canadian hospitals. Best practice performance (the fewest hours/unit of workload) is not a reasonable target for the purposes of operational/funding review. (However, it is noted that many hospitals are benchmarking and attempting to achieve best practice performance as part of their Continuous Quality Improvement Exercises.)

It is our experience that the best quartile benchmark is only a starting point. After the detailed review of each functional centre, the overall recommended savings are usually about half way between the best quartile and the median potential. We have no reason to believe that the results here would be different from our prior experience if we completed a detailed departmental review.

8.1 Laboratory Services Productivity Review

The Essex Hospitals (WRH, HDGH, and Leamington) have implemented a distributed laboratory service under single management. Leamington is not part of this review. The productivity data for the two Windsor Hospitals were combined for the productivity analysis. It was noted that the productivity at the section level could not reasonably be calculated. Thus, the potential is calculated for the lab overall. In this case the peer data were similarly recast for the comparison. The results of this comparison are shown in Exhibit 8.1.

The best quartile achieved a productivity of 0.0205 worked hours per patient care workload unit (48 patient care workload units per worked hour). The WRH and HDGH combined laboratories

CONFIDENTIAL DRAFT

produced 37.28 patient care workload units per worked hour in 2000/01 and 30.94 patient care workload units per worked hour in 2001/02.

These results suggest the laboratories have a long way to go to become as cost efficient as the hospitals' peers. With median performance the hospitals would have produced the same quantity of laboratory workload with 34.5% fewer staff. Note that the difference between the median and best quartile is relatively small. To achieve the median performance the hospitals would have spent about $2.9 million less in 2001/02.

WRH has estimated the negative impact of restructuring on their laboratory operating costs at $500,000 per year. Even assuming this estimate is accurate and that HDGH is similarly affected ($667,000 based on relative lab expense), there appears to be significant productivity potential of about $1.9 million in laboratory services (using the average of the best quartile and median 2001/02 performance).

These laboratories are presently in temporary locations in the midst of restructuring, so it is not surprising that their productivity does not look good. Hopefully, the hospitals have laid the groundwork for a laboratory services model that will both achieve the goals of Laboratory Reform, and will achieve benchmark productivity. The hospitals' peers have shown that a productivity of 48 patient care workload units per worked hour is achievable, and the Essex Hospitals should target that productivity. Realistically, achieving the target will require completion of further facilities redevelopment. The Laboratories facilities need to be completed at the Metropolitan and HDGH sites. Also, the Grace site must be closed to begin to achieve full productivity.

It is recommended that:

(9) The Essex Hospitals should develop a plan for the Integrated Laboratory Services to achieve a productivity of 48 patient care workload units per worked hour. The timing of implementation to be determined within the Implementation Plan.

CONFIDENTIAL

Exhibit 8.1
Laboratory Services Productivity Potential
(in thousands of dollars)

	@ Best Quartile		@ Median		@ Worst Quartile	
	FTE	$	FTE	$	FTE	$
2000/01 Productivity	(32.7)	(2,003)	(29.4)	(1,802)	(20.9)	(1,288)
2001/02 Productivity	(50.7)	(3,104)	(48.0)	(2,937)	(41.0)	(2,510)

8.2 WRH Productivity Review

Appendix B provides the detailed WRH results of the performance screening component of this review for each functional centre. These screening results are shown in summary in the exhibits below. Exhibit 8.2 shows the potential based on 2000/01 productivity, and Exhibit 8.3 shows the potential based on 2001/02 productivity. These exhibits should be read as "Exhibit 8.2 suggests that there is a potential for WRH to achieve a savings of $8.37 million if functional centres currently performing at less than the best quartile could achieve this level of performance."

Exhibit 8.2
WRH Productivity Potential based on 2000/01 Productivity
(in thousands of dollars)

	@ Best Quartile		@ Median		@ Worst Quartile	
	FTE	$	FTE	$	FTE	$
Corporate Services	(30.9)	(1,375)	(14.7)	(646)	(0.4)	(22)
Hotel Services	(15.9)	(628)	-	-	-	-
Inpatient Nursing	(52.9)	(3,199)	(26.0)	(1,594)	(6.9)	(444)
Outpatient Nursing	(33.5)	(1,866)	(21.3)	(1,188)	(8.1)	(474)
Diag & Therapeutic	(26.0)	(1,301)	(19.2)	(961)	(14.0)	(706)
Potential Range	(159.3)	(8,370)	(81.2)	(4,389)	(29.4)	(1,646)

Exhibit 8.3
WRH Productivity Potential based on 2001/02 Productivity
(in thousands of dollars)

	@ Best Quartile		@ Median		@ Worst Quartile	
	FTE	$	FTE	$	FTE	$
Corporate Services	(40.7)	(1,953)	(21.2)	(1,030)	(7.8)	(420)
Hotel Services	(29.5)	(1,175)	(0.0)	(0)	(0.0)	(0)
Inpatient Nursing	(60.1)	(3,761)	(30.2)	(1,885)	(8.0)	(492)
Outpatient Nursing	(42.7)	(2,529)	(30.2)	(1,790)	(7.4)	(436)
Diag & Therapeutic	(13.4)	(685)	(6.8)	(341)	(1.8)	(84)
Potential Range	(186.4)	(10,103)	(88.3)	(5,046)	(24.9)	(1,432)

CONFIDENTIAL DRAFT

Comparisons between the two years should be made carefully. However, it appears that diagnostic and therapeutic services productivity showed improvement at WRH in 2001/02. At the same time, both inpatient and outpatient nursing productivity grew worse. Corporate services also grew worse, but some of these areas' results may be distorted by one-time expenses incurred early in the year being projected across the full year.

Based on this analysis of departmental performance, WRH would have spent about $5.0 million less in 2001/02 had all functional centres achieved at least median productivity. Operating expenses would have been about $10.1 million less in 2001/02 had all functional centres achieved best quartile productivity.

Based on the 2000/01 best quartile and the median potential, we suggest that a reasonable estimate of the WRH productivity savings potential would be $6.38 million.[56]

8.3 HDGH Productivity Review

Appendix B provides the detailed HDGH results of the performance screening component of this review for each functional centre. These screening results are shown in summary in the exhibits below. Exhibit 8.4 shows the potential based on 2000/01 productivity, and Exhibit 8.5 shows the potential based on 2001/02 productivity. These exhibits should be read as "Exhibit 8.4 suggests that there is a potential for HDGH to achieve a savings of $14.260 million if functional centres currently performing at less than the best quartile could achieve this level of performance."

[56] Based on a simple average between "best quartile" and "median"

Exhibit 8.4
HDGH Productivity Potential based on 2000/01 Productivity
(in thousands of dollars)

	@ Best Quartile		@ Median		@ Worst Quartile	
	FTE	$	FTE	$	FTE	$
Corporate Services	(50.4)	(2,523)	(33.5)	(1,657)	(10.6)	(563)
Hotel Services	(55.2)	(2,019)	(19.0)	(749)	(3.7)	(141)
Inpatient Nursing	(102.0)	(6,030)	(80.0)	(4,703)	(60.2)	(3,445)
Outpatient Nursing	(12.9)	(799)	(9.3)	(583)	(2.1)	(127)
Diag & Therapeutic	(50.4)	(2,889)	(32.6)	(1,886)	(14.5)	(841)
Potential Range	(271.0)	(14,260)	(174.5)	(9,578)	(91.1)	(5,118)

Exhibit 8.5
HDGH Productivity Potential based on 2001/02 Productivity
(in thousands of dollars)

	@ Best Quartile		@ Median		@ Worst Quartile	
	FTE	$	FTE	$	FTE	$
Corporate Services	(70.5)	(3,569)	(54.1)	(2,700)	(28.7)	(1,435)
Hotel Services	(64.6)	(2,443)	(28.0)	(1,155)	(10.0)	(458)
Inpatient Nursing	(71.6)	(4,832)	(47.2)	(3,128)	(13.6)	(839)
Outpatient Nursing	(26.6)	(1,713)	(22.2)	(1,434)	(11.1)	(719)
Diag & Therapeutic	(60.7)	(3,547)	(42.1)	(2,463)	(19.3)	(1,130)
Potential Range	(294.0)	(16,104)	(193.6)	(10,879)	(82.8)	(4,580)

Comparisons between the two years should be made carefully. However, It appears that in all categories productivity declined at HDGH in 2001/02.

Based on this analysis of departmental performance, HDGH would have spent about $10.9 million less in 2001/02 had all functional centres achieved at least median productivity. Operating expenses would have been about $16.1 million less in 2001/02 had all functional centres achieved best quartile productivity. Using these figures, we suggest that a reasonable estimate of the HDGH productivity savings potential would be $13.5 million.[57]

8.4 Operational Disruption of Renovations Activity

Both Hospitals are in the midst of a long-term redevelopment that involves significant renovation of existing space. Such development

[57] Based on a simple average between "best quartile" and "median"

CONFIDENTIAL DRAFT

activity causes much disruption to normal operating processes. This disruption compromises each hospital's ability to achieve full productivity potential.

Operational Disruption of Renovations at WRH

Over the past two years, WRH has relocated the following areas to enable construction:

- Administration
- Day Surgery
- Library
- Food & Nutrition
- Labour & Delivery
- OPI
- Telemetry
- Women's & Children's
- Opened Expanded ER
- CCAC
- Education
- Facilities Management
- Foundation
- Medical Records
- Social Work
- Volunteer Services

The Burn Unit, Oncology and Medical & Surgical beds have been relocated. Oncology floor rooms have been renovated, and the Front Entrance, In-fill and Cancer Centre Construction completed. WRH is about to embark on major redevelopment at the Metropolitan campus that will see continuation of operational disruption for another four years.

Operational Disruption of Renovations at HDGH

Over the past two years, HDGH has accommodated the following changes:

- Opened outpatient psychiatry
- Opened Inpatient Psychiatry, including partial transfer of WRH patients
- All acute psych admissions through HDGH ER
- Upgraded air handling in Jeanne Mance Building
- Relocated Library
- St. John Nursing temporary move
- Relocated & consolidated Health Records
- Diagnostic Imaging (except Nuclear Medicine) moved to new area
- Neurosciences and Nursing Units moved into 8th floor
- Relocated renal dialysis to Hôtel Dieu site

CONFIDENTIAL DRAFT

- Replaced four boilers
- Opened new emergency
- Opened some new ambulatory clinics
- Opened new Operating Rooms
- Laboratory services rearrangement
- Many departmental moves related to the Grace site

HDGH is still in the process of its major redevelopment that will see continuation of operational disruption for another two years.

The effect of renovation disruption must be taken into account when evaluating productivity or cost performance. The impact of such disruption has never been quantified directly. However, in previous analyses of redevelopment options for the MOHLTC, a factor of 5% of OCDM operating cost has been used as a proxy for the operating cost impact during renovations. If such a factor were applied to the potential identified previously for the two hospitals, the current potential would be reduced as shown in Exhibit 8.6 and 8.7.

Exhibit 8.6
HDGH Productivity Potential (in thousands of dollars)

Savings @ Best Quartile Performace	(16,104)	
Savings @ Median Performance	(10,879)	
Savings Target (average of Best & Median)		(13,492)
Less		
OCDM 2000/01 Total Net Cost	114,350	
Renovations Disruption - 5% OCDM		5,718
Net Productivity Potential		$ (7,774)

Exhibit 8.7
WRH Productivity Potential (in thousands of dollars)

Savings @ Best Quartile Performace	(8,370)	
Savings @ Median Performance	(4,389)	
Savings Target (average of Best & Median)		(6,380)
Less		
OCDM 2000/01 Total Net Cost	110,046	
Renovations Disruption - 5% OCDM		5,502
Net Productivity Potential		$ (877)

It is recommended that:

(10) The Board of HDGH should develop an immediate plan to reduce on-going staffing costs by an effective

CONFIDENTIAL DRAFT

$7,774,000. The plan should demonstrate what savings are derived from:

- **Reducing earned hours while addressing existing volumes**
- **Achieving targeted PCOP approved volumes with no additional staff**

(11) The Board of HDGH should develop a plan to reduce on-going staffing costs through improved productivity by a further $5,718,000 to take full effect once redevelopment has been completed.

(12) The Board of WRH should develop an immediate plan to reduce on-going staffing costs by $877,000. The timing of implementation should be determined within the Implementation Plan.

(13) The Board of WRH should develop a plan to reduce on-going staffing costs through improved productivity by a further $5,502,000 to take full effect once redevelopment has been completed.

Timing of Potential Productivity Savings

WRH should be able to develop and implement a plan to achieve $877,000 in operating savings within twelve months.

HDGH is about to open several new and expanded service areas. According to the hospital, productivity performance has been compromised by increasing staffing to be ready for the opening of these areas. The increased workload volumes should provide help in correcting productivity problems. Also, PCOP funding will provide revenue to pay for the staff providing increased volumes of service. These changes should address some of the productivity performance problem and the mismatch between expense and revenue. However, it is expected that additional measures aimed specifically at bringing productivity into line will be required.

CONFIDENTIAL DRAFT

9.0 Capital Redevelopment Projects

The Windsor Hospitals are three years into an integrated redevelopment plan that has at least another six years to complete.

9.1 WRH Redevelopment

WRH Redevelopment includes the following major areas to achieve an acute care services focus at Metropolitan Campus and a long term care services focus at Western Campus. WRH has recently been given approval to proceed to tender with the Metropolitan Campus Expansion Project.

Metropolitan Campus Expansion Project:

- New sub-acute beds
- Birthing Program (New LBRP beds, NICU and Antenatal transfer from Grace site)
- Ambulatory Clinics
- Operating Room expansion
- Critical Care Consolidation
- Paediatrics transfer from Hôtel Dieu site
- Child and adolescent mental health
- Sexual Assault Treatment transfer from Grace site
- Integrated Laboratory Services Project
- Infrastructure upgrades

Western Campus:

- New Specialized Rehabilitation Beds (long term rehab)
- New Complex Continuing Care Beds
- Regional Tertiary Mental Health received in transfer from the former London Psychiatric Hospital now managed and governed by SJH-London

In section 3.0 of this report we noted that the percent of hospital expenditures in Essex County used for non-acute inpatient services was the lowest in the province. The redevelopment at WRH will increase the capacity for non-acute services, and as activity volumes increase, will help to rebalance the mix of acute and non-

CONFIDENTIAL DRAFT

acute services in Windsor. On an interim basis, WRH should, with the MOHLTC, investigate options to increase non-acute service volumes in advance of completion of the redevelopment project.

It is recommended that:

(14) The CEO of WRH should, with the assistance of the MOHLTC, investigate the feasibility of utilizing available capacity at the WRH to provide increased non-acute services in advance of completion of the full WRH redevelopment project.

9.2 HDGH Redevelopment

HDGH Redevelopment provides for the centralization of trauma, cardiovascular, neurosciences, and acute adult psychiatric services at Hôtel-Dieu site and the closure of the Grace Site. It encompasses construction of a New Wing and Renovations at the Hôtel Dieu site, including:

- Diagnostic Imaging Services, including MRI and Nuclear Medicine
- Emergency Department
- Outpatient Clinics
- Surgical Suite
- ICU Beds
- Day Care/Day Procedures Suites
- Dialysis Services
- Rehabilitation Services (short term rehab)
- Inpatient Beds (Cardiac, Neurosciences, Psychiatry)
- Integrated Laboratory Services Project
- Infrastructure Upgrades

HDGH is currently working to complete Phase 4 of its redevelopment, with two more Phases to follow.

9.3 Interdependent Redevelopment

Each Hospital is undergoing a massive transformation to provide a different range of clinical services while consolidating activity to close the Grace site. Redevelopment at each site depends on completion of prior steps at another site. Renovations work

CONFIDENTIAL DRAFT

requires significant staging of activity and relocation of existing services during construction. Both organizations have managed the projects well. There are no issues related to the management of the physical work involved in these capital redevelopment projects.

For the most part, construction has proceeded without undue delay once started. However there have been significant delays in getting started on various phases. The Metropolitan Campus expansion, in particular was delayed more than 3 years. Poor soil conditions were discovered after initial planning was completed, forcing the project to a halt while additional funds were secured to finance the work.

The impact has been felt on project cost, overall project delay, and operations. The OB/Psych transfer transition has been extended, the closure of the Grace Site delayed, and the conversion of the Western campus delayed by years as a result of these problems that were beyond the control of the hospitals.

9.4 Project Financing

The Hospitals draw upon a range of sources for capital financing. These include:

MoHLTC/Superbuild Fund – Each hospital has received significant advances on the MOHLTC share of project cost.

