# Rouge Valley Health System and The Scarborough Hospital Facilitated Integration Process

# Due Diligence Workbook:

# Maternal Child (DRAFT)

A Facilitated Process of the Central East LHIN

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|---|---|---|---|
| **Authors:** | Maternal Child Working Group | **Version Number:** | 2 |
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# 1. Current State Assessment & Leading Practice Review

## 1.1. Overview of Services/Programs

*Use the following table to document the high-level profile of the services/programs within the area of focus, including key quality and performance metrics.*

| | |
|---|---|
| **Location of Service/Program** *Where are the services/ programs delivered? At both hospitals? At specific sites?* | Rouge Valley Health System (RVHS) has two campuses (Centenary in Scarborough and Ajax/Pickering in Ajax) both providing obstetrical/gynecological and paediatric care to patients. The Scarborough Hospital (TSH) has two campuses (General and Birchmount) both providing obstetrical/gynecological and paediatric care to patients. Both hospitals provide a multidisciplinary approach to care inclusive of: social work, chaplaincy and perinatal bereavement.<br><br>For the purpose of the due diligence process, this workbook will focus only on the three hospital sites within the Scarborough cluster (Centenary [RVC], The Scarborough Hospital General and Birchmount site) and the clinical programs offered at those sites.<br><br>**Paediatrics**<br>**RVC -** The Centenary campus offers a paediatric inpatient unit with 4 acute care beds, day surgery, a level IIc Neonatal Intensive Care Unit with 20 beds and a wide variety of subspecialty paediatric services and clinics. These clinics include paediatric consult, gastroenterology, nephrology, rheumatology, sickle cell clinic, haematology, diabetes, nutrition/diabetic education, diabetic education, immunology/allergy, oncology, adolescent medicine, paediatric/adolescent mental health, scoliosis clinic, respiratory syncytial virus (RSV), breastfeeding, neonatal follow-up, Toronto Preschool Speech and Language, paediatric occupational therapy, Pulse Dye Laser (PDL) surgeries, Child Life Specialist, and paediatric pre-operative clinic. RVC offers consult services and subspecialty services such as cardiology, neurology, respirology, endocrinology, physiotherapy and infectious disease.<br><br>**TSH -**The Scarborough Hospital offers a paediatric inpatient unit, day surgery, and a level IIb Neonatal Intensive Care Unit with 10 beds at both sites. Both campuses are offer a wide range of paediatric subspecialty services including: general paediatric day clinic (both sites), RSV clinic (both sites), developmental screening clinic (General campus), neonatal follow-up, neurology, Toronto Preschool Speech and Language, paediatric occupational therapy, orthopaedic clinic in partnership with SickKids, paediatric day surgery including the “Till I Sleep Program”, and the paediatric pre-operative clinic, Paed Link (Emergency Department fast-track), and Child Life Specialist program. TSH offers a Sexual Assault and Domestic Violence Program at its Birchmount Campus. |

**Location of Service/Program** (continued)

**Obstetrics/Gynecology**

**RVC -** The Birthing Centre at the Centenary campus functions at level IIc and can deliver babies at 30+ weeks gestation. There are a number of clinics available to the obstetrical patients such as: non-stress test clinic, early pregnancy clinic, genetics, obstetrical triage, gestational diabetes services, newborn follow-up clinic and breastfeeding. RVHS offers a midwifery program. Gynecology and urogynecology services are also offered including minimally invasive surgeries (MIS) and colposcopy.

**TSH -**The Family Maternity Centres at both campuses function at level IIb and can deliver babies at 32+ weeks gestation. There are a number of clinics available to the obstetrical patients such as: antenatal fetal assessment, obstetrical triage, breastfeeding clinics, early pregnancy assessment clinic (Birchmount), five day/five night mental health program, postpartum depression services, postpartum/newborn assessment clinic, gestational diabetes services and a midwifery program. Gynecology and urogynecology services are also offered including minimally invasive surgeries (MIS), uterine artery embolization (UAE) and colposcopy.

**Volume of Activity**
*What is the current volume of activity? (e.g. service levels, patient volume) Are there important trends? (e.g. growth, decline)*

| Fiscal Year 2012/13 | RVC | TSH-G | TSH-B |
|---|---|---|---|
| Birth Volumes | 2237 | 2820 | 2097 |
| Obstetrics Occupancy Rate | 68% | 75% | 58% |
| NICU Inpatient Days | 5466 | 2552 | 2465 |
| NICU Inpatient Occupancy Rate | 75% | 75% | 68% |
| Paediatric Ambulatory Clinic Volumes | 9720 | 9697 | 6011 |
| Percentage of Emergency Department Visits that are Paediatric | 20% | 17% | 17% |
| Paediatric Inpatient Occupancy Rate | 73% | 43% | 42% |
| Paediatric Day Surgery Volumes | 1495 | 1292 | 1307 |
| Paediatric Inpatient Days | 2400 | 529 | 572 |

**Mode of Delivery**
*How are the services/programs delivered? (e.g. inpatient, ambulatory)*

All three hospital sites in Scarborough use a service delivery model of care that is driven by a commitment to outstanding quality patient centered care and interdisciplinary team approaches including:

- nursing care inclusive of registered nurses and registered practical nurses

| | |
|---|---|
| **Mode of Delivery (continued)** | • offering a family centered option for women to labour, deliver, and recover in a private room with their families<br>• identification and support for families in need of social work services<br>• family integrated care such as care-by-parent rooms, sleep rooms, family lounges, infant rooming-in with mother, availability of private rooms for families to stay with their child<br>• Caesarean-sections performed within the obstetrical units<br>• a commitment to preserve, promote and protect breastfeeding<br>• provide ongoing support after discharge (i.e. discharge phone calls, discharge follow-up clinics)<br>• supporting acute paediatric patients close to home<br>• collaborate with community partners as appropriate (i.e. Community Care Access