Report of the President & CEO to the Board of Directors

Date: March 2011

"It pays to plan ahead. It wasn't raining when Noah built the ark."

I highlight two reports written 12 years apart. The first is the 1998 report of the Essex County Health Services Restructuring Committee (HSRC) and the second a report written by the Ontario Health Quality Council (OHQC) in 2010.

Excerpts from the Report of the HSRC - February 1998

- Essex County has 1,985 Long Term Care beds in 15 facilities.
- Essex County will need an additional 1,331 long term care places **by 2003**, with **446 of this total placed in nursing homes or home for the aged**, and 886 places in supportive housing, long term home care, attendant care and adult day care.
- To meet the current lack of long term care beds, the Salvation Army Grace Hospital could provide long term care (LTC).
- Malden Park should be converted to a complex continuing care centre. This should happen when a LTC facility(ies) is planned/opened with same or more capacity.
- In 1997 the waiting list for LTC was 524. Out of that list 163 were already in a LTC facility they were just awaiting the home of their first choice to open.
- 1995-2003 Progressive Conservatives formed the Government of Ontario.

Fast Forward to today

- Essex County has 2,357 Long Term Care beds in 19 facilities. An increase of 372 beds since 1998. Any growth in long term care beds has occurred in last 8 years.
- September 6, 2007, Premier McGuinty announced approval to proceed with construction of three new long term care facilities in Windsor to add 448 new long term care beds in Windsor/Essex.
- Late 2003-present Liberals form the Government of Ontario.
- Today approximately 1500 individuals are on a wait list for a long term care facility.

Excerpt from the 2010 Report on Ontario's Health - OHQC[1]

There are serious problems with how patients move through the healthcare system, from the Emergency Department (ED) to hospital to LTC. Patients wait too long and the system is wasting resources.

Wait times for an LTC bed are too long — an average of 105 days, or more than three months. For people waiting while at home, the wait time is 173 days (almost half a year). Wait times have tripled since the spring of 2005.

Wait times for LTC affect hospitals, since frail individuals who cannot go home typically spend 53 days in hospital waiting for placement. As a result, currently 16% of all hospital beds in Ontario are occupied by patients designated as ALC, who do not need to be in hospital. Indeed, every increase of 3.3 days of average time spent waiting in hospital for LTC placement is associated with a 1% increase in the proportion of beds that are ALC. Not only is this a waste of hospital resources, but it puts patients at risk because they are being cared for by staff who are not trained to deal with their needs. This problem has gotten much worse in the last three years.

The backlog of ALC patients in hospital is one of the key factors affecting ED wait times. Patients admitted to hospital from the ED spend far too much time waiting for a hospital bed after the decision to admit — typically, 3.4 hours. They occupy a bed in the ED while waiting, which in turn slows the flow of less acute patients through the ED. In 2009, 25% of patients spent more time in the ED receiving care than the recommended target. The majority of patients did not get to see a doctor within the timeframe recommended by national experts. About 6% of them left the ED before being seen, likely because they were tired of waiting. This indicator is at its worst level in the past five years. Overall, our ED wait times are among the worst in the world.

We are concerned that the problems with patient flow may have some indirect impact on surgical wait times. On the positive side, wait times have decreased for cataract surgery and hip and knee replacements and are generally good for cardiovascular procedures. However, for overall surgeries, our healthcare system struggles to meet wait time targets for urgent (priority 2) cases. For example, only 53% of urgent cancer cases are completed within the two-week target. We do not know all of the reasons for these waits, and recognize that there are likely multiple, complex causes. However, one issue to consider is that priority 2 cases are generally more complicated and may require timely access to an ICU bed after surgery. If hospital bed capacity is very tight because of the ALC bed situation, that could make it more difficult to schedule these urgent cases. Last year, we reported that one hospital (North York General Hospital) ensured that all patients got their urgent surgery on time by implementing improvements in the scheduling

[1] http://www.ohqc.ca/pdfs/2010_report_-_english.pdf

process, as well as ideas to reduce ALC beds. In this example, addressing these flow issues made a huge difference. Numerous activities are currently taking place to improve patient flow. Within the ED, there is a Process Improvement Program to help hospitals improve their internal processes, as well as public reporting of wait times, a pay-for-results initiative and a Nurse Practitioner program to reduce ED visits from LTC homes. These are all strategies that have promise and we look forward to reporting on their impact in future years. However, they do not address one of the key root causes: the backlog of people waiting for LTC placement.