HDGH Capital Fund – HDGH has paid $15.0 million from its capital fund for the costs of Phases 1 through 4.[58]

WRH Foundation – The Windsor Regional Hospital Foundation has about $16.0 million. It has committed to cover HSRC mandated construction costs "providing hospital operates with balanced budget to meet capital needs not covered by HSRC orders and funding"

Together in Caring – This community based fundraising initiative has had a fundraising goal of $40.0 million. The proceeds are shared among the three hospitals in Essex County. Whether or not this goal is achieved, the initiative is scheduled to expire in December, 2002.

[58] The total project costs for Phases 1 to 4 have been $70.5 M. $49.2 M has been provided by MOHLTC/SuperBuild grants (including some for Phases 5 and 6), $6.3 M from Together in Caring, and $15.0 M from the HDGH capital fund.

CONFIDENTIAL DRAFT

When the Together in Caring campaign realized that it might not reach its goal, the Windsor hospitals each agreed to pledge to provide their share of the anticipated $4 million shortfall through internal fundraising.

It is recommended that:

(15) The Chairs of the Boards of the Windsor hospitals should initiate a review of their approach to fund raising and their capacity to raise the "local share" funds required to complete hospital restructuring in Windsor.

(16) The Chairs of the Boards of the Windsor hospitals should develop appropriate independent and joint initiatives to continue the fund raising effort after the Together in Caring program is completed.

9.5 HDGH Project Cash Flow

HDGH is in a very difficult position. As noted in Chapter 4, the Hospital borrowed $20.8 million from its capital fund in order to maintain its daily operations. At this point, the Hospital has no more cash to continue with its capital development pending the repayment of the $20.8 million by the operating fund. The Hospital will need all of that money to help to pay for its portion of the remaining capital redevelopment costs. The remaining project costs are shown in total in Exhibit 9.1.

Exhibit 9.1
HDGH Capital Redevelopment Costs
(in thousands of dollars)

Year		Total
2002/03	$	10,900
2003/04	$	17,700
2004/05	$	10,900
2005/06	$	6,800
Total	$	46,300

It is unrealistic to assume that the hospital's redevelopment will be unaffected by the hospital's financial situation. In fact it appears that the Hospital does not have sufficient funds to complete Phases 5 and 6. The ministry has confirmed that there will be no capital funds available for HDGH beyond the total approved to date

CONFIDENTIAL DRAFT

including the $12.3 million increase in the MOHLTC capital grant announced on May 6, 2002.

Without funds it will be necessary to delay or reconfigure plans for completion of Phases 5 and 6. Because of the interdependencies, a delay in completion of Phases 5 and 6 could also affect WRH.

It is recommended that:

(17) The Board of HDGH should consider modifications to Phases 5 & 6 of the capital plan to ensure that any renovations required to enable closure of the Grace site be planned with a cost not to exceed available ministry and local capital funds.

(18) The Board of HDGH, in consultation with WRH and the MOHLTC, should prepare a contingency plan to mitigate the potential impacts of delay in completion of Phases 5 and 6.

9.6 WRH Project Cash Flow

WRH capital financing is in place provided the Foundation is not called upon to assist with the fall out of operating funding shortfalls. WRH's remaining capital redevelopment costs are shown in total in Exhibit 9.2.

Exhibit 9.2
WRH Capital Redevelopment Costs
(in thousands of dollars)

Year	Met Campus	Western Campus	Total
2001/02	$ 10,542	$ 1	$ 10,543
2002/03	$ 10,621	$ 2,525	$ 13,146
2003/04	$ 29,412	$ 10,098	$ 39,510
2004/05	$ 28,595	$ 10,098	$ 38,693
2005/06	$ 13,072	$ 2,524	$ 15,596
Total	$ 92,242	$ 25,246	$ 117,488

9.7 PCOP Development

HDGH PCOP Development is discussed in some detail in Chapter 11. It appears that the MOHLTC could flow additional operating

CONFIDENTIAL DRAFT

dollars to HDGH through the PCOP if HDGH could satisfy the reporting requirements.

WRH has not begun PCOP development. It appears that the MOHLTC could flow additional operating dollars to WRH through the PCOP for the now completed ER expansion. WRH must apply for this funding. A PCOP submission is also required for the planned opening of CCC and rehabilitation beds at the Western campus in 2002/03.

MOHLTC funding provided through the PCOP is designed to cover the additional costs of planned incremental volumes. The calculation of funding approval is based on a high level calculation involving volume and rate (such as 100 weighted cases at $3,000 per weighted case). Detailed line by line resource requirements planning is required internally to manage within funding provided by such high level formulae.

It is recommended that:

(19) The HDGH CFO should complete the MOHLTC PCOP application data requirements to secure available funding.

(20) The HDGH CFO should develop a comprehensive multi-year operating plan to ensure that HDGH can manage expected additional volumes within the funding provided.

(21) The WRH CFO should complete the MOHLTC PCOP application to secure available funding.

(22) The WRH CFO should develop a comprehensive multi-year operating plan to ensure that WRH can manage expected additional volumes within the funding provided.

9.8 OB/Psych Program Transfer Agreement

In January, 2000, WRH & HDGH agreed to begin the process of consolidating program responsibility for Obstetrics with WRH and for Mental Health with HDGH as directed by the HSRC. The rationale for moving forward in advance of facilities being ready was that the transfer would require significant planning to ensure that services were organized and staff trained to each

CONFIDENTIAL DRAFT

organization's satisfaction. To try to do that in the midst of relocating staff and patients into new facilities would be too much. It was also expected that the construction at WRH Metropolitan Campus would move forward much sooner than has been possible.

As it turns out, it will be another two years before the OB activities at the Grace site can move to the Metropolitan Campus. This temporary arrangement has created some friction between WRH & HDGH:

- The agreed staffing costs at transfer (original calculation of staffing cost for Obstetrics was $5,824,000, for Mental Health was $3,075,000) were both underestimated. According to analysis by WRH, the net annual WRH shortfall, at the time of the transfer was $551,087. WRH has estimated that the shortfall has subsequently increased to $1.5 million, because of a combination of wage rate increases, obstetrical volume increases, and mental health bed reductions. (Since HDGH has not been in a position to make up the difference, WRH apparently withheld $500,000 of the physician job action funding that had been flowed through WRH that was intended for HDGH.)
- Sometime after the original agreement was struck, inpatient Psychiatric beds were closed at the Metropolitan Campus and a smaller number of Psychiatric beds was opened at HDGH. The net decrease was 28 beds. WRH feels that their payment to HDGH should be significantly reduced as a result. It has also been noted that the MOHLTC had a moratorium on acute mental health bed closures during this period.

Other issues related to this arrangement include:

- Mismatch between the CIHI data hospital identification and the organization actually responsible for the patients at both hospitals (See Chapter 6)
- The accounting approaches used by the hospitals are different, but both potentially lead to the overstatement of hours & FTE, revenues and expenses. (There are no improprieties in the accounting, but different valid approaches can give different results. That affects comparability and understanding of the story that the financial record is supposed to tell.)
- The arrangement covers only staff and staff costs. Supplies, equipment, and other non-labour costs are not included.

CONFIDENTIAL

With the many issues facing HDGH and WRH that require their joint effort and cooperation, it is important to address and eliminate the friction being caused by this partial program transfer arrangement. The hospitals should reopen the program transfer agreement, and with the assistance of the MOHLTC (and a facilitator, if needed) revise the agreement to make it more fair to each hospital and to ensure that consistent accounting and reporting approaches are used.

It is recommended that:

(23) The WRH and HDGH Boards should revise the program transfer agreement to ensure fairness to each hospital and the use of consistent accounting and reporting approaches.

(24) The Board of HDGH should develop a plan to open the full directed complement of acute adult mental health beds within the existing operating funds including the funds received in transfer for the beds from WRH.

CONFIDENTIAL DRAFT

10.0 Medical Staff Organization and Management

Impact of Physician Shortages

In section 3 of this report we discussed the Windsor and Essex County physician workforce. During interviews we were told that physician shortages in the community increased the reliance of the population on the Windsor hospitals for health services and hindered early discharge of inpatients. We were also told that the workload concerns of physicians with hospital privileges reduces their ability and willingness to participate in administrative activities or provide clinical coverage without supplemental compensation.

Influence on Decision Making

Board and management decisions (particularly at HDGH) are heavily influenced by consideration of the potential impact of the decisions on the perceived fragility of the medical staffs. An example of this was the recent development of a proposal to temporarily redevelop the Grace site to accommodate all of the birthing activity in the city.

Grace Site Redevelopment Proposal

The proposal was a response to the HDGH anaesthetists' announcement that because of the delays in consolidation of obstetrics at WRH, and the ongoing requirement to cover both the Hôtel Dieu and Grace sites, anaesthetic coverage would no longer be provided at the Grace site after June 2002. The proposal, which was presented to a joint meeting of the executive committees of the Windsor hospitals (and not at the JEC), identified a one time cost of $3.7 million and an ongoing operating cost of $3.8 million. Without exception, all administrative staff and Board members asked about the proposal stated that it had been an obvious "non-starter", but that it had been necessary to allow the proposal preparation and presentation to proceed so that the medical staffs could participate in joint problem solving.

At the end of the meeting the decision was made to circulate the proposal to the two Boards and in parallel work on a back-up plan. At the next HDGH Board meeting the Board agreed that the proposal should be submitted to the MOHLTC, on the condition that both the capital and operating costs should be considered to be WRH costs (an explicitly identified principle in the plan had been that HDGH would contribute resources for indirect/support services). Subsequently, after the WRH anaesthetists offered to cover the Grace site without the proposed site redevelopment and consolidation, the HDGH anaesthetists decided to continue to provide coverage.

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Call for Greater Coordination of Medical Staffs

During the discussion of the Grace site anaesthesia issue some participants called for the Windsor participants to "get our act together as a medical community" and stated that "our physician manpower problems will drive us to the solution of city-wide call groups".

Currently, each hospital maintains a separate medical staff through discrete credentialling and reappointment processes. Many physicians (not all) have privileges at both hospitals.

Varied Approaches to Coverage

Some specialties provide coverage to both hospitals (e.g., cardiology, gastroenterology, plastics, and orthopaedics). Some specialties provide coverage at only at one site (e.g., radiology, general surgery, and anaesthesia). We were told (and we agree) that physicians have excessive flexibility to determine their own call schedules and coverage models.

Subspecialty ER Call

Emergency call is provided by primarily by subspecialties. The subspecialty call model is onerous for various specialty departments and subspecialty divisions. There are insufficient medical staffs to fully staff both hospitals using this model and it does not guarantee optimal coverage of the emergency department. Shortages are most pressing in:

- Internal Medicine
- Cardiology
- Psychiatry
- Obstetrics and Gynecology

Primary Care Involvement and Hospitalists

In general, most Windsor primary care physicians have largely disengaged from the hospitals. The HDGH has established a hospitalist model for unaffiliated patients, whereby a defined group of family practitioner assume responsibility for these patients. WRH has established a hospitalist model whereby family practitioners are offered the opportunity to participate in providing coverage for unaffiliated patients. While the HDGH model is perceived to limit family practitioner involvement in hospital care, the WRH model allows a small subset of family practitioners who wish to stay involved in hospital care the opportunity to do so.

Collaboration Between WRH and HDGH

The Windsor hospitals have had a history of competing with each other. Collaboration is improving, but is still sub-optimal in key areas such as:

- Recruitment

CONFIDENTIAL DRAFT

- Joint physician human resources planning
- Utilization management
- Potential for service rationalization.

There continues to be a dynamic tension between the two hospitals about maintaining a fair balance of clinical services at their separate sites.

Increased Teaching Role

On October 1, 2001, the Minister of Health and Long-Term Care announced that the University of Western Ontario would establish a new clinical education campus in Windsor. One goal of this initiative is to increase the number of physicians who may opt to practice in Windsor and the surrounding rural areas. It is anticipated that the first residents will enter the network program in July of 2002 with the intention to develop a full clinical clerkship for third-year medical students in Windsor by 2004. The hospitals are working together to prepare for the expansion of the teaching role of the Windsor hospitals and further collaboration with respect to outstanding medical staff issues will be important.

Physician Influence on Hospital Competition

Having two separate medical staffs has encouraged physicians to play one hospital against the other (e.g. in order to get the best possible financial deal or best operating conditions). Specialty groups at one hospital have threatened to leave to go to the other hospital in order to exact concessions. Physician practice preferences also influence where programs and services are located.

Physician Remuneration

There are increasing expenditures at each hospital for physician stipends for patient care:

- Hospitalists
- Emergency physicians
- General medicine (HDGH)
- Anaesthesia
- Others

The financial commitment is offset by physician fee for service billing in some, but not all, cases. Physician groups have been able to enhance compensation arrangements at each hospital by threatening to withdraw services.

HDGH medical administration and on-call coverage costs have increased by $4.6 million, an 18-fold increase since 1998/99.

WRH medical administration and on-call coverage costs have increased by $2.3 million, a 9-fold increase since 1998/99. Both hospitals are individually reviewing their physician compensation policies and defining the associated performance expectations (both clinical and administrative) of the physicians receiving the payments. This review should be conducted jointly, and should include assessment of compensation rates, since each hospital is directly impacted by the rates paid by the other.

It is recommended that:

(25) The CEOs of the Windsor hospitals should initiate a joint review of medical reimbursement policies and rates to ensure that a standardized approach is followed.

Recruitment Challenges

Historically, the Windsor hospitals have recruited physicians separately and often in competition with each other. Recently there has been more shared recruitment, but this appears to have been on an ad hoc basis only (e.g. Director of Laboratory Medicine, ER physicians, Neurology, etc.). Recruitment may no longer be competitive, but it is not yet fully coordinated.

The Regional Physician Human Resources working group of the JEC, in their April 2001 report, identified potential recruitment strategies, but did not recommend any formal approaches to joint recruitment. The mandate of the working group as reported in the July 2000 JEC minutes had included the "development of a more coordinated recruitment strategy". The September 19 2001 report to the JEC from each hospital identified their individual recruitment initiatives, with no suggestion that a coordinated effort was in place or being considered.

Discouragement of New Recruits by Existing Medical Staff

We were told of examples of situations where potential recruits for specialties for which there is an acknowledged shortage (particularly surgery and anaesthesia) in Windsor were discouraged to come by the staff already working in Windsor. This discouragement of potential recruits was attributed to concern of the existing staff about negative impact on their income if additional medical staff is added. Thus, while over-work and stress was identified as a major concern for specialists, this concern may be balanced by concern about lost income associated with reduced workload in the current fee for service environment.

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Informal Pressure on Potential Recruits to Withdraw Applications

When we asked to review data regarding medical staff applications and disposition of the applications at HDGH, we were told that this data would not demonstrate rejection of applicants. This is because the pressure on applicants to withdraw their applications was informal and linked to cautions that the existing staff would not be willing to give up OR or clinic time to accommodate newcomers. Thus applicants withdraw their applications prior to formal consideration by the MAC and the Board.

Recruitment to the Windsor hospitals may be affected by external perceptions that the medical politics in Windsor are intense and that the Windsor physician community does not welcome new physicians.

Credentialling

The April 2001 Regional Physician Manpower Planning report to the JEC recommended that:

"A common credentialling process be considered by the three area hospitals. The advantages of a joint approach include the following:

- Ease and accessibility of candidate to apply to all three hospitals with a single application form
- Efficient use of resources for hospitals to establish the authenticity of, and investigate the qualifications of each applicant for appointment
- Standardized criteria for credentialling of physicians/dentists coming to Essex County."

In September 2001 the JEC asked that a meeting of the Chiefs of Staff and CEOs of the three hospitals be held to discuss a common credentialling process.

In February 2002 it was reported to the JEC that a single credentialling committee was not "the best solution, at this time", but that "a common database may be more feasible." Common credentialling could be achieved by:

- Sharing information of individual's credentials between the hospitals
- Standardizing, where possible the information to be collected by each hospital
- Developing a common credentialling policy amongst the hospitals

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We do not believe that the proposed approach will provide the benefits of the joint approach proposed in the Regional Physician Manpower Planning report and urge the hospitals to move to a shared credentialling process.

Medical Staff – Board Relations

Representation at the hospital Boards is through the Chief of Staff and Medical Staff Association leadership at each hospital. The physician leadership at each site feels that physicians are well represented at the Board, and that both Boards are receptive to physician input. The physician leadership feels that the Boards have acted responsibly regarding supporting and maintaining the quality of medical care in the Windsor hospitals. The rank and file medical staffs at each hospital appear to feel that the Boards do not sufficiently understand physician issues. Some members of the physician leadership expressed concern that physicians have too much control and influence on the Boards (and administration) by virtue of the fact that Windsor is a "seller's market" for physician services.

Medical Staff - Management Relations

The physician leadership regards relations with administration as productive at both hospitals. There have been more challenges historically at HDGH than at WRH, but the situation is seen to be improving. Much of the discussion at HDGH administrative committee meetings is focused on physician issues.

Physician-administration relationships at both hospitals have been more collaborative in the last three years. There has been growing identification of, and work toward common goals. Shared concern about under-funding of hospital services in Windsor and concern about the prolonged restructuring process, has united the Boards, administration, and medical staff.

Physician shortages, and the fear of the risk of further departures of medical staff, causes management at both hospitals to be cautious about resolving call, coverage, and further rationalization of clinical services issues.

Joint MAC

Under the Public Hospitals Act, each hospital must have its own MAC. However, there are models in use in Southwest Ontario whereby the MACs of separate hospitals meet and work together (e.g. London, Sarnia, Chatham). It is possible to have a joint MAC that can act as the MAC for each hospital. It would have to be separately constituted at each hospital, with a common membership (i.e. all physicians would have privileges at both

CONFIDENTIAL

hospitals), and each meeting would serve as a MAC meeting for both hospitals.

In Sarnia, the joint MAC was established with the direction that the hospitals would "develop a common MAC and appoint a single chair of the MAC and a single Chief of Staff ... to be accountable to the board of directors of each hospital".

While the focused review Steering Committee members acknowledged that there are opportunities for greater medical staff and medical administration collaboration, they urged the consultants to identify the goals of further collaboration, but not to specify that a joint MAC be the vehicle recommended to achieve the goals.

We believe that there are opportunities for the Windsor hospitals to jointly address the medical staff issues associated with physician shortages that impede efficient operation and successful implementation of the HSRC directions. Joint activity is required with respect to:

- Establishment of city-wide call groups for all specialties
- Rationalization of emergency call and identification of mid- to long-term strategies to move away from a subspecialty call system
- Identification of further opportunities for clinical service rationalization, where low volumes at one site make coverage difficult and are below critical mass requirements
- Joint credentialling across the three Essex County hospitals
- A coordinated and non-competitive approach to physician recruitment
- Development of, and monitoring of adherence to, common clinical protocols
- Common utilization management and reporting
- Preparation for the increased teaching role of the Windsor hospitals

Contrary to the view expressed by members of the focused review steering committee, we believe that the history of competition between the hospitals and the slow progress in increasing cooperation and coordinating medical staff initiatives requires a more formal and structured approach, such as can be obtained with a single medical staff.

CONFIDENTIAL
DRAFT

Consequently, we recommend that a joint MAC be established for the Windsor hospitals, to provide joint leadership of the medical and dental staff. Under this model, there should be a single chief of the major programs (e.g., single chief of medicine, single chief of surgery, etc.) responsible for the program at both hospitals.

It is recommended that:

(26) The Boards of the Windsor hospitals should develop a joint MAC and appoint a single chair of the MAC and Chief of Staff to be accountable to the Board of directors of each hospital.

(27) The Boards of the Windsor hospitals should work towards establishment of a single medical staff for the Windsor Hospitals.

CONFIDENTIAL
DRAFT

11.0 Decision-Making

A specific objective of the focused review (as identified in the Request for Proposal) has been to conduct a "review and assessment of the hospitals' planning and decision-making processes". The primary information source for this review has been the written documentation of planning decisions, especially meeting minutes. Information obtained from a limited number of interviews has also been used to supplement the written materials.

The focus of the review of decision-making has been to try to understand the relationship between the decision-making processes and the resulting decisions to the operational and financial pressures now faced by the Windsor hospitals.

Hospital Board and Administration Responsibility for Fiscal Integrity of Hospital

Our evaluation of the decision making processes and decisions is based on our understanding of the responsibilities of hospital boards in Ontario, and the role of the administration in supporting the Board in fulfillment of these responsibilities. A fundamental responsibility of the hospital board is the fiscal integrity of the hospital and its long-term solvency. It is accountable to:

- the hospital's corporation,
- the community and
- the province acting on behalf of that community

for the long-term viability of the hospital. The board should be monitoring and ensuring the effective fiscal management of the hospital. The fiscal solvency of the hospital is critical to its ability to respond to the care requirements of the community. Hospital boards that allow the hospital's debt to exceed the its ability to repay that debt are putting the hospital, its ability to provide service to the community and the health of the community at risk. This is not good or reasonable stewardship of public and charitable funds and is not in keeping with the board's and the hospital corporation's long-term obligations to its community.

Appendix C contains a description of some of the governance and management structures and processes at the Windsor hospitals that impact decision-making. Rather than repeat these descriptions, this section of the report highlights the decision-making processes and decisions that have most contributed to the current financial situation of the Windsor hospitals. Other decisions that have impacted the financial status of the hospitals have been previously described in the financial history sections of this report.

CONFIDENTIAL DRAFT

WRH Decision-Making and Decisions

For the most part WRH has been fiscally conservative in its decision-making and so there is little to say about the processes or the outcomes. We do believe that there are opportunities for WRH to reduce expenditures and to contribute towards financial recovery, and these opportunities have been previously identified in this report.

It is important that the WRH Board and management maintain their fiscally conservative approach even as they proceed through the operationally difficult Metropolitan campus construction.

11.1 HDGH Operational Planning and Budgeting

"Ramping Up"

The current financial situation of the HDGH is almost entirely attributable to the costs of restructuring and redevelopment and the Hospital's decisions to incur these costs in the magnitude that they were incurred. One key decision has been to incur additional operating costs by increasing staffing for the redeveloped facilities far in advance of the expanded workload actually occurring. HDGH has described this as "ramping up", and it has been a conscious strategy employed to ensure that the hospital will be prepared to respond to new demands immediately upon opening new and redeveloped facilities. There was a sense of urgency at HDGH to fulfill the HSRC directives. The HDGH ramping up should be differentiated from increases in staffing in conjunction with increased workload; the HDGH ramping up involved increases in staffing long before the arrival of the increased workload, and caused reduced productivity across the hospital.

Justification for Ramping Up

HDGH administration and Board have considered ramping up to be a reasonable approach to preparing for the restructured hospital (and the anticipated and directed increased volumes) because:

- The challenges of recruiting and retaining medical and other staff in Windsor are so great that additional resources must be used to preserve teams and programs and support recruitment and retention
- The high needs for health care services of the Windsor and Essex County population mean that HDGH should be prepared to provide the HSRC directed volume of services immediately upon availability of the redeveloped facilities.

CONFIDENTIAL DRAFT

- Ramping up is particularly necessary for the OR and other specialized areas, where it may require 6 to 12 months to get nursing staff "up to speed"

Ramping Up Strategy Communicated to MOHLTC

HDGH administration and Board members reported that the ramping up strategy had been clearly communicated to the MOHLTC and that they had received no formal indication that it was inappropriate. The 2001/02 HDGH operating plan clearly described the "ramping up" of staffing in anticipation of providing the HSRC directed volumes, and refers to this as part of the PCOP.[59]

Contrast in Approaches

During the HDGH Board 2001/02 budget development discussions, the approaches of WRH and HDGH were contrasted:

"Windsor Regional is indicating that if the money does not flow than they are not moving forward with operational or capital improvements. On the other hand, [Hôtel Dieu Grace] will be indicating to the Ministry that we are moving forward in any event, that we need to maintain functioning teams in order to resolve recruitment and retention issues and the only way to do that is to move forward."[60]

Ramping up (in the sense of preparing for future workload) would seem to be different from maintaining functioning teams and resolving recruitment and retention issues, since these, alone, do not necessarily suggest increasing staff. (Staffing has increased in an all areas of the Hospital, not just those where the functional program shows growth, suggesting that these additional reasons may have contributed to the thinking behind decisions to increase staffing).

No PCOP Prohibition on Ramping Up… But No Guarantee of Funding

HDGH staff reported that they had "carefully reviewed the PCOP submission requirements DRAFT guidelines and related correspondence and can find no prohibition of hiring staff and "ramping up" in advance of HSRC directed programming".[61]

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[59] While the HDGH operating plan identifies the increases in staffing and links these increases to the anticipated volume increases incorporated in the PCOP, it does not specify how far in advance of the arrival of the increased volume the staff would be in place.

[60] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 28 March, 2001

[61] April 29 2002 HDGH Letter to consultants re: PCOP Ramp-Up and Communication with MOHLTC.

CONFIDENTIAL DRAFT

We agree that there is no prohibition to ramping up, but there is also no reason to anticipate that additional MOHLTC funding will be provided to support the ramping up. A hospital cannot reasonably proceed with incurring additional operating expenses without first identifying and confirming the source of the additional funds required to support the increased costs.

PCOP Process

The MOHLTC Post Construction Operating Plan (PCOP) process does accommodate funding adjustments in advance of arrival of workload, but the time frames involved are usually a few months, and operating funding increases are subsequently adjusted to reflect the workload increase that actually occurs. The PCOP process supports adjustments to operating funding on the basis of actual changes in workload. It does not address changes to the base funding of a hospital without increases in patient volume.

HDGH reported that it was only in the latter part of 2001 that they were advised that operating funding increases would only be provided following actual workload increases, and that funding would not be provided to support the ramping up strategy.

MOHLTC Communications Link Funding Increases with Volume Changes

In a June 13 2000 memorandum to all Ontario hospital Board chairs and CEOs, the ADM announced that the MOHLTC "will manage the necessary operational funding adjustments [for HSRC directed capital projects] through the use of PCOPs". The memo stated that "Funding adjustments will be focused on service changes. This approach differs from the historical approach." The guidelines attached to the memo identified the hospital's responsibility for identifying all operational service volumes as they are expected to be after the project completion. The PCOB process (which preceded the PCOP process) also did not provide funding for staffing in advance of commissioning of new facilities and space.

Responsibility to Operate within Means

The HDGH Board and management have consistently worked towards ensuring that HDGH could provide the volume of service directed by the HSRC to be available in 2003. However well intentioned, the long-term focus on ensuring that the redeveloped physical infrastructure would be in place, and that the medical and other staff would be ready, has taken precedence over the more immediate focus on the hospital's operating position. Whether opening new facilities or operating ongoing services, all hospitals have a responsibility to operate within their means. HDGH has acted boldly in a desire to open new facilities at full speed, but actual volumes are not increasing, and actual volumes are most

CONFIDENTIAL

likely to increase gradually. The hospital Board and administration have addressed a range of challenges of preparing and moving into new facilities, but by adding staff, they have created a more difficult problem with the result that the financial viability of the organization is at risk.

It is recommended that:

(28) The Board of the HDGH should stop all hiring pending development of the recovery plan.

(29) The CEO of the HDGH should develop a plan to deploy staff to new service areas aligned with the MOHLTC accepted elements of the PCOP submission.

11.2 HDGH Capital Planning, Financing, and Management

As noted in Chapter 4, the practice of inter-fund borrowing has landed the Hospital in a very difficult position. The Hospital borrowed $20.8 million from its capital fund in order to maintain its daily operations.[62] Because of this use of the Hospital's capital funds, the Hospital has no more cash to continue with its capital development pending the repayment of the $20.8 million loan from the operating fund.

It is recommended that:

(30) The Board of the HDGH should not approve loans of funds from the capital fund to the operating fund without a reasonable expectation that the loans can be repaid.

HDGH Capital Equipment Spending

The redevelopment has included some of the most capital-intensive areas of the hospital including diagnostic imaging, operating rooms, and CSR. However, HDGH appears to have spent more than prudent on its capital equipment, given the hospital's financial position. Some background is noted:

[62] The HDGH Capital Fund has also contributed $15.0 million towards the Phase 1 through 4 project costs. The consultants were advised by HDGH that any funds in the Capital Fund that were restricted to use for capital projects were used only for these project expenditures and were not part of the loan to the operating fund.

CONFIDENTIAL DRAFT

- The MOHLTC has a long-standing policy to only fund new equipment as part of facilities redevelopment projects. Funding is not provided to replace existing equipment deemed too old to use in the new facilities.
- The MOHLTC provided a generous equipment approval of $15.5 million for the project. The amount technically exceeded MOHLTC guidelines for equipment funding for capital projects.
- HDGH has spent about $18.5 million on capital equipment for the project, including $8.0 million for replacement equipment.
- To finish its redevelopment HDGH still feels it needs to spend another $8.8 million on capital equipment

An example of the approach taken to capital equipment replacement by HDGH is diagnostic imaging, where all new equipment was acquired. HDGH management maintains that it was absolutely necessary to replace all of its diagnostic imaging equipment to maintain services during the transition. They were unaware of any other hospital relocating an entire diagnostic imaging department equipment into new facilities one room at a time. This approach would have split the diagnostic imaging department over an extended period of time. The Hospital felt that the distances of a split department to emergency and the operating room would have had a negative effect on patient care. MOHLTC representatives have noted that several hospitals have made such compromises because they felt they did not have the money to buy all new equipment. Availability of fiscal resources does not seem to have been a significant enough factor in HDGH decision making.

Clarification of Future Service Volumes

The HSRC identified future (2003) service volumes by estimating the percent increase in patient volumes based on the population projections available to them at the time of their report. They then translated this estimate of inpatient volume into an estimate of the number of beds that would be required to accommodate the patients. Given that the PCOP process, and associated operating funding changes are driven by service volume changes, rather than simply physical capacity changes, it is incumbent on both the hospitals and the MOHLTC to ensure that functional programs reflect anticipated and approved future service volumes.

For HDGH it is not clear to us that there is the necessary common understanding between the hospital and the MOHLTC as to the future service volumes assumed by the HSRC, or the starting point

for determination of changes in activity. During the review it became clear that there is not agreement about the extent to which these future volumes reflect service increases or decreases, after the program transfers are taken into account.

The general approach of the HSRC was to assume that service volumes (e.g. cases) would stay relatively constant, but that efficiencies would be obtained by reducing lengths of stay, eliminating ALC days, and shifting inpatient activity to ambulatory care. Once these efficiencies were obtained, any HSRC projected increase in beds due to growth would necessarily be accompanied by (and due to) an increase in service volumes. The HDGH and MOHLTC should review the HSRC growth estimates and ensure that the HDGH functional program reflects the projected increase in individual program service volumes that would lead to full utilization of the planned bed capacity at the clinical efficiency targets.

It is recommended that:

(31) The HDGH and MOHLTC should review the HSRC growth estimates and ensure that the HDGH functional program reflects the projected increase in individual program service volumes.

11.3 Windsor Hospital Restructuring and the Joint Executive Committee

HSRC Direction for JEC

The Health Services Restructuring Commission (HSRC) directed Hôtel-Dieu Grace Hospital, Leamington District Memorial Hospital and Windsor Regional Hospital to:

"*Appoint a joint executive committee and delegate the powers to make decisions on behalf of the Hospitals which would implement the directions to the Hospitals by the Health Services Restructuring Commission*."[63]

The JEC has established a number of task forces to address specific programs such as paediatrics, maternal/newborns, cardiology, mental health, rehabilitation, etc. These task forces have a mandate to provide advice and recommendations to the JEC.

[63] Joint Executive Committee Terms of Reference, 29 September 1998.

In creating the JEC, the HSRC anticipated a significant role for the JEC. The terms of reference cited above delegated broad decision making authority to the JEC.

JEC Membership

The original membership of the JEC was:

- 5 members each from the Board of Directors of each Essex County hospital (1 of whom is the Chief of Staff)
- One member each from the Board of Directors or executive committee of the Essex County Medical Society, the Windsor Essex Community Care Access Centre, the Canadian Mental Health Association, and Cancer Care Ontario Regional-South
- One member of the DHC who is a resident of Essex County
- The senior staff members of the representative organizations (as ex-officio, non-voting members)

Ministry of Health representatives attend the JEC meetings.

Additions to JEC

Representatives of Essex County long-term care facilities, the Windsor Regional Cancer Centre, and the Windsor/Essex County Health Unit have also been added to the JEC membership. Staff (as well as Board members) from the non-hospital organizations represented on the JEC usually attend the JEC meetings. The JEC has become a very large group, usually with more than 30 people in attendance. The senior nursing officers from the Windsor hospitals do not attend JEC meetings.

Meeting Frequency

The JEC currently meets a minimum of five times per year (every second month with the exception of the summer), with special meetings as required. In 1998 and 1999, the JEC met 7 times. In 2000, it met 6 times. In 2001, it met the minimum 5 times.

JEC CEO Committee

In December 1999 the JEC voted "that the JEC support the formation of a JEC CEO Committee to assist the JEC and to coordinate all activities to the development and implementation of health services restructuring for Windsor Essex County".