If this backlog is the origin of the problem, then what are the ideas for improvement? Last year, we described a case study from the health region around Lethbridge, Alberta, which kept its wait times to 28 days and used one-third fewer LTC beds compared to Ontario. That region had different publicly funded options for assisted living or supportive housing, where people could live in a home-like environment with 24-hour assistance when needed, if they required less care than that provided by LTC but more than that offered by home care. There may be important lessons for Ontario from this and other similar examples. Such a strategy would also require that safeguards and monitoring be in place to ensure that best standards for quality of care are maintained in these settings.

Some Interesting Facts:

- ✓ One of the fastest-growing age groups in Windsor-Essex County (WEC) is the 55 to 64 year old age group, the pre-retirement population. For WEC, the 2006 Census counted 42,665 persons in this group, an increase of 27.0%, or 9,075 persons, since 2001 (Statistics Canada, 2002a, 2007b). **In 2011 this group is now 60-69 years of age.**

- ✓ This age group represents the front-end of the baby boomer population. Because the baby boomers make up such a large proportion of WEC's population, they will have a big impact on the workforce as they retire. In 2006, the pre-retirement population represented 10.8% of the population of WEC. This is projected to increase to 14.3% in 2021 before declining.

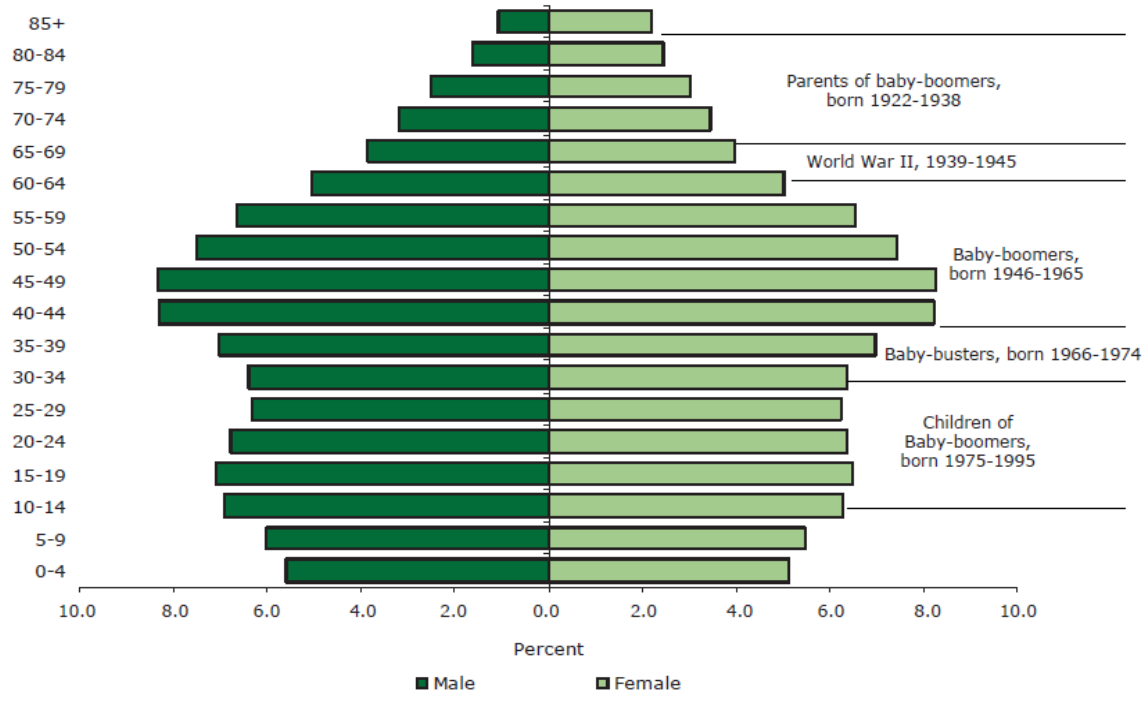
- ✓ At the same time, the proportion of young people beginning to enter the work force (ages 15 to 24) is on the decline. Currently, this group represents 13.6% of the population. This number is expected to drop to 11.3% by 2031.[2]

- ✓ Average age of admission at WRH – 66 years of age.