The CEO Committee includes the CEOs of the three Essex County hospitals as well as the CEOs or executive directors of the DHC, Windsor Regional Cancer Centre, the CCAC, the Essex County Medical Society, the Windsor-Essex Health Unit, and

CONFIDENTIAL DRAFT

representatives of the Long Term Care Association and the CMHA.[64]

JEC Focus is Communications and Information Sharing

Our review suggests that since its inception, the JEC has increasingly become a communications and information sharing vehicle, rather than a decision-making body. Most of the agenda of each meeting is consumed by updates provided by various county health care agencies. This is attributed by some stakeholders to the lack of progress on restructuring in Windsor (due to delays in capital projects) and the consequent lack of specific restructuring-related issues to be resolved.

Underfunding Frequent JEC Topic

The most frequently raised item at the JEC meetings is the under-funding of health care in Essex County, followed by physician resource planning. On February 14th 2001, after a meeting with the ADM, MOHLTC, where the results of analysis of per-capita funding in Essex County was presented, it was agreed by the JEC that "to move forward with the per capita issue would not be productive at this time". At the next JEC meeting (April 11, 2001), following a discussion of physician shortages, the JEC approved a motion "that there is no substitute for appropriate funding for this area, the Ministry of Health should be held accountable as hospital are for the quality of care (sic)".

Hospital Updates Focus on Construction Projects, Seldom Finances

Updates from the hospitals focus on the status of the construction projects and not the financial capacity of the hospitals to proceed. At the June 14 2001 JEC meeting WRH reported that it was "unable to fund outstanding community commitments (30%) due to its underwriting of the community's share of the cancer centre related projects. The hospital is not prepared to move forward until the financing is in place". No discussion of the ability of HDGH to fund its capital projects was minuted until February 13th 2002, when it was stated that "there have been some money difficulties in proceeding with phase 5".

Some Restructuring Issues Not Raised at JEC

The specific tensions between the Windsor hospitals related to restructuring are seldom raised at the JEC. Indeed, the involvement of many other parties makes the JEC a less appropriate venue for discussion of specific restructuring issues. Examples of outstanding restructuring issues not discussed at the JEC include:

[64] We received conflicting information regarding the ongoing status of the CEO meetings (e.g. we were told that they had been discontinued; the most current meeting minutes we received were for December 14, 2001).

- Review of the ongoing appropriateness of program transfer costing and reconciliation
- Proposal to redevelop the Grace site to temporarily accommodate all obstetrical activity
- Access of all hospitals to programs or services rationalized at a single hospital (e.g. cardiac catheterization, short-term rehabilitation, regional mental health)
- Together in Caring fundraising campaign and decision that hospitals would contribute $4 million to the goal (and options for hospitals to find the additional money)
- Deviations in actual allocation of program activity from that recommended by the HSRC
- Joint recruiting strategies for nursing and other professional staff[65]
- Impact of the differences in the WRH conservative approach to funding restructuring and the HDGH "ramping up" on the progress of restructuring plans.

That these restructuring related issues were not considered to be appropriate for discussion at the JEC table shows us that stakeholders do not necessarily see the JEC as the venue for dealing with all restructuring issues.

Original HSRC Plans for JEC

The HSRC Essex County Health Services Restructuring Report recommended that "each hospital board will delegate decision-making authority to its executive committee on matters relating to the operation of its hospital, including:

- The restructuring of hospital services, the allocation of services and the continuum of care provided to patients
- The implementation of a plan to address the impact of the hospital restructuring, which includes the recommendations from the MOH review of emergency services
- The financial and operating plans for the hospitals
- The promotion of the development of an integrated health system in Essex County

[65] The chief nursing officers of the Essex County hospitals prepared a proposal for a joint nursing recruitment strategy, for submission to the OHA Change Foundation. Upon rejection of the proposal by the Change Foundation, it was not brought forward to the JEC for their consideration.

CONFIDENTIAL DRAFT

- Opportunities for the appropriate integration of shared services to reduce unnecessary duplication."

Focus on Implementation of Restructuring Required

We believe that the Essex County JEC has strayed far from the original role envisioned by the HSRC. The expansion of membership has helped to turn it into an effective communications vehicle regarding health system issues in Essex County but has weakened its focus on implementation of the hospital restructuring plan in Essex county. There is a need to refocus a smaller group on addressing the considerable challenges of implementing hospital restructuring. This might be accomplished by re-establishing a smaller joint executive committee. However, the limited duration of the current JEC,[66] and its mandate to deal with restructuring for all three Essex County hospitals, make it less likely to be effective as a vehicle to deal with the ongoing inter-hospital issues in Windsor.

On-going Joint Meetings of the Windsor Hospital Executive Committees

We believe that there should be regular (e.g. quarterly) joint meetings of the executive committees of the Windsor hospitals (as was done for the Grace site anaesthesia issue), and that these meetings be used to address conflict and ensure coordination between the two hospitals. The joint meetings of the two executive committees can also be used to identify further opportunities for coordination of activity and opportunities to reduce administrative duplication.

Consider Models for Administrative Overlap

Other Ontario communities have established overlapping administrative positions (e.g. single Vice-President Finance for the two London hospitals) or a single administration for two hospitals (Sault Area Hospitals). This has been done while maintaining separate governance for the individual hospitals. While we are not prepared to make a formal recommendation that the Windsor hospitals pursue either of these models, we do believe that they should be considered as the executive committees examine ways to enhance the joint decision making and problem solving between the hospitals.

Implementation Steering Committee

For the purposes of implementation and oversight of the recovery plan developed as a result of this review, there should be an implementation steering committee. This can be an extension of the steering committee for the study and should include Board

[66] The official JEC term has expired, but the participants have voted each year to continue.

CONFIDENTIAL

representatives, CEOs, Chiefs of Staff, Chief Nursing Officers, and the CFOs, as well as MOHLTC representatives.

It is recommended that:

(32) The Executive Committees of the Windsor hospital Boards should meet on a regular basis to address inter-hospital conflicts and coordination requirements.

(33) The Windsor Hospitals Focused Review Steering Committee should be re-constituted as an implementation steering committee, with the responsibility to oversee implementation of the recovery plan.

11.4 Other Comments re Decision- Making Processes

In Camera Board Meetings

The Boards of both hospitals make extensive use of in camera sessions. Both Boards have written policies defining when in camera Board meetings are appropriate. The HDGH policy defines matters of confidentiality as: "public security, personnel matters, property acquisitions, labour relations/negotiations and litigation."[67] WRH Board policy indicates that meetings be held in camera when discussing:

- security and acquisition of property,
- personal matters about an identifiable individual,
- labour relations or employee negotiations, and
- litigation or potential litigation matters.[68]

In past two years, in camera meetings have become more frequent and lengthier. Each in camera meeting lasts between one and two hours. The justifications for holding an in camera meeting, with reference to the reasons given in the Board policies, are not explicitly identified.

It is our opinion that not all in camera issues necessarily require confidentiality – i.e., operating plan presentations, recently ratified

[67] Religious Hospitallers of St. Joseph Health Centre Policy Number 100.C.033.

[68] Windsor Regional Hospital *Policy for Open Board Meetings*, dated 24 November, 1998.

CONFIDENTIAL DRAFT

collective agreements, capital redevelopment issues. Our analysis of in camera agendas and minutes suggest that discussion of issues that may result in poor publicity for the hospital, or that may fuel political debate or community concern, are often referred to in camera meetings. If the Boards of the hospitals believe that political sensitivities justify reliance on in camera meetings, then the Board policies for when in camera meetings should be held should be modified to reflect this.

It is recommended that:

(34) The Board Chairs and CEOs of the Windsor hospitals should limit use of in camera Board meetings to discussion of issues considered to be sensitive or confidential in accordance with written Board policies.

Program Transfer

There appear to be unresolved issues relating to the costing and guidelines for ensuring access for programs transferred between hospitals and for services consolidated in a single hospital. It was not clear that formal Program Transfer Plans had been developed for the programs transferred between the Windsor hospitals. These plans should be developed and refined as required, using the MOHLTC program transfer guidelines as a reference. In addition to the description of the financial and accountability arrangements, there should be explicit identification of the processes by which patients from one hospital will access services or programs located at the second hospital.

It is recommended that:

(35) The JEC should ensure that program transfer plans assure equitable access of all Windsor hospital patients to all Windsor hospital programs and services are developed and periodically updated.

(36) The WRH and HDGH should submit JEC endorsed draft program transfer plans consistent with the ministry's draft guidelines for all relevant services to the MOHLTC for its review and approval within 90 days.

CONFIDENTIAL DRAFT

12.0 Summary of Cost Savings Opportunities and Recommendations

12.1 Summary of Estimated Cost Savings Opportunities

The following table shows a summary of the estimated cost savings opportunities from clinical efficiency and productivity improvement for the Windsor hospitals. More detailed examination of the timing and amounts of savings or efficiencies gained through increased workload volumes, is included in the implementation plan.

Exhibit 12.1
Summary of Estimated Cost Savings Opportunities

Item		HDGH	WRH	Windsor Hospitals Total
Initial Target	Clinical Efficiency Savings	$ 4,984,200	$ 3,566,200	$ 8,550,400
	Laboratory Productivity Improvement			$ 3,020,000
	Other Productivity Improvement	$ 13,492,000	$ 6,380,000	$ 19,872,000
	Sub-Total			$ 31,442,400
Adjustments	Reduction in CE Target	$ (1,495,260)	$ (1,069,860)	$ (2,565,120)
	Reduction in Other Productivity Tgt.	$ (5,718,000)	$ (5,502,000)	$ (11,220,000)
	Total	$ (7,213,260)	$ (6,571,860)	$ (13,785,120)
Net Targets	Clinical Efficiency Savings	$ 3,488,940	$ 2,496,340	$ 5,985,280
	Laboratory Productivity Improvement			$ 3,020,000
	Other Productivity Improvement	$ 7,774,000	$ 878,000	$ 8,652,000
	Total			$ 17,657,280

The appropriateness of the adjustments to the clinical efficiency and operational productivity targets will be dependent on the timing of investment in non-acute services and the timing for completion of the redevelopment projects. For example, the hospitals have indicated that upon completion of redevelopment they will target to achieve the best quartile productivity level.

CONFIDENTIAL

12.2 Listing of Recommendations

It is recommended that:

(1) **The Board of WRH should establish a dialogue with the MOHLTC to develop options for resolving the operating deficit situation at Malden Park Continuing Care Centre.**

(2) **The CEOs of the Windsor hospitals should investigate the feasibility of re-assignment of patient abstract records prior to submission to CIHI to better reflect hospital responsibility for management of the patient stays.**

(3) **The CEO of WRH should request that CIHI include WRH patient records in the proposed Ontario re-abstraction study.**

(4) **The Chiefs of Staff of the Windsor hospitals should initiate a joint project to develop standard clinical protocols for common procedures in the Windsor hospitals.**

(5) **The CEO of HDGH should set clinical efficiency targets that will reduce the length of stay of typical patients to 12.5% below the 2000/01 CIHI expected length of stay over the next two years.**

(6) **The CEO of WRH should set clinical efficiency targets that will reduce the length of stay of typical patients to 12.5% below the 2000/01 CIHI expected length of stay over the next two years.**

(7) **The CEOs of the Windsor hospitals should initiate a review of the current distribution of rehabilitation beds to ensure that it best meets the needs of patients requiring rehabilitation care following acute care, and if necessary, develop a revised local plan for rehabilitation beds for consideration by the MOHLTC.**

(8) **The CEOs of the Windsor hospitals should re-establish the Windsor Hospitals Joint Utilization Management Steering Committee and assign it responsibility for implementation of a plan to meet**

CONFIDENTIAL DRAFT

the clinical efficiency targets identified in the focused review.

(9) **The Essex Hospitals should develop a plan for the Integrated Laboratory Services to achieve a productivity of 48 patient care workload units per worked hour. The timing of implementation to be determined within the Implementation Plan.**

(10) **The Board of HDGH should develop an immediate plan to reduce on-going staffing costs by an effective $7,774,000. The plan should demonstrate what savings are derived from:**

- **Reducing earned hours while addressing existing volumes**
- **Achieving targeted PCOP approved volumes with no additional staff.**

(11) **The Board of HDGH should develop a plan to reduce on-going staffing costs through improved productivity by a further $5,718,000 to take full effect once redevelopment has been completed.**

(12) **The Board of WRH should develop an immediate plan to reduce on-going staffing costs by $877,000. The timing of implementation should be determined within the Implementation Plan.**

(13) **The Board of WRH should develop a plan to reduce on-going staffing costs through improved productivity by a further $5,502,000 to take full effect once redevelopment has been completed.**

(14) **The CEO of WRH should, with the assistance of the MOHLTC, investigate the feasibility of utilizing available capacity at the WRH to provide increased non-acute services in advance of completion of the full WRH redevelopment project.**

(15) **The Chairs of the Boards of the Windsor hospitals should initiate a review of their approach to fund raising and their capacity to raise the "local share" funds required to complete hospital restructuring in Windsor.**

CONFIDENTIAL DRAFT

(16) The Chairs of the Boards of the Windsor hospitals should develop appropriate independent and joint initiatives to continue the fund raising effort after the Together in Caring program is completed.

(17) The Board of HDGH should consider modifications to phases 5 & 6 of the capital plan to ensure that any renovations required to enable closure of the Grace site be planned with a cost not to exceed available ministry and local capital funds.

(18) The Board of HDGH, in consultation with WRH and the MOHLTC, should prepare a contingency plan to mitigate the potential impacts of delay in completion of Phases 5 and 6.

(19) The HDGH CFO should complete the MOHLTC PCOP application data requirements to secure available funding.

(20) The HDGH CFO should develop a comprehensive multi-year operating plan to ensure that HDGH can manage expected additional volumes within the funding provided.

(21) The WRH CFO should complete the MOHLTC PCOP application to secure available funding.

(22) The WRH CFO should develop a comprehensive multi-year operating plan to ensure that WRH can manage expected additional volumes within the funding provided.

(23) The WRH and HDGH Boards should revise the program transfer agreement to ensure fairness to each hospital and the use of consistent accounting and reporting approaches.

(24) The Board of HDGH should develop a plan to open the full directed complement of acute adult mental health beds within the existing operating funds including the funds received in transfer for the beds from WRH.

(25) The CEOs of the Windsor hospitals should initiate a joint review of medical reimbursement policies and

CONFIDENTIAL DRAFT

rates to ensure that a standardized approach is followed.

(26) The Boards of the Windsor hospitals should develop a joint MAC and appoint a single chair of the MAC and a single Chief of Staff to be accountable to the Board of directors of each hospital.

(27) The Boards of the Windsor hospitals should work towards establishment of a single medical staff for the Windsor Hospitals.

(28) The Board of the HDGH should stop all hiring pending development of the recovery plan.

(29) The CEO of the HDGH should develop a plan to deploy staff to new service areas aligned with the MOHLTC accepted elements of the PCOP submission.

(30) The Board of the HDGH should not approve loans of funds from the capital fund to the operating fund without a reasonable expectation that the loans can be repaid.

(31) The HDGH and MOHLTC should review the HSRC growth estimates and ensure that the HDGH functional program reflects the projected increase in individual program service volumes.

(32) The Executive Committees of the Windsor hospital Boards should meet on a regular basis to address inter-hospital conflicts and coordination requirements.

(33) The Windsor Hospitals Focused Review Steering Committee should be re-constituted as an implementation steering committee, with the responsibility to oversee implementation of the recovery plan.

(34) The Board Chairs and CEOs of the Windsor hospitals should limit use of in camera Board meetings to discussion of issues considered to be sensitive or confidential in accordance with written Board policies.

CONFIDENTIAL DRAFT

(35) The JEC should ensure that program transfer plans assure equitable access of all Windsor hospital patients to all Windsor hospital programs and services are developed and periodically updated.

(36) The WRH and HDGH should submit JEC endorsed draft program transfer plans consistent with the ministry's draft guidelines for all relevant services to the MOHLTC for its review and approval within 90 days.

CONFIDENTIAL
DRAFT

13.0 Implementation Plan

The Hospitals and MOHLTC representatives who will form the Steering Committee for the Implementation Plan have developed the following plan. It is anticipated that this group will monitor and adjust timeframes, clarify expectations, and ensure that recommended targets are achieved."