- ✓ Government of Ontario - 1995-2003 Progressive Conservatives; 2003-present Liberals.

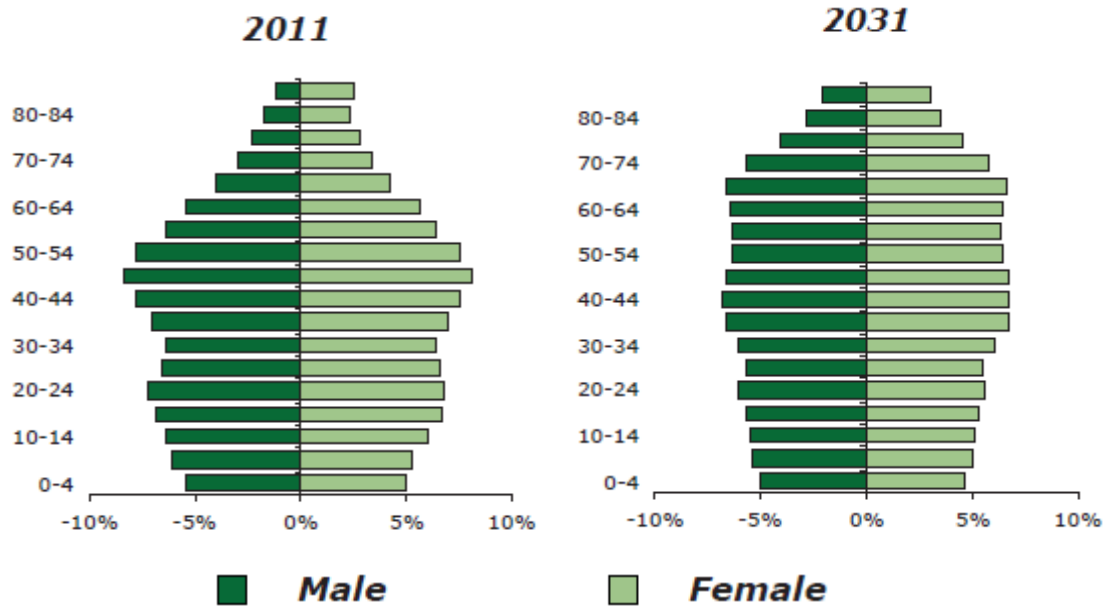
[2] http://www.wechealthunit.org/about-us/reports/2009_WEC_populationreport.pdf/view

FIGURE 2
Cohorts within the Age Pyramid of the Canadian Population in 2006



Source: (Statistics Canada, 2006a)

Essex County – Population Age/Sex 2011 compared to 2031



Strategic Direction – Embed Patient Quality and Safety in Our Culture

Windsor Regional Has Three Initiatives Selected to Make Oral Presentation at the Mayo Clinic

- On May 3, 2011, the Mayo Clinic in Rochester, Minnesota is hosting its 15th Annual International Conference entitled "Creating and Paying for Value in Health Care".

- Windsor Regional Hospital has been honoured in having NOT one, NOT two BUT three (3) of its Initiatives selected to provide an oral presentation to the attendees.

- The primary audiences for this conference include physicians, administrators, managers, allied health care providers, health care systems engineers, operations research professionals and educators. Improving health care quality and patient safety is a top priority in health care today. Every patient deserves high-quality, efficient, accessible, patient-centered care and there are significant improvement opportunities that don't require government action. Quality leaders are working to integrate human factors, quality improvement, teamwork, professionalism and patient-centered care into clinical practice. Yet traditionally, caregivers have not been trained in the effective use of these techniques. This conference provides participants with the latest information from local and national leaders in health care quality improvement initiatives. These best practices can be implemented in any clinical practice setting and will ultimately lead to greater efficiencies and improved care for patients. This course offers an excellent opportunity for education, collaboration and modeling of systems engineering techniques such as Lean and Six Sigma. In addition, human factor tools such as systems, processes, and workflows are demonstrated.