Implementation Plan			Timetable		Accountable
Hospital	Recommendation	Action	Start	Complete	Position
WRH	(1) The Board of WRH should establish a dialogue with the MOHLTC to develop options for resolving the operating deficit situation at Malden Park Continuing Care Centre.	Make formal request to Ministry to begin meetings	Jun-02	Dec-02	CEO - WRH
HDHG & WRH	(2) The CEOs of the Windsor hospitals should investigate the feasibility of re-assignment of patient abstract records prior to submission to CIHI to better reflect hospital responsibility for management of the patient stays.	The CEOs of the Windsor hospitals should investigate the feasibility of re-assignment of patient abstract records prior to submission to CIHI to better reflect hospital responsibility for management of the patient stays.	Jun-02	Jun-02	CFOs - HDGH & WRH
WRH	(3) The CEO of WRH should request that CIHI include WRH patient records in the proposed Ontario re-abstraction study.	Make formal request to CIHI and advise Ministry of response from CIHI	Jun-02	Jul-02	CEO - WRH
HDHG & WRH	(4) The Chiefs of Staff of the Windsor Hospitals should initiate a joint project to develop standard clinical protocols for common procedures in the Windsor hospitals.	Form Joint Task Force to develop & recommend shared protocols, including implementation plan for approval by Boards	Sep-02	Jun-03	COSs - HDGH & WRH
HDGH	(5) The CEO of HDGH should set clinical efficiency targets that will reduce the length of stay of typical patients to 12.5% below the 2000/01 CIHI expected length of stay over the next two years.	Develop and submit detailed workplan to achieve clinical efficiencies within 2 years and capture recommended savings.	May-02	Sep-02	CEO - HDG
WRH	(6) The CEO of WRH should set clinical efficiency targets that will reduce the length of stay of typical patients to 12.5% below the 2000/01 CIHI expected length of stay over the next two years.	Develop and submit detailed workplan to achieve clinical efficiencies within 2 years and capture recommended savings.	May-02	Sep-02	CEO - WRH

CONFIDENTIAL

Implementation Plan			Timetable		Accountable
Hospital	Recommendation	Action	Start	Complete	Position
HDHG & WRH	(7) The CEOs of the Windsor hospitals should initiate a review of the current distribution of rehabilitation beds to ensure that it best meets the needs of patients requiring rehabilitation care following acute care, and if necessary, develop a revised local plan for rehabilitation beds for consideration by the MOHLTC.	Form Joint Task Group to evaluate, assess impact and make a formal recommendation to Boards and Ministry	Jul-02	Sep-02	CEOs - HDGH & WRH
HDHG & WRH	(8) The CEOs of the Windsor hospitals should re-establish the Windsor Hospitals Joint Utilization Management Steering Committee and assign it responsibility for implementation of a plan to meet the clinical efficiency targets identified in the focused review.	Re-constitute Joint UM Steering Committee with updated terms of reference and accountability for development and monitoring of joint clinical efficiency initiatives, targets and implementation plans to be submitted to Boards for approval. Committee representation to include CCAC & LDMH	Jun-02	Sep-02	CEOs - HDGH & WRH
HDHG & WRH	(9) The Essex Hospitals should develop a plan for the Integrated Laboratory Services to achieve a productivity of 48 patient care workload units per worked hour. The timing of implementation to be determined within the Implementation Plan.	Develop 3 year operating plan for Integrated Lab Service, which achieves productivity improvement target by the end of the operating plan period. The plan to include operating costs & volumes, capital and human resources, tied to HSRC directed capital project timelines. Obtain approval for operating plan by ministry.	Jun-02	Sep-02	Integrated Lab Services Management Committee
HDGH	(10) The Board of HDGH should develop an immediate plan to reduce on-going staffing costs by an effective $7,774,000. The plan should demonstrate what savings are derived from: • Reducing earned hours while addressing existing volumes • Achieving targeted PCOP approved volumes with no additional staff	Develop plan. Implementation Steering Committee (refer to Recommendation #33) to review & approve. Begin implementation.	Jun-02	Sep-02	HDGH - BoD

CONFIDENTIAL

Implementation Plan			Timetable		Accountable
Hospital	Recommendation	Action	Start	Complete	Position
HDGH	(11) The Board of HDGH should develop a plan to reduce on-going staffing costs through improved productivity by a further $5,718,000 to take full effect once redevelopment has been completed.	Develop plan. Implementation Steering Committee (refer to Recommendation #33) to review & approve. Begin implementation.	May-05	Jul-05	HDGH - BoD
WRH	(12) The Board of WRH should develop an immediate plan to reduce on-going staffing costs by $877,000. The timing of implementation should be determined within the Implementation Plan.	Develop plan. Implementation Steering Committee (refer to Recommendation #33) to review & approve. Begin implementation.	Jun-02	Jul-02	WRH - BoD
WRH	(13) The Board of WRH should develop a plan to reduce on-going staffing costs through improved productivity by a further $5,502,000 to take full effect once redevelopment has been completed.	Develop plan. Implementation Steering Committee (refer to Recommendation #33) to review & approve. Begin implementation.	May-05	Jul-05	WRH - BoD
WRH	(14) The CEO of WRH should, with the assistance of the MOHLTC, investigate the feasibility of utilizing available capacity at the WRH to provide increased non-acute services in advance of completion of the full WRH redevelopment project.	Develop joint work plan with Ministry and submit proposal for approval by Ministry	Jun-02	Oct-02	CEO - WRH
HDHG & WRH	(15) The Chairs of the Boards of the Windsor hospitals should initiate a review of their approach to fund raising and their capacity to raise the "local share" funds required to complete hospital restructuring in Windsor.	Each Hospital to develop individual capital program financing plans required to complete restructuring, subject to acceptance by M o H & LTC and approval of capital projects and related funding	Jun-02	Sep-02	Board Chairs - HDGH & WRH
HDHG & WRH	(16) The Chairs of the Boards of the Windsor hospitals should develop appropriate independent and joint initiatives to continue the fund raising effort after the Together in Caring program is completed.	Form Joint Task Force to complete review and make recommendations to both Boards of Directors.	Jun-02	Dec-02	Board Chairs - HDGH & WRH
HDGH	(17) The Board of HDGH should consider modifications to phases 5 & 6 of the capital plan to ensure that any renovations required to enable closure of the Grace site be planned with a cost not to exceed available ministry and local capital funds.	Review after Recommendation 15 is complete.	Sep-02	Jan-03	HDGH - BoD

CONFIDENTIAL DRAFT

Implementation Plan			Timetable		Accountable
Hospital	Recommendation	Action	Start	Complete	Position
HDGH	(18) The Board of HDGH, in consultation with WRH and the MOHLTC, should prepare a contingency plan to mitigate the potential impacts of delay in completion of Phases 5 and 6.	HDGH Board to prepare a contingency plan to mitigate the potential impacts of delay in completion of Phases 5 and 6.	Jun-02	Sep-02	HDGH - BoD
HDGH	(19) The HDGH CFO should complete the MOHLTC PCOP application data requirements to secure available funding.	Complete MOHLTC PCOP application data requirements submitted April 26, 2002.	Apr-02	Apr-02	CFO - HDGH
HDGH	(20) The HDGH CFO should develop a comprehensive multi-year operating plan to ensure that HDGH can manage expected additional volumes within the funding provided.	Develop and submit 5 year operating plan for approval by Board of Directors and Ministry of Health & LTC	Jun-02	Sep-02	CFO - HDGH
WRH	(21) The WRH CFO should complete the MOHLTC PCOP application to secure available funding.	Submit PCOP application to Ministry for review and approval, including retroactive funding for ER expansion	Jun-02	Aug-02	CFO - WRH
WRH	(22) The WRH CFO should develop a comprehensive multi-year operating plan to ensure that WRH can manage expected additional volumes within the funding provided.	Develop and submit 5 year operating plan for approval by Board of Directors and Ministry of Health & LTC	Jun-02	Sep-02	CFO - WRH
HDHG & WRH	(23) The WRH and HDGH Boards should revise the program transfer agreement to ensure fairness to each hospital and the use of consistent accounting and reporting approaches.	Form Joint Task Group to review current transfer agreements and recommend appropriate amendments to respective BOD's	Jun-02	Sep-02	Board Chairs - HDGH & WRH
HDGH	(24) The Board of HDGH should develop a plan to open the full directed complement of acute adult mental health beds within the existing operating funds including the funds received in transfer for the beds from WRH.	The Board of HDGH should develop a plan to open the full directed complement of acute adult mental health beds within the existing operating funds including the funds received in transfer for the beds from WRH.	Sep-02	Nov-02	HDGH - BoD
HDHG & WRH	(25) The CEOs of the Windsor hospitals should initiate a joint review of medical reimbursement policies and rates to ensure that a standardized approach is followed.	Form Joint Advisory Committee with representatives from Administration and MAC to develop and recommend common policies for Medical Staff Compensation for clinical and administrative duties & accountabilities	Jun-02	Sep-02	CEOs - HDGH & WRH

CONFIDENTIAL

Implementation Plan			Timetable		Accountable
Hospital	Recommendation	Action	Start	Complete	Position
HDHG & WRH	(26) The Boards of the Windsor hospitals should develop a joint MAC and appoint a single chair of the MAC and a single Chief of Staff to be accountable to the Board of directors of each hospital.	Form Joint Task Group to develop a detailed implementation plan for approval by the Boards (including phase-in steps/process)	Jun-02	Dec-02	Board Chairs - HDGH & WRH
HDHG & WRH	(27) The Boards of the Windsor hospitals should work towards establishment of a single medical staff for the Windsor Hospitals.	Form Joint Task Group to develop a detailed implementation plan for approval by the Boards (including phase-in steps/process)	Jun-02	Dec-02	Board Chairs - HDGH & WRH
HDGH	(28) The Board of the HDGH should stop all hiring pending development of the recovery plan.	HDGH Board approve hiring freeze pending development of the recovery plan.	May-02	May-02	HDGH - BoD
HDGH	(29) The CEO of the HDGH should develop a plan to deploy staff to new service areas aligned with the MOHLTC accepted elements of the PCOP submission.	Develop plan. Steering Committee to review & approve. Begin implementation. Do with Recommendation #10.	Jun-02	Sep-02	CEO - HDGH
HDGH	(30) The Board of the HDGH should not approve loans of funds from the capital fund to the operating fund without a reasonable expectation that the loans can be repaid.	Policy (for approval by B of D) to be prepared and implemented to ensure that loans of funds from the capital fund to the operating fund NOT be approved without a reasonable expectation that the loans can be repaid.	Jun-02	Jun-02	HDGH - BoD
HDGH	(31) The HDGH and MOHLTC should review the HSRC growth estimates and ensure that the HDGH functional program reflects the projected increase in individual program service volumes.	Make formal request to Ministry to meet to review and agree on growth estimates.	Jun-02	Jun-02	CFO - HDGH
HDGH & WRH	(32) The Executive Committees of the Windsor Hospital Boards should meet on a regular basis to address inter-hospital conflicts and coordination requirements.	Begin by preparing terms of reference for this body for approval by both Boards.	Sep-02	Oct-02	Board Chairs - HDGH & WRH
HDHG & WRH	(33) The Windsor Hospitals Focused Review Steering Committee should be re-constituted as an implementation steering committee, with the responsibility to oversee implementation of the recovery plans.	Group should meet quarterly to start.	Jun-02	Jul-05	Board Chairs - HDGH & WRH

CONFIDENTIAL

Implementation Plan			Timetable		Accountable
Hospital	Recommendation	Action	Start	Complete	Position
HDHG & WRH	(34) The Board Chairs and CEOs of the Windsor hospitals should limit use of in camera Board meetings to discussion of issues considered to be sensitive or confidential in accordance with written Board policies.	Each Hospital Executive Committee to review established guidelines for conduct of pubic board meetings to determine current compliance, and incorporate revisions into current policy if required.	Jun-02	Sep-02	Board Chairs - HDGH & WRH
HDHG & WRH	(35) The JEC should ensure that program transfer plans assure equitable access of all Windsor hospital patients to all Windsor hospital programs and services are developed and periodically updated.	Develop and submit plan for ensuring equitable access of patients to services provided by each Hospital.	Jun-02	Dec-02	Chair - JEC
HDHG & WRH	(36) The WRH and HDGH should submit JEC endorsed draft program transfer plans consistent with the ministry's draft guidelines for all relevant services to the MOHLTC for its review and approval within 90 days.	Obtain guidelines form Ministry; negotiate agreement; submit to Ministry.	Jul-02	Sep-02	Board Chairs - HDGH & WRH

CONFIDENTIAL DRAFT

Appendix A – Windsor Hospital Acute Care Activity Trends

Both Windsor Hospitals Combined

Activity Measure	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002 Forecast	Change from 98/99 to 01/02	% Change	2002/ 2003 Plan
Medical Beds	242	243	242	251	9	4%	257
Medical Days	89,606	87,091	85,498	85,909	(3,697)	-4%	88,379
Medical Cases	10,805	9,759	11,676	11,164	359	3%	11,458
Medical Occupancy	101%	98%	97%	94%	-8%	-8%	94%
Medical LOS	8.3	8.9	7.3	7.7	(0.6)	-7%	7.7
Surgical Beds	177	174	153	131	(46)	-26%	145
Surgical Days	53,565	50,896	47,781	45,389	(8,176)	-15%	48,142
Surgical Cases	9,749	9,168	10,049	9,021	(728)	-7%	9,500
Surgical Occupancy	83%	80%	86%	95%	12%	14%	91%
Surgical LOS	5.5	5.6	4.8	5.0	(0.5)	-8%	5.1
Inpatient Days in ER	438	530	2,620	3,195	2,757	629%	3,195
Paediatric Beds	33	33	33	33	0	0%	33
Paediatric Days	8,694	8,255	7,990	7,762	(932)	-11%	7,800
Paediatric Cases	2,798	2,559	2,746	2,374	(424)	-15%	2,395
Paediatric Occupancy	72%	68%	66%	64%	-8%	-11%	65%
Paediatric LOS	3.1	3.2	2.9	3.3	0.2	5%	3.3
ICU Beds	46	46	48	43	(3)	-7%	48
NICU Bassinets	13	13	13	13	0	0%	13
ICU Days	13,585	11,897	11,187	10,003	(3,582)	-26%	11,130
ICU Occupancy	81%	71%	64%	64%	-17%	-21%	64%
Obstetrics Beds	60	60	60	57	(3)	-5%	57
Obstetrics Days	12,491	12,170	11,978	12,706	215	2%	12,871
Obstetrics Occupancy	57%	55%	55%	61%	4%	7%	62%
Mental Health Beds	110	105	76	82	(28)	-25%	82
Mental Health Days	33,931	31,634	30,594	25,882	(8,049)	-24%	26,308
Mental Health Cases	2,697	2,505	2,186	2,256	(441)	-16%	2,300
Mental Health Occupancy	85%	82%	110%	86%	2%	2%	88%
Mental Health LOS	12.6	12.6	14.0	11.5	(1.1)	-9%	11.4
Total Acute Beds	668	661	612	597	(71)	-11%	622
Total Bassinets	45	45	45	42	(3)	-7%	42
Adult and Paed. Days	212,310	202,473	197,648	190,846	(21,464)	-10%	197,825
Adult and Paed. Cases	28,840	29,464	32,309	30,428	1,588	6%	31,403
Neonatal, Newborn Cases	3,885	4,180	4,219	4,237	352	9%	4,279
Acute Beds Occupancy	87%	84%	88%	88%	1%	1%	87%
Average Adult/Paed LOS	7.4	6.9	6.1	6.3	(1.1)	-15%	6.3
Rehabilitation Beds	32	36	56	60	28	88%	60
Rehabilitation Days	12,799	11,908	13,765	15,109	2,310	18%	15,813
Rehabilitation Cases	380	348	751	864	484	127%	1,019
Rehabilitation Occupancy	109.6%	90.4%	67.3%	69.0%	-41%	-37%	72.2%
Rehabilitation LOS	33.7	34.2	18.3	17.5	(16.2)	-48%	15.5
Complex CC Beds	75	75	75	75	0	0%	75
Complex CC Days	27,164	24,903	24,749	25,358	(1,806)	-7%	26,000
Complex CC Cases	138	174	245	265	127	92%	273
Complex CC Occupancy	99.2%	90.7%	90.4%	92.6%	-7%	-7%	95.0%
Complex CC LOS	196.8	143.1	101.0	95.7	(101.2)	-51%	95.2
Inpatient OR Cases	9,606	10,248	9,515	9,166	(440)	-5%	9,332
Outpatient OR Cases	19,802	20,130	20,712	20,859	1,057	5%	21,219

Hôtel-Dieu Grace Hospital Activity

Activity Measure	1998/1999	1999/2000	2000/2001	2001/2002 Forecast	Change from 98/99 to 01/02	% Change	2002/2003 Plan
Medical Beds	127	127	127	126	(1)	-1%	132
Medical Days	45,937	45,014	42,174	41,622	(4,315)	-9%	44,092
Medical Cases	5,026	5,215	5,436	4,876	(150)	-3%	5,170
Medical Occupancy	99%	97%	91%	91%	-9%	-9%	92%
Medical LOS	9.1	8.6	7.8	8.5	(0.6)	-7%	8.5
Surgical Beds	112	106	85	81	(31)	-28%	95
Surgical Days	34,741	32,587	29,249	27,855	(6,886)	-20%	30,608
Surgical Cases	4,951	4,469	5,334	4,861	(90)	-2%	5,340
Surgical Occupancy	85%	84%	94%	94%	9%	11%	88%
Surgical LOS	7.0	7.3	5.5	5.7	(1.3)	-18%	5.7
Inpatient Days in ER			1,631	2,200	2,200		2,200
Paediatric Beds	33	33	33	33	0	0%	33
Paediatric Days	8,694	8,255	7,990	7,762	(932)	-11%	7,800
Paediatric Cases	2,798	2,559	2,746	2,374	(424)	-15%	2,395
Paediatric Occupancy	72%	68%	66%	64%	-8%	-11%	65%
Paediatric LOS	3.1	3.2	2.9	3.3	0.2	5%	3.3
ICU Beds	25	25	27	24	(1)	-4%	29
NICU Bassinets	13	13	13	13	0	0%	13
ICU Days	7,186	7,106	6,578	6,118	(1,068)	-15%	7,245
ICU Occupancy	79%	78%	67%	70%	-9%	-11%	68%
Obstetrics Beds	28	28	28	28	0	0%	28
Obstetrics Days	6,177	6,060	5,461	6,478	301	5%	6,643
Obstetrics Occupancy	60%	59%	53%	63%	3%	5%	65%
Mental Health Beds	34	34	34	40	6	18%	40
Mental Health Days	10,789	10,771	11,080	12,953	2,164	20%	13,308
Mental Health Cases	1,204	1,212	1,125	1,432	228	19%	1,475
Mental Health Occupancy	87%	87%	89%	89%	2%	2%	91%
Mental Health LOS	9.0	8.9	9.8	9.0	0.1	1%	9.0
Total Acute Beds	359	353	334	332	(27)	-8%	357
Total Bassinets	13	13	13	13	0	0%	13
Adult and Paed. Days	113,524	109,793	104,163	104,988	(8,536)	-8%	111,896
Adult and Paed. Cases	18,430	17,857	17,359	16,008	(2,422)	-13%	17,375
Neonatal, Newborn Cases	2,018	1,887	1,748	1,903	(115)	-6%	1,945
Acute Beds Occupancy	87%	85%	85%	87%	0%	0%	86%
Average Adult/Paed LOS	8.0	6.8	6.0	6.4	(1.56)	-20%	6.4
Rehabilitation Beds			20	24	24		24
Rehabilitation Days			1,813	2,396	2,396		3,100
Rehabilitation Cases			435	525	525		680
Rehabilitation Occupancy			24.8%	27.4%	27%		35.4%
Rehabilitation LOS			4.2	4.6	4.6		4.6
Complex CC Beds							
Complex CC Days							
Complex CC Cases							
Complex CC Occupancy							
Complex CC LOS							
Inpatient OR Cases	5,922	5,752	5,147	4,884	(1,038)	-18%	5,050
Outpatient OR Cases	10,906	10,962	10,800	10,640	(266)	-2%	11,000

Windsor Regional Hospital Activity

Activity Measure	1998/1999	1999/2000	2000/2001	2001/2002 Forecast	Change from 98/99 to 01/02	% Change	2002/2003 Plan
Medical Beds	115	116	115	125	10	9%	125
Medical Days	43,669	42,077	43,324	44,287	618	1%	44,287
Medical Cases	5,779	4,544	6,240	6,288	509	9%	6,288
Medical Occupancy	104%	99%	103%	97%	-7%	-7%	97%
Medical LOS	7.6	9.3	6.9	7.0	(0.5)	-7%	7.0
Surgical Beds	65	68	68	50	(15)	-23%	50
Surgical Days	18,824	18,309	18,532	17,534	(1,290)	-7%	17,534
Surgical Cases	4,798	4,699	4,715	4,160	(638)	-13%	4,160
Surgical Occupancy	79%	74%	75%	96%	17%	21%	96%
Surgical LOS	3.9	3.9	3.9	4.2	0.3	7%	4.2
Inpatient Days in ER	438	530	989	995	557	127%	995
Paediatric Beds							
Paediatric Days							
Paediatric Cases							
Paediatric Occupancy							
Paediatric LOS							
ICU Beds	21	21	21	19	(2)	-10%	19
NICU Bassinets	0	0	0	0	0		0
ICU Days	6,399	4,791	4,609	3,885	(2,514)	-39%	3,885
ICU Occupancy	83%	62%	60%	56%	-27%	-33%	56%
Obstetrics Beds	32	32	32	29	(3)	-9%	29
Obstetrics Days	6,314	6,110	6,517	6,228	(86)	-1%	6,228
Obstetrics Occupancy	54%	52%	56%	59%	5%	9%	59%
Mental Health Beds	76	71	42	42	(34)	-45%	42
Mental Health Days	23,142	20,863	19,514	12,929	(10,213)	-44%	13,000
Mental Health Cases	1,493	1,293	1,061	824	(669)	-45%	825
Mental Health Occupancy	83%	80%	127%	84%	1%	1%	85%
Mental Health LOS	15.5	16.1	18.4	15.7	0.2	1%	15.8
Total Acute Beds	309	308	278	265	(44)	-14%	265
Total Bassinets	32	32	32	29	(3)	-9%	29
Adult and Paed. Days	98,786	92,680	93,485	85,858	(12,928)	-13%	85,929
Adult and Paed. Cases	14,581	13,350	14,950	14,027	(554)	-4%	14,028
Neonatal, Newborn Cases	1,867	2,293	2,471	2,334	467	25%	2,334
Acute Beds Occupancy	88%	82%	92%	89%	1%	1%	89%
Average Adult/Paed LOS	6.8	6.9	6.3	6.1	(0.7)	-10%	6.1
Rehabilitation Beds	32	36	36	36	4	13%	36
Rehabilitation Days	12,799	11,908	11,952	12,713	(86)	-1%	12,713
Rehabilitation Cases	380	348	316	339	(41)	-11%	339
Rehabilitation Occupancy	109.6%	90.4%	91.0%	96.8%	-13%	-12%	96.8%
Rehabilitation LOS	33.7	34.2	37.8	37.5	3.8	11%	37.5
Complex CC Beds	75	75	75	75	0	0%	75
Complex CC Days	27,164	24,903	24,749	25,358	(1,806)	-7%	26,000
Complex CC Cases	138	174	245	265	127	92%	273
Complex CC Occupancy	99.2%	90.7%	90.4%	92.6%	-7%	-7%	95.0%
Complex CC LOS	196.8	143.1	101.0	95.7	(101.2)	-51%	95.2
Inpatient OR Cases	3,684	4,496	4,368	4,282	598	16%	4,282
Outpatient OR Cases	8,896	9,168	9,912	10,219	1,323	15%	10,219

Appendix B – Operational Productivity Calculations

Provided in Excel tables, "Windsor Performance Screening-Appendices.xls"

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Appendix C – Governance and Management Minutes Review

Hospital Governance

Hospitals in Ontario are significantly dependent on the provincial government for their operating and capital funds. The public holds the provincial government accountable for the funding, organization, delivery, and to a large extent, the quality of hospital services. However, the hospital is a private entity, owned by the hospital's corporation, and governed by an independent board of governors. Because of the public's perspective and the amount of public funds being provided to hospitals, the government has increasingly stressed the accountability of hospitals and hospital boards for their use of these public funds and for the effectiveness, efficiency and the long-term viability of hospitals.

Although the government holds hospital boards accountable, it has also allowed them to operate with a great deal of independence and latitude to respond, as best they can, to the interests and needs of their communities. The position of the government is that once it has agreed with the hospital's general program, it remains at 'arms length' from the hospital's day-to-day activities unless and until a major issue occurs. At that point the Ministry has the right and the power to intervene as it deems appropriate. The types of intervention available to the government include:

- Audit to verify and determine the scope of the issue
- Operational Review to confirm the scope of the problem and to determine the feasibility of remedying the problem
- Investigation to provide a formal report "on the quality of the management and administration of a hospital and the quality of the care and treatment of patients in the hospital."[69]
- Supervision to "give advice and guidance to the board and the administrator of the hospital for the purposes of improving the quality of the management and administration of the hospital and the care and treatment of patients in the hospital".[70]

[69] Public Hospitals Act, April 1990, Article 7a.

[70] Ibid.

The Ministry of Health and Long-Term Care is "responsible for determining and ensuring a planned and coordinated system of health care. The hospital's responsibilities are to manage and deliver its mandated services in the most effective and efficient manner it can, to optimize the use of the resources available to it and to strive continuously to improve the availability and quality of its services."[71] The hospital defines its mandate within the framework established by the Ministry.

Governance is the exercise by the hospital's board of directors of authority, direction and control over the hospital.[72] Fundamental responsibilities of governance are:

- defining the purposes, principles, and objectives of hospital
- ensuring and monitoring the quality of hospital services
- ensuring fiscal integrity and long-term future of hospital
- arranging for and monitoring the effectiveness of the hospital's management
- approving annual operating plans and budgets of hospital

The board of a hospital is directly accountable to the corporation of the hospital. The board and corporation are accountable to the patients and communities served by the hospital, to the provincial government that funds the hospital on behalf of these patients and communities as well as to staff of the hospital.

The hospital board and the fiscal integrity of the hospital

A fundamental responsibility of the hospital board is the fiscal integrity of the hospital and its long-term solvency. It is accountable to:

- the hospital's corporation,
- the community and
- the province acting on behalf of that community

for the long-term viability of the hospital. The board should be monitoring and ensuring the effective fiscal management of the hospital. The fiscal solvency of the hospital is critical to its ability to respond to the care requirements of the community. Hospital

[71] From "Into the 21st Century: Ontario's Public Hospitals, Report of the Steering Committee, Public Hospitals Act Review, Ontario Ministry of Health, Toronto, Ontario, February, 1992.

[72] Ibid.

CONFIDENTIAL DRAFT

boards that allow the hospital's debt to exceed the its ability to repay that debt are putting the hospital, its ability to provide service to the community and the health of the community at risk. This is not good or reasonable stewardship of public and charitable funds and is not in keeping with the board's and the hospital corporation's long-term obligations to its community.

Governance of The Hôtel-Dieu Grace Hospital

The following paragraphs provide a brief description and evaluation of the ownership and governance structures and processes of The Hôtel-Dieu Grace Hospital.

A hospital is accountable to the community served as reflected and represented by the hospital corporation. The Hôtel-Dieu Grace Hospital Corporation is limited to "persons who are members of the religious congregation of the Religious Hospitallers of St. Joseph."[73] Members of the Corporation can include members of the Provincial Council of Ville Marie Province and members of the RHSJ Health System executive.

Responsibilities of the Members include the appointment of the Board of Directors, appointment or dismissal of the CEO in consultation with or on recommendation by Board, approval of new construction or major renovations, and approval of the annual capital and operating budgets of the hospital.

The Members of the Corporation delegate all authority and responsibility to manage the affairs of the health centre to the Board.

The limited membership means that the corporation will not necessarily be fully reflective of communities served by and interested in the hospital.

Governance of the Windsor Regional Hospital

There are three classes of membership in the Windsor Regional Hospital Corporation, namely:

- Elected members,
- Honorary members, and
- Life Members

Elected members "reflect the diversity of the Windsor/Essex County community, taking into account the linguistic, religious,

[73] Administrative By-Laws of the Religious Hospitallers of Hôtel-Dieu of St. Joseph of the Diocese of London. Section 2.1

ethno-cultural and socio-economic differences of the community…"[74]. Honorary members are appointed upon resolution of the Board, and Life members are appointed "based on recognition of such individuals' outstanding service to the Corporation and to the Windsor and Essex County community."[75]

Composition and Size of Board - HDGH

The current Board of the Hôtel-Dieu Grace Hospital consists of 25 to 30 Directors appointed by Members of the Corporation, at least two of whom must be French speaking. There are six ex-officio directors, President, Vice-President and Chief of Medical Staff, President of Volunteer Association, nominee of Bishop and Divisional Commander of Salvation Army, representative from Windsor City Council, representative from County Council, and of the remaining number, 40% are nominees of Salvation Army.[76]

Composition and Size of Board - WRH

The Board of the Windsor Regional Hospital consists of 24 Directors. Eighteen members of the Corporation are nominated and elected for a three-year term. Each year the term of six Directors expires and six new Directors are elected. In addition to the 18 elected members, the following individuals are ex officio Directors:

- President of the Corporation
- Immediate Past Chair of the Board
- President of the Medical/Dental Staff
- Vice-President of the Medical/Dental Staff
- Immediate Past President of the Medical/Dental Staff
- Chief of Staff

The size of the board at each of the hospitals is relatively large. There are at least two potential pitfalls of a large board:

- The size of the board might be expected to reduce the effectiveness of its deliberation and decision making.
- The size might also make it difficult for the board to demonstrate strong and decisive leadership of the organization.

[74] Administrative By-laws of the Windsor Regional Hospital, Article 3.3.

[75] Administrative By-laws of the Windsor Regional Hospital, Article 3.5.

[76] Administrative By-Laws of the Religious Hospitallers of Hôtel-Dieu of St. Joseph of the Diocese of London. Section 4.1(a).

CONFIDENTIAL DRAFT

Board Nomination and Election - HDGH

According to the by-laws of the Hôtel-Dieu Grace Hospital, Directors are "appointed on the basis of their experience, knowledge, interest, personal integrity and their ability to identify with and commit themselves to the Philosophy and Mission Statements of the Corporation."[77]

Board nomination is delegated to the Nominating, Board Membership and Evaluation Committee, which is comprised of the President of the Corporation (or her designate), the Board Chair and Vice Chairs, the Executive Director (by invitation, non-voting) and the Liaison Persons. It is the role of the Nominating, Board Membership and Evaluation Committee to "identify prospective candidates, and submit to the Board for recommendation to the members of the Corporation, nominees to serve as Directors."[78]

Board Nomination and Election - WRH

Nomination to the Board of Windsor Regional Hospital is overseen by the Nominating Committee which:

- Nominates persons for consideration by the Board for election to the Board to fill any vacancies,
- Nominates Directors for consideration by the Board for election or appointment as Officers of the Corporation, and
- Nominates persons for consideration by the Board for appointment on the Committees of the Board.[79]

In selecting persons as nominees for election to the Board, as Officers of the Corporation, and to the Committees of the Board, the Committee is required to:

- Endeavor to provide for representation of the linguistic, religious, ethno-cultural and socio-economic diversity of the community, and
- Consider the "standing and reputation in the community," the "record of public service," and "potential contributions in relation to various corporate functions and the goals of the Mission Statement,"

prior to nominating individuals.[80]

[77] Administrative By-Laws of the Religious Hospitallers of Hôtel-Dieu of St. Joseph of the Diocese of London. Section 4.1(c).

[78] Administrative By-Laws of the Religious Hospitallers of Hôtel-Dieu of St. Joseph of the Diocese of London. Section 4.22(a).

[79] Administrative By-Laws of Windsor Regional Hospital, Article 50.2 (a-c).

CONFIDENTIAL DRAFT

Committee Structures & Processes - HDGH

There are eleven standing committees of the Board at Hôtel-Dieu Grace Hospital. These include:

- Executive
- Finance
- Personnel Relations
- Ethics and Values Audit
- Quality Management
- Development and Public Affairs
- Comprehensive Planning
- Joint Conference
- Nominating, Board Membership and Evaluation
- Special Resources
- Long-Term Care

There is no minimum requirement for Directors to serve on any standing committees.

Membership of each committee varies and is described in the administrative by-laws. Committee membership ranges from as few as four individuals (i.e., Finance Committee, Personnel Relations Committee), to as many as 19 (Quality Management Committee).

The by-laws do not indicate who may vote on committees, except that the Chief Executive Officer may not vote. The Chief Executive Officer is also referred to as the Executive Director within the by-laws.

Committee Structures & Processes - WRH

There are seven standing committees of the Board at Windsor Regional Hospital. These include:

- Executive
- Finance/Audit
- Joint Conference
- Nominating
- Human Resources / Public Relations
- Facilities

[80] Administrative By-Laws of Windsor Regional Hospital, Article 50.3 (b) (i-iii).

CONFIDENTIAL DRAFT

- Patient Care / Standards
- Long-Term Care[81]

There is no minimum requirement for Directors to serve on any standing committees. Membership of each committee varies and is described in the administrative by-laws.

Committee Processes

A significant amount of the work of the Board of each of the two hospitals is being delegated, appropriately, to the standing committees of the board. The committees review information and debate issues more comprehensively than could be achieved by the full board. Currently, standing committees:

- Report their recommendations for board action,
- Support their recommendations with documentation of issues and discussions that took place at the committee level, and
- Provide the detailed minutes of their meetings for the information of the full board,

Except in unusual circumstances, these processes and practices are minimizing the need for the full board to reconsider and re-debate issues that have been dealt with at the committee level. Board members will ask the subcommittee to clarify facts, issues and recommendations; they do not repeat the debate that has already taken place at the subcommittee level. The board will then vote on the recommendation of the Committee, accepting or rejecting the recommendation as appropriate.