- The three selected for oral presentation are as follows:

  "Starting the Week off Right: Use of Monday Morning Huddle to Improve Patient Safety"
  Submitted by Corry O'Neil

  This is already recognized by the Minister of Health and Long Term Care as a cost effective, relatively straightforward practice that all healthcare providers can start without much effort. In addition, it was recognized as a Leading Practice at the 2009 International Ontario Hospitals Association Conference as a Leading Practice.

In early 2008, Windsor Regional Hospital engaged in a Strategic Planning exercise that involved hundreds of front line employees, physicians and Board members in setting a Vision of *Outstanding Care-No Exceptions!* One of the strategic directions arising from the Strategic Planning was to **Embed patient quality and safety in the culture of the hospital**. This strategic direction was operationalized in July 2008, with the creation of a weekly Directors' 'Huddle'. Every Monday morning, Directors 'check the pulse' of the hospital by reviewing key quality and safety indicators. This enables:

- communication and ownership,
- a culture of patient quality and safety by focusing on current outcomes,
- timely access to data and promotes accountability for action, and
- each leader being responsible for implementing and monitoring patient safety improvements.

Capitalizing on the weekly 'huddles', Windsor Regional Hospital next engaged its Board of Directors and other leaders directly in Patient Safety and Quality issues. An electronic tool was created allowing users to see updated indicators. Characteristics include a high-level roll-up with a 'red-green-yellow' format to indicate where each of the established indicators of quality are; dynamic representation of data allowing individualized drilldown and, dissemination of results for action planning with built-in accountability to facilitate problem-solving for improvement.

Windsor Regional Hospital then took it to the unprecedented level of sharing all of these results with the public by placing them on their Internet and in the monthly written communication of the President and CEO for the entire community and world to track its performance. Performance has improved by this active monitoring quality and action. As a result, participation and follow-up are immediately evident. Examples include 50% improvement in Pathway compliance, more than 90% hand washing compliance and reduced hospital acquired infections. Now, the organization focuses on outcomes without confusing 'what' the hospital is doing with 'how' it is doing, paying attention to the data, and not mistaking improvement for achievement.

A Recipe for Success…Not a Cookie Cutter Approach to Patient Falls
Submitted by Dr. Gina Bulcke

In Canadian acute care hospitals, falls are a significant patient safety concern. The Evidence Based Fall Reduction Program reflects the hospital's patient safety and quality focus and the strong leadership commitment to improvement and a culture of innovation. As a results-oriented program, Leading the Transformation at the Bedside to Reduce Falls provides for a definitive patient experience that increases awareness and understanding among bedside nurses; creates significant and sustainable changes in practice outcome and culture and has resulted in improved patient care. The program identified: best practices for fall reduction; engaged front line staff in process and work design; engaged patients and their families, transformed the patient safety culture, tested and measured changes; implemented and sustained best practices and spread the initiative from a pilot unit to other units, both acute and non-acute throughout the hospital.

Results show that since its implementation on a pilot Unit, the program has demonstrated a significant and sustainable reduction in falls and falls with injury. The program tested and measured changes in practice included the risk assessment tool, interventions and root causes. Fall rates are evaluated pre-program implementation, weekly and monthly over time.

Excel Your Bottom Line Profits: Tech Staffing Innovation = Financial Savings
Submitted by Dr. Gina Bulcke

Effective scheduling management requires the simultaneous juggling of many factors. The scheduling tracker was technology developed to respond to unfavorable salary and wages that resulted from retrospective financial and statistical (hours) information that did not adjust to occupancy rates. The organization needed to develop a way to recover deficits attributed to over-staffing in acute inpatient care - and the staffing tracker became a technological innovation breakthrough. The staffing tracker is an excel spread sheet designed specifically for each individual unit, where base staffing levels are mapped out by day and by shift and include: actual staffing, sick and modified shifts, the number of admissions, discharges, total occupancy and the number of patients deemed Alternative Level of Care. The tracker calculates the variance to budget as well as the staffing ratio based on the information entered and provides immediate feedback as to the appropriateness of staffing levels.