This approach to deliberation and decision-making makes Board meetings more efficient. It allows the full board to focus its deliberations on the most critical issues.

In Camera Meetings - HDGH

It is the policy of the Board of Hôtel-Dieu Grace Hospital that "[a]ll meetings of the Board are open to staff, physicians, patients, media and the general public unless otherwise determined by the Board."[82] In camera meetings are decided upon by the Board chair and the Executive Director in order to discuss "issues requiring confidentiality".[83] Separate agendas and minutes are prepared for

[81] The Administrative By-laws do not include the Long-Term Care Committee in the listing of Standing Committees in Article 43.1 (a); however, a description of the committee is included in Article 54 of the by-laws.

[82] Religious Hospitallers of St. Joseph Health Centre Policy Number 100.C.033

[83] Religious Hospitallers of St. Joseph Health Centre Policy Number 100.C.033.

CONFIDENTIAL DRAFT

in camera meetings and regular Board meetings. The Board defines matters of confidentiality as: "public security, personnel matters, property acquisitions, labour relations/negotiations and litigation."[84]

At the November 28, 2001 meeting of the Board, a Director "asked why total content of committee meetings is in-camera and not only certain sensitive items. The chairman responded that he will review this with Committee Chairs."[85] There may be opportunities to increase the level of openness and public accountability of Board processes at Hôtel-Dieu Grace Hospital.

In Camera Meetings - WRH

Windsor Regional Hospital Board meetings became open to the public in 1998. In-camera meetings at Windsor Regional hospital are required when sensitive matters are being discussed. Board policy indicates that meetings be held in-camera when discussing:

- security and acquisition of property,
- personal matters about an identifiable individual,
- labour relations or employee negotiations, and
- litigation or potential litigation matters.[86]

In past two years, in camera meetings have become more frequent and lengthier. Each in camera meeting lasts between one and two hours.

It is our opinion that not all in-camera issues necessarily require confidentiality – i.e., operating plan presentations, recently ratified collective agreements, capital redevelopment issues. Our analysis of in camera agendas and minutes suggest that issues that may result in poor publicity for the hospital is a criterion for holding an in camera meeting.

Defining & Maintaining Purposes & Principles of Hospital

The health care industry has clearly recognized the importance for hospitals to develop coherent sets of objectives and plans. Planning is recognized as a critical component of hospital governance and management. Hospitals should develop plans in response to the needs of the community and in collaboration with the community

[84] Religious Hospitallers of St. Joseph Health Centre Policy Number 100.C.033.

[85] Hôtel-Dieu Grace Hospital Minutes of In-Camera Board meeting held 28 November, 2001

[86] Windsor Regional Hospital *Policy for Open Board Meetings*, dated 24 November, 1998.

and other health care and social service agencies. Effective hospital planning should include the following elements:

- Identifying the communities to be served by the hospital,
- Establishing the objectives for the hospital (Vision, Mission and Core Values),
- Selecting the health needs of the composite community that might be appropriately served by the hospital (Role Statement),
- Defining and describing the programs and services required to be offered by the hospital to respond to the health needs of the population and achieve the hospital's objectives (Long-Range Plan),
- Detailing plans for implementing the program and service goals of the long-range plan and thus achieving the Vision and fulfilling the Mission of the hospital (Strategic Plan), and
- Translating the objectives, plans and strategies into specific activities to be initiated in the next fiscal year (Operational Plan).

We believe that a Vision/Mission Statement, Role Statement, Long Range Plan and Strategic Plan are critical to the successful governance and management of a hospital. Decision-making in the absence of clearly articulated Long- Range and Strategic Plans are often uncoordinated and inconsistent. The complexity of a hospital and its levels of governance and management require that decisions must be made with reference to a set of long-term objectives (Vision/Mission/Role) and a plan for achieving these objectives (long-range and Strategic Plans) that are generally accepted by the critical hospital stakeholders. These documents provide a framework for annual operational planning and budgeting. If prepared through the collaboration of the board, the medical staff, management and hospital staff and in consultation with the community and other health care agencies, they can become the basis for clear communication of the hospital's priorities and for collaborative and supportive actions to achieve the hospital's objectives.

In keeping with the need to distinguish between governance and management, organizational objectives and long-range goals for programs and services should be considered primarily a responsibility of governance; strategies and operational plans for achieving these objectives and goals should be considered

CONFIDENTIAL DRAFT

primarily a responsibility of management. Although primarily a responsibility of governance, it is unrealistic to expect that boards can or should develop long range objectives or plans independently. Although led by the board, management staff of the hospital will support the development of these statements and plans.

Long Range Objectives: The Hospitals' Vision and Mission – HDGH

Hôtel-Dieu Grace Hospital's *Statement of Beliefs* and *Mission Statement* are articulated as part of the Administrative By-Laws, revised most recently in June, 1997.

HDGH is founded upon Christian philosophies and values of the Roman Catholic Church and The Salvation Army, as evidenced by the following statements:

- "We believe that all persons are created by God and have God-given rights from the moment of conception throughout their life span until death…"
- "We believe in the values and principles inherent in the Medical-Moral teaching of the Church…"
- "We believe that the personnel of the Health Centre should be a community of caring persons who witness Christ's love to those whom they serve…"[87]

The Mission Statement and Vision of the hospital were revised as part of the 2001 Strategic Planning process. This planning process identified the hospital's programs and specialty services, which include:

- Medicine,
- Surgery,
- Mental Health,
- Long-Term Care,
- Adult Acute Psychiatry,
- Trauma,
- Neurosciences,
- Cardiovascular Medicine, and
- Dialysis/Renal[88]

[87] *Statement of Beliefs*, contained in Administrative By-Laws of the Religious Hospitallers of Hôtel-Dieu of St. Joseph of the Diocese of London. Section 1.4.

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Long Range Objectives: The Hospitals' Vision and Mission – WRH

The mission of Windsor Regional Hospital is as follows:

"We exist to provide the best health care possible to all who need us."[89]

The values of the hospital include:

- We will preserve the dignity and rights of individuals and their families at all stages of life
- We embrace an approach to the delivery of care that is patient-centred, interdisciplinary, integrated and collaborative
- We are committed to having facilities that are up-to-date, well maintained and welcoming to all.[90]

Ensuring & Monitoring Effective Management & Financial Health

For the board of a hospital to exercise its responsibility in ensuring effective management and the financial health of the hospital, there must be strong processes for operational planning and budgeting and for reporting on progress in achieving these plans and budgets.

A hospital board should start the operational planning process by drawing from the hospital's long-range plan to set the annual objectives for the organization and to define the parameters for operational planning and budgeting. The board must take the initiative in setting goals and initial targets for the size of the hospital's operating surplus or loss for the coming year. Budget targets should take into account the Board's responsibility to ensure the current and future financial health of the hospital. The Board should then critically review and approve the operating plan and budget developed by management to achieve its objectives and to accommodate its budget parameters. If the hospital's resources are insufficient to implement the hospital's plans, then the Board must take responsibility for directing management to defer initiatives, suggest alternative strategies for achieving the hospital's vision or, if necessary, to rethink the vision for the organization.

Operational Planning and Budgeting at HDGH

The 2001/2002 plan presented to the Finance Committee of the Board contained a budget deficit of $16.7 million (consisting of $7.4 in wages & supplies, $7.4 million in additional staff and the

[88] Hotel-Dieu Grace Hospital *Strategic Plan*

[89] Administrative By-Laws of the Windsor Regional Hospital, Preamble.

[90] Administrative By-Laws of the Windsor Regional Hospital, Preamble.

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balance consisting of depreciation, physician remuneration, etc.).[91] There was considerable discussion by the committee of the draft plan, with many items for administration to follow-up before the Board could approve the plan. Administration was to ask the Ministry for an extension of the submission deadline.

During the development of the 2002/03 Business Planning Brief, the Finance Committee was advised by hospital management that using the Ministry's "unrealistic" assumptions of 0% funding increase, the projected deficit for 2002/2003 would exceed $32 million.[92] The hospital's position at that time was that since it is not possible to incur two years in a row of large deficits and maintain a positive cash position, therefore, the Business Plan is not realistic.[93] It was noted that "a service reduction / abandonment of the HSRC directives would be the only opportunity to accumulate the large amount of savings necessary to balance under a 0% revenue assumption."[94] It appears that reversing or delaying the "ramping up" of staffing in advance of the arrival of the anticipated workload was considered to be equivalent to abandoning the HSRC directives, and therefore unacceptable.

Monitoring Effectiveness of Management

The board of a hospital bears overall responsibility for the effectiveness of the hospital in fulfilling its mission. It is, however, dependent on management to provide it with sufficient information to fulfill this responsibility.

Monitoring Financial Health - HDGH

There are opportunities to improve the reporting to the Board of Trustees on the operations and financial performance of Hôtel-Dieu Grace Hospital. The board does not receive regular indicators of hospital operations, beyond that which is provided to the finance committee. There is no balanced scorecard or any

[91] Hôtel-Dieu Grace Hospital minutes of Finance Committee meeting held March 20, 2001

[92] Hôtel-Dieu Grace Hospital minutes of in camera Finance Committee meeting held 22 January, 2002

[93] Hôtel-Dieu Grace Hospital minutes of in camera Finance Committee meeting held 22 January, 2002.

[94] Hôtel-Dieu Grace Hospital minutes of in camera Finance Committee meeting held 22 January, 2002.

comprehensive set of corporate indicators provided to the Board.[95]

The board does not receive the minutes of the MAC, but rather, a shorter report that includes only the motions brought forward for approval. Annual reports of hospital programs are provided to the quality of care committee on a rotating basis such that one program reports each month.

Members of the finance committee do receive monthly financial statements and detailed variance reports. Current statements and cash flow forecasts are provided each month.

From the finance committee, Oct 16, 2001:

> "[The] worst case scenario shows us running out of money in November and accumulating as much as $27 million of debt by year end. In order to minimize potential borrowing, Mr. Bagatto suggested that we write to the Ministry and indicate that we clearly cannot repay the $9 million operating advance nor the CJD advance of almost $4 million. In addition, our request for capital grants and/or advances must be strongly re-emphasized. A meeting is planned for November 1 which would provide an opportunity to do so. We will need to cash our capital investments sooner than hoped in order to avoid borrowing.

In September 2001, the HDGH retained an outside firm to do a comparative peer review of performance data. This was characterized as an opportunity for HDGH to understand what the consultants would see during the focused review, not as a vehicle for identifying opportunities to reduce expenditures.

Cash Flow Situation

By November 2001, despite a YTD deficit of approximately $9 million and a risk that the hospital was reaching its borrowing limit, there was little discussion of the financial situation of the hospital.

A member of the HDGH Finance Committee asked whether over budget variances were being carefully scrutinized. It was "noted

[95] During the review we were notified that the key indicators provided to the Quality Management Committee would in the future be provided to the Finance Committee and on a quarterly basis to the Board.

CONFIDENTIAL DRAFT

that they were, however there is great sensitivity to the tentative human resource situation that we find ourselves in."[96]

The Finance Committee continued to show concern about the state of the hospital's financial situation, as evidenced from the discussion held at its 22 Jan 2002 meeting:

- "Adding a sense of urgency to the overall capital and operating positions is our deteriorating cash flow position. The attached schedule shows that without further Ministry assistance we would need to borrow some $20 million by the end of March. The hospital has been able to negotiate with the Royal Bank for $15 million to cover the Ministry's recovery of the $9 million operating advance and $6 million CJD advance. When combined with the $5 million line of credit we would have enough borrowing ability to meet our anticipated cash deficiency."

- "…however, without further Ministry funding, both the next phase of our construction project as well as the continued roll out of our PCOP would be jeopardy. Administration will need to vigorously pursue every opportunity: capital advances, restructuring reimbursement, PCOP funding, the focused operational review, etc. to maintain a positive cash position and allow the completion of our HSRC directed projects."

All of the opportunities identified are directed at increasing revenues, rather than decreasing expenditures.

At an in-camera session, the Board voted to "not borrow additional funds in the short term beyond the previously approved Board limit; and that a letter be sent asking the Minister of Health to review our operational status urgently given the Ministry's failure to approve this year's Operating Plan and the delay in commencing the Focused Review for fiscal 2002/03 and beyond."[97]

Use of Capital Funds

That capital funds had been used to support hospital operations was not explicitly discussed at meetings of the Board or its subcommittees. Discussions of the Comprehensive Planning Committee considering the purchase of 1100 Ouellette Avenue, it

[96] Hôtel-Dieu Grace Hospital minutes of Finance Committee meeting held 20 November, 2001

[97] Hôtel-Dieu Grace Hospital Minutes of In-Camera Board meeting held 27 February 2002

was noted that "[a]lthough we don't have any capital reserves currently, [management] indicated that if the Ministry were to fund our deficit we may have money in our capital account shortly."[98]

Reporting to the Board at WRH

Statistics typically provided to the Windsor Regional Hospital Board in its meeting package include:

- Quarterly census / weekly breakdown (incl. Adult admissions, infant admissions, daily visits)
- ELOS, ALOS for the following acute diagnoses: CVA, pneumonia, COPD, CHF. Data comparing total hospital results with the unattached Program are also presented.

There are no other standardized indicators brought forward to the WRH Board. Program-specific balanced scorecards and statistics such as patient volumes, satisfaction and the hospital's financial position are communicated separately through committee reports or as attachments to Board packages.

Reports Provided to Finance Committee - WRH

The Windsor Regional Hospital Finance Committee receives a monthly report entitled, "Comments on Consolidated Financial Statements" which examines the following services:

- Comparison – Budget to Actual
- Hospital Operations
- Malden Park continuing Care Centre
- Regional Children's Centre

For each of the above services, revenues and the following types of expenses are reviewed:

- Salaries and wages
- Employee benefits
- Medical staff fees
- Medical and surgical supplies
- Other supplies and expenses
- Equipment lease/rental expense
- Restructuring costs & recoveries

[98] Hôtel-Dieu Grace Hospital Minutes of in-Camera Comprehensive Planning Committee meeting held 31 January 2002.

CONFIDENTIAL DRAFT

Also provided is a comparison of current month and same period last year. The balance Sheet statements show current month and variance (favourable/unfavourable), Budget YTD against Actual YTD, total budget as reported in annual operating plan, and actual YTD for same period in the previous year.

Finance committee also receives Case Cost Results summary and trend information. Comparisons of cost per weighted case, per diem rates for CCC, per diem rates for rehab and indirect costs are compared. WRH results are compared with median change within their peer group.

Cash Flow

At the March 27, 2000 meeting of the Windsor Regional Hospital Finance committee, it was reported that the projected cash flow shows that "monthly cash in-flows and outflows have to be in balance by February, 2001, otherwise WRH's credit facilities will be exceeded. The conclusion to be drawn from the projection is that budget-balancing actions must be decided upon no later than June 2000 in order to ensure the monthly financial impact is realized no later than next February."[99]

Ensuring & Monitoring Quality of Services

A fundamental responsibility of governance is ensuring and monitoring the quality of services and continuing improvement of quality in all aspects of hospital operations.

Also, the Public Hospitals Act states that: "The medical advisory committee shall report in writing to the board at each regularly scheduled meeting of the board, respecting the practice of medicine in the hospital,"[100] and "…the head of each [medical] department may be made responsible by by-law of the hospital…to advise the medical advisory committee with respect to the quality of medical diagnosis, care and treatment provided to the patients and out-patients of his department."[101] Both to fulfill these obligations under the Act and to better understand the quality of care at the hospital, the MAC should more formally report to the Quality Committee on the quality of medical care at the hospital.

[99] Windsor Regional Hospital minutes of in camera Finance Committee meeting held 27 March, 2000.

[100] Ontario Regulations 518/88 under the Public Hospitals Act, 6 (5).

[101] Public Hospitals Act, 31 (2).

CONFIDENTIAL DRAFT

HDGH Quality Management Committee

The Quality Management Committee at Hôtel-Dieu Grace Hospital receives annual presentations of patient care areas. These presentations follow a similar format as follows:

- sample of monthly key indicator report
- learning as a result of tracking indicators
- improvements made as a result of tracking indicators
- areas of focus in relation to "Ten Pillars of Continuous Improvement"

These presentations occur annually on a revolving basis.

WRH Quality Reporting to Board

At WRH, the Joint Medical Q.A. and Clinical Utilization committee is a sub-committee of the MAC.

Annual Objectives and Performance Review of CEO - HDGH

To be an effective component of the governance processes of the hospital it is important for the board to ensure that the annual objectives are, and are seen to be the board's objectives for the hospital.

It is the responsibility of the Nominating, Board Membership and Evaluation Committee of the Hôtel-Dieu Grace Board to evaluate the CEO. According to its terms of reference, this committee is supposed to:

"*evaluate the performance of the Chief Executive Officer in relation to his/her duties as set out in the by-laws, position description and agreed annual statement of his/her goals and objectives*."[102]

Annual Objectives and Performance Review of CEO - WRH

At Windsor Regional Hospital, it is the responsibility of the Board as a whole to "ensure the ongoing evaluation of the Chief Executive Officer."[103] No explicit annual goals and objectives were identified in the Board minutes.

Hospital Management

It is generally accepted in the hospital industry that management is "responsible for the effective and efficient operation of the hospital

[102] Administrative By-Laws of the Religious Hospitallers of Hôtel-Dieu of St. Joseph of the Diocese of London. Section 4.21 (c) (iii).

[103] Administrative By-laws of Windsor Regional Hospital. Article 18.1 (d).

CONFIDENTIAL DRAFT

in accordance with the direction set by the board."[104] Management of a hospital is expected to fulfill its responsibility by:

- Providing leadership to the hospital community
- Developing and implementing strategies for achieving the hospital's objectives
- Creating organizational structures and processes
- Directing and overseeing the delivery of hospital services
- Improving efficiency of hospital services
- Improving effectiveness and quality of hospital services and care
- Recruiting and developing staff
- Reporting to Board on the effectiveness of the hospital

The organizational health and effectiveness of a hospital is dependent on the successful execution of these responsibilities. In this section we consider the management structures and processes of Windsor Regional Hospital and Hôtel-Dieu Grace Hospital in relation to these expectations of the management of a hospital.

Senior Management Organization - HDGH

Hôtel-Dieu Grace Hospital uses a traditional from of management structure; it does not use a program management model of service delivery.

Hôtel-Dieu Grace Administrative Committee

The administrative Committee meets weekly on Wednesdays for approximately two to three hours. Meetings alternate between the Villa Maria, Hôtel-Dieu and Grace Sites. Membership on the Committee includes the following individuals:

- President & CEO
- VP Patient Care (3)
- VP Finance
- VP Human Resources and Physical Plant
- Chief of Staff
- Medical Director
- Liaison Positions (Salvation Army and RHSJ)

[104] From "Into the 21st Century: Ontario's Public Hospitals, Report of the Steering Committee, Public Hospitals Act Review, Ontario Ministry of Health, Toronto, Ontario, February, 1992.

CONFIDENTIAL DRAFT

Committee Process

The Administrative Committee appears to be a forum for communications among senior managers. Each individual provides a report on issues impacting his/her area. Medical issues are always presented first and appear to dominate the meetings. The minutes of the Administrative Committee are brief. It does not appear that many decisions are taken.

Windsor Regional Hospital Strategic Leadership Team

The Strategic Leadership Team at Windsor Regional Hospital used to meet weekly, with a limited number of issues on agenda – typically between one and five. The length of each meeting was not included in minutes. There is very little documentation of SLT meetings held between January 2000 and August 2001. Minutes are approximately one page in length.

The work process of the SLT changed to monthly meetings starting August 29, 2001. Each meeting lasts approximately two hours. Meetings occur at the end of each month. While there is now a more "traditional" form of documentation of meetings, minutes are concise.

Strategic Planning

As has been discussed, planning is a critical component of hospital governance and management. In keeping with the need to distinguish between governance and management, organizational objectives and long-range goals for programs and services should be considered primarily a responsibility of governance; strategies and operational plans for achieving these objectives and goals should be considered primarily a responsibility of management.

Management will participate in and provide support for the Board's initiatives to:

- Establish the objectives for the hospital (Vision, Mission and Core Values)
- Select the health needs of the composite community that might be appropriately served by the hospital (Role Statement)
- Determine the programs and services to be offered by the hospital in response to the health needs of the population and in order to achieve the hospital's objectives. (Long Range Plan)

However, management is responsible for developing a strategic plan that identifies the initiatives that will be employed to implement the enhancements, expansion and/or rationalization of programs and services suggested by the long-range plan thereby achieving the Vision and fulfilling the Mission of the hospital. It is also responsible for translating the objectives, plans and strategies into

CONFIDENTIAL

an operational plan that will specify the activities to be initiated in the each fiscal year.

HDGH Strategic Plan

The strategic plan at Hôtel-Dieu Grace Hospital was under development in mid-to-late 2001. The final strategic plan was presented to the Board August 29, 2001 and adopted at its meeting of September 19, 2001.

The Strategic Plan states that "Essex County hospitals are entitled to approximately 20% more funding". The Vision statement refers to creating a Health Centre of Excellence "by advocating for resources and creating partnerships that improve the quality of health services". The Values include "we are responsible to manage the affairs and resources of the Health Centre ethically, creatively, and with accountability".

WRH Strategic Plan

Windsor Regional Hospital's strategic plan was updated in 1999. A formal strategic planning process was used to develop a mission statement and organizational goals as well as a strategic plan. The process involved Board Retreats (moderated by external consultant) as well as formal strategic planning sub committees representing each functional area. The process involved Board members as well as administration (VP's, etc).

Stakeholder (internal and external) feedback was collected and used to develop seven board policies that provide direction for administration. The seventh of these policy statements is that "WRH will provide quality services in a fiscally responsible manner".

The Strategic Leadership (senior) Team developed a Strategic Directions document that established specific actions and targets to implement the Policies. This document was then used in developing the Operating Plan for the following year.

Operational Planning & Budgeting

Operational planning and budgeting are the annual management processes through which a hospital implements its long-range plans and fulfills its mission. Typically these processes will include setting:

- Annual objectives for the organization
- Plans for the development, enhancement, maintenance, contraction or elimination of programs and/or services
- Performance expectations related to the volume, productivity, cost and quality of services provided by each program and by each therapeutic, diagnostic, support and administrative service department,

CONFIDENTIAL DRAFT

- Targeted expenditure levels for each element of the program, and
- Estimates of revenues.

A hospital needs the operating plan and related budget to describe and quantify its annual objectives and its planned program, service and fiscal initiatives. The plan and budget should be reviewed and approved by the board, and thus is one of the most effective vehicles for ensuring accountability of hospital management and staff to the board, and to the hospital corporation and the communities served by the hospital.

Administrative Committee Involvement in Operating Plan and Budget Development at HDGH

The extent to which HDGH's financial reports are presented and discussed at the Administrative Committee is not clear from the minutes. For example, between October 2000 and 28 February 2001, there was no discussion at Administrative Committee with respect to 2001/02 budget development.

It was reported at the March 28, 2001 Administrative Committee meeting that the operating plan is being finalized.

The first time that the HDGH Operating Plan is discussed at the Administrative Committee is in the context of what WRH plans are. It was noted that, "Windsor Regional is indicating that if the money does not flow than they are not moving forward with operational or capital improvements. On the other hand, [Hôtel-Dieu Grace] will be indicating to the Ministry that we are moving forward in any event, that we need to maintain functioning teams in order to resolve recruitment and retention issues and the only way to do that is to move forward."[105]

In the Operating Plan discussions the state of the budget is not discussed in terms of "deficit", but rather: "HDGH Operating Plan is proposing an increase of $17 million…" [106]

It was reported that an April 2001, payment of $1,670,000 by the Ministry of Health eliminated the deficit of HDGH. It was reported

[105] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 28 March, 2001

[106] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 28 March, 2001

CONFIDENTIAL DRAFT

in July 2001, that the hospital was required to resubmit its Operating Plan.[107]

HDGH Administrative Committee and Financial Situation 2001/02

It was reported in September, 2001, that "there is a significant deficit which is due to an increase of 146.9 FTE's, an increase of medical staff remuneration, post employment benefits, restructuring, depreciation, Ministry of Health deficit funding and other costs. Even with the increase in our expenses, our cost per weighted case is also increasing. The cash flow information indicates that at this rate, we will run out of cash by the end of the year."[108] This was the first time in 2001/02 that financial reports were quoted in Administrative Committee minutes. At that time, the hospital's strategy for recovery was to provide that information "to the respective departments in order to look at opportunities for improvements."[109]

It was reported that due to the cash flow situation, "the Finance Committee is looking at making arrangement to set up an $18 million loan facility. Some explanation will be required for RHSJ approval."[110]

2002/03 HDGH Budget

The Finance Committee was presented a plan that calls for a $32 million deficit for 2002/03. "The three key reasons are the continuing build-up towards [the] Post Construction Operating Budget, inflation and other unavoidable cost issues such as pension plan costs."[111] It was reported that HDGH has borrowed its limit of $15.5 million.

Controlling Expenditures

The primary focus of management of a hospital is providing for and ensuring the effective and efficient provision of patient care. Controlling expenditures suggests that management needs to set in place processes for managing hospital efficiency. These processes should include:

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[107] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 18 July, 2001

[108] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 26 September, 2001

[109] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 26 September, 2001

[110] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 21 November, 2001

[111] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 23 January, 2002

CONFIDENTIAL DRAFT

- Cost Management-Controlling the cost of each unit of labour and material used by each department of the hospital in providing its services or producing its products.
- Productivity Management-Measuring, monitoring and controlling the number of units of labour and materials employed in producing departmental services
- Utilization Management-Measuring, monitoring and controlling the resources used in each episode of patient care (including length of stay in hospital)
- Utilization Management-Ensuring the appropriateness of each episode of patient care
- Production Management-Measuring, monitoring and controlling the number of episodes of patient care.

Management of a hospital uses these processes to manage the overall content and cost of hospital operations. To be effective in the execution of its responsibilities, management needs to be able to influence and ultimately manage all aspects of the clinical and non-clinical activities of a hospital.

HDGH Clinisaver Project

It was reported that the hospital proceeded with the purchase of Clinisaver from McCartney Consultants in August, 2001, "to carry out a review of our performance using their various software tools".[112] This approach of using of external comparators was adopted in preparation for the operational review and was not previously built into the financial or clinical utilization management processes.

HDGH Clinical Audit

Consultants were hired to review a sample of 100 charts. Findings indicate that the hospital could realize between 20% - 30% improvement of RIW through improved documentation.

"Ramping Up"

The issue of "ramping-up" was addressed indirectly in the 01/02 budget development discussions:

"Windsor Regional is indicating that if the money does not flow than they are not moving forward with operational or capital improvements. On the other hand, [Hôtel Dieu Grace] will be indicating to the Ministry that we are moving forward in any event, that we need to maintain functioning teams in order to resolve

[112] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 15 August, 2001

CONFIDENTIAL DRAFT

recruitment and retention issues and the only way to do that is to move forward."

The Ministry has indicated that it is prepared to provide funding for the opening of additional beds when the hospital incurs the additional expense. The hospital responded that they need the funding in order to incur the additional expense.

Monitoring of Expenditures at Windsor Regional Hospital

"There are some key organizational performance measures that must be monitored on an ongoing basis; indicators that we should have as a committee on a monthly or quarterly basis."[113]

By October 2001, WRH was running a $2.3 million deficit. The hospital attributed this variance to an increase of between 80-100 FTE over two years previous. At an SLT meeting, it was noted that the hospital "'threw' staff at the problem and… made a lot of progress in solving the problem but are at a point now where we should start to take staff out once again. We must focus in on how we can remove positions without disrupting the organization."[114]

SLT decided that effective immediately every vacancy will require four signatures prior to filling it: the senior staff member responsible for the area, the Vice President, Finance, the Chief Executive Officer, and the Vice President, Human Resources.[115]

Management Reporting

There must be a balance in management reporting. Too little information and too much information should both be avoided. Management information should focus on the "critical success factors" of an organization. For any organization, the critical success factors are the limited number of areas in which satisfactory results must be achieved in order to ensure the successful performance of the organization. These are the few key areas where "things must go right" for the organization to flourish. If results in these few significant areas are good, the organization will be successful. If results in these few areas are not adequate, the organization's overall performance for this period will be less than desired. The critical factors are areas of activity that should receive constant, careful attention from management. The current status of

[113] Windsor Regional Hospital minutes of Strategic Leadership Committee held 29 August 2001

[114] Windsor Regional Hospital minutes of Strategic Leadership Committee held 24 October 2001

[115] Windsor Regional Hospital minutes of Strategic Leadership Committee held 24 October 2001

performance in each area should be continuously measured and made available to the appropriate managers.

The critical volume, productivity, cost, revenue and overall performance targets specified in an operational plan/budget should provide the foundation for effective management reporting. Management reports should provide managers with an indication of departmental performance in relation to operating targets and budgets for:

1. Utilization (e.g. Laboratory Tests per Separation)
2. Volume (e.g. Tests, Exams, Attendances)
3. Workload (e.g. Laboratory Workload Units)
4. Productivity (workload units per variable worked hour –per UPP worked hour)
5. Overhead worked hours (Management and Operational Support hours)
6. Benefit hours
7. Total paid hours
8. Total Labour Costs
9. Total Supplies Costs
10. Total Operating Costs
11. Revenues
12. Quality of service

Then, throughout the year, an effective management reporting system will concentrate on:

- Comparing actual results to targets
- Providing this information in a timely and accurate manner to support operating decisions.

So that managers are able to understand and explain significant variances and develop plans for corrective actions to achieve the budgeted levels of performance. (Alternatively, if the causes of variance are outside the control of the hospital, consideration might be given to formally changing the performance targets.).

WRH Reporting for Departmental Managers

Windsor Regional Hospital has developed a number of management reports. These reports are generated and distributed electronically, as part of a comprehensive system of reporting. The

CONFIDENTIAL DRAFT

reports are generated from various systems and distributed separately through the corporate e-mail system. Reports readily available for managers include:

- Capital Summary Reports
- Management Reports (YTD budget and actual revenues and expenses by department, rolled up to VP level, including charts)
- Payroll Summary
- Performance Management Reports (including Balanced Scorecard, benchmarking information and unit performance reports)
- Sick and Overtime Reports (by functional centre, department, VP, and site).

WRH Performance Indicators

When discussing the contents of management reports, it was noted that, "there is an urgency for the program teams to be using this data because the Accreditors will ask the teams what indicators they use."[116]

HDGH Quality Management Processes

A new quality management program was introduced at Hôtel-Dieu Grace Hospital in September, 2000. "All patient care committees, clinical departments and non-clinical departments will be expected to establish key performance indicators and report on them regularly. A periodic report of these indicators will be made to the Board Quality Management Committee."[117]

HDGH Administrative Committee Focus on Medical Staff Issues

The Hôtel-Dieu Grace Hospital's Administrative Committee appears to be closely involved in issues related to the medical staff, such as new physicians[118] privileges, allocation of resources[119,120],

[116] Windsor Regional Hospital minutes of Strategic Leadership Committee held 28 November 2001

[117] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 04 October, 2000

[118] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 10 January 2001

[119] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 13 September, 2000

[120] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 27 September, 2000

CONFIDENTIAL DRAFT

on-call coverage[121] recruitment[122,123], retention, scope of practice[124,125,126] etc.

There appear to be many issues relating to dissatisfaction and dysfunction among the medical staff.

- Board hearings[127]
- Quality of care issues requiring external investigation[128],[129]
- Loss of medical staff
- Behavioural issues

The Senior Management Team includes the Chief of Staff and the Medical Director.

Board Relations

The minutes of the Windsor Regional Hospital's SLT are not sufficiently clear regarding how issues are brought forward to the Board (i.e., which issues are brought to board committees as opposed to those brought directly to the board). This is also true for the HDGH Administrative Committee.

Communications with Ministry of Health

The MOHLTC has identified differences in communications with the Windsor hospitals. WRH is considered to be "more business like" (i.e. refuses to proceed with initiatives requiring increased expenditures without formal commitments of resources from the MOHLTC). HDGH concentrates on the ultimate vision of the fully restructured Windsor hospital system. HDGH has assumed that as

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[121] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 05 September, 2001

[122] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 27 September, 2000.

[123] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 11 October, 2000

[124] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 27 September, 2000

[125] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 01 November, 2000

[126] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 19 September, 2001

[127] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 24 January, 2001

[128] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 24 January, 2001

[129] Hôtel-Dieu Grace Hospital minutes of Administrative Committee meeting held 28 March, 2001

CONFIDENTIAL DRAFT

long as the end goal is that directed by the HSRC and the MOHLTC, steps they consider reasonable to reach the end goal should be taken, even if not explicitly approved by the MOHLTC.

HDGH is less likely to proactively inform the MOHLTC of impending issues (including financial) or community concerns. WRH often contacts the MOHLTC regional team to inform them of upcoming issues and to jointly develop a strategy to respond to the issues.

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