Results show that since August 2009, the staffing tracker has recovered year-to-date deficits and has contributed to the organization's overall surplus. The technology has more than doubled the targeted amount of shifts and hours saved and created significant savings ($170,000) in salaries and wages across the Acute Care portfolio.

Windsor Regional Hospital Selected as Participant at the Clinical Scholarship: Promoting Evidence-Informed Interprofessional Practice in CCC

- On April 8, 2011, at the Clinical Scholarship: Promoting Evidence-Informed Interprofessional Practice in CCC Windsor Regional Hospital has been selected to provide a poster presentation on

"Busting the Myth" - How WRH nurses nourish and sustain the development needs of the novice nurse"
Submitted by Sandra Shearme and Cheryle Johnston

Not all staff that work on the Complex Care Palliative Unit advance their knowledge of palliative care independently when they start with us. Due to this lack of knowledge/experience in palliative principles, the result may be a less than optimal experience for these patients. Two staff enrolled in the CAPCE program identified the need for increased staff education on this unit, particularly during orientation.

The objectives are to develop a 30 minute "champion-led" education session to increase palliative knowledge and skills in new hires (Goal = 100% of new hires). Develop e-

learning modules for all new employees (Goal = 100% of new hires) on the following topics:

– Overview of Palliative Care – Pain Assessment / Management,
– PPS – Managing other common problems in palliative care, and
– ESAS.

Several frontline staff identified a knowledge gap among both novice and seasoned staff new to Palliative Care. They indicated that care provided to the Palliative patients was not supported by evidence and/or best practice, particularly when it came to pain control.

Staff "champions" developed education material for the novice Palliative nurse and worked with management to meet with new staff and teach them the basics of Palliative Care. Education was provided to all new hires. To ensure all staff had the same basis, knowledge, efforts were made to provide this same education to those hired in the previous year as well.

Five Palliative Care e-learning modules were created and assigned to all new hires for completion within the first month of hire. To reinforce the content, these modules were also assigned to staff hired within the previous 2 years. Staff who completed the education sessions / e-learning modules felt they were a good review and provided them with the basics required in Palliative Care. Frontline "champions" helped to empower staff and improved care provided to patients. They have also been identified as leaders and mentors in Palliative Care amongst their new colleagues.

One hundred percent of new Palliative Care hires completed their e-learn modules within 5 weeks of the modules being assigned. One hundred percent of new Palliative Care hires in the last 2 years have received classroom education, however, not all within their orientation weeks. As a result of lessons learned from this program, we now ensure that classroom education is scheduled during Nursing Classroom Orientation Week, ensuring we catch all new hires right from the start, rather than having to re-organize schedules once staff start their rotational shifts on the floor.

Because education is provided upon hire, new staff to the Palliative Unit gain a better understanding of what Palliative Care is, and how to provide evidence-based care, rather than having to learn through trial and error. It has also helped to improve the nurses' approach to patients and families, particularly for those that may not fully understand the Palliative concept.

Strategic Direction – Cultivate an Environment of Accountability and Transparency

Accreditation 2011

- Accreditation 2011: Be a Part of it! Complete the "Worklife Pulse" and "Patient Safety Culture" surveys for a chance to win a $100 gift card. Find the surveys on the WRH Intranet - Accreditation 2011 website. Click on the tabs on the left side to access the

surveys. They only take about 10 minutes each! Once you have completed these surveys, fill out a ballot located at both Met and Western campuses. Surveys are available from February 7 - February 28th.

Strategic Direction – Build and Sustain Financial Health

2011-2012 Budget Process

- Following the March 2011 Board Meeting I will be making a presentation to all of you on the plans we have adopted entering the 2011-2012 Budget Year. We have to project no greater than a 1.5% base funding increase this upcoming fiscal year. We will not know the actual funding amount until it is announced by the Provincial Government. Unfortunately we could be a couple months into the new fiscal year before we know the actual amount.

- The 1.5% is only on our base funding. We receive approximately $220 million in base funding from the Province. The remainder of our funding comes from non-Ministry of Health programs, preferred accommodations and revenue from some diagnostic exams. Therefore, although our operating budget is approximately $300 million, only $220 million of that amount receives an adjustment.

- We will be ending 2010-2011 in a small surplus situation. This is as a result of the amazing work and the results each of you identified and implemented during the Zero Based Budgeting Process (ZBB).

- Our approach to 2011-2012 is to be fiscally responsible BUT also not to make drastic changes that negatively impact patient services or hospital jobs. However, if funding is less than 1.5% or our costs are not as planned (i.e. settlements/arbitrators' awards/loss of funding/unexpected expenses) then we will have no other choice but to revisit our planning and make further changes.

Strategic Direction – Enhance our Status as an Employer of Choice

Windsor Regional Hospital Night at Spitfire Game

- Invite your family, friends and colleagues to attend the last regular season game of the Windsor Spitfires on Thursday, March 17. Tickets are just $18 with a portion going to the Windsor Regional Hospital Foundation. Tickets are available by contacting Kim Willis-More at x52458 or kim_willis-more@wrh.on.ca.

Diversity Training (LGBTT) Available

- The Diversity Committee has made arrangements for Diversity Training to Staff on LGBTT issues. A group from Windsor Pride (the 50+ Proud group) will provide training. The focus will be on the needs of the elders in the LGBTT Community who will require care from local agencies and care facilities, however the training is applicable to all age

groups. The sessions offer an opportunity to explore some of the issues that may arise in caring for patients/clients from the LGBTT community. The next sessions are March 15, 2011 (Malden Rehab Meeting Room). All sessions are from 1 pm to 4 pm. For more information contact Melissa Simas at ext. 72302.

Strategic Direction – Distinguish Ourselves through Superior Performance, Innovation and Exceptional Customer Service

Cancer Care Ontario's 2011 Human Touch Awards - Call for Nominations

- Now in its fifth year, the Human Touch Awards recognize health care professionals, providers and volunteers in the cancer system who demonstrate exemplary compassionate patient care. All part-time and full-time health care professionals, providers and volunteers who provide direct patient care at either a Regional Cancer Centre or as part of a Regional Cancer Program are eligible. Further information and nomination forms have been posted to our WRH website, or visit cancercare.on.ca. Previous winners of this prestigious award are Donna Danelon, Dietician, and Jo-Anne McGuire, Social Worker in our Windsor Regional Cancer Program! The submission deadline is March 4/11**.**

Strategic Direction – Strengthen our Relationships with External Partners

Dr Len Cortese Reaches out to our Children's Educators

- On Friday, February 11, 2011, Dr. Len Cortese Chief of Psychiatry at Windsor Regional Hospital reached out to the individuals that educate and care for our children on a daily basis while they attend school at the Windsor-Essex Catholic District School Board.

- Len made a presentation on Student Mental Health and Well-Being. Len's presentation focused on the alarming rate increase of children's mental health issues and how our educators can identify signs early on and the services that are available to the students.

- The presentation was streamed live to all secondary school sites. Each site was hosted by the Principal of the Secondary School. In addition to the staff from the Secondary Schools, Principals, Vice-Principals, Teachers, Educational Assistants, Learning Commons Specialists and Secretaries from their feeder elementary schools took part in the event. Faculty of Education students from the University of Windsor also attended.

- In addition to teaching staff, attendees included, Speech-Language Pathologists, Psychology Staff, Social Workers, Behaviour Specialists, Consultants, Coordinators and System Support Staff. The presentation is another example of the community's commitment and dedication to helping students and families who may be affected by mental illness.

- Thanks Len for taking the time to make this presentation. I am confident others will be contacting you for a similar presentation.

Educating Our Youth about Opportunities in Health Care

- On February 14, 2011, Jacques Kenny, WRH Board Member, Gisele Sullens and I had a opportunity to attend both E.J. Lajeunesse and L'Essor High School to discuss the various activities, challenges and opportunities for our youth in healthcare in our region and across the world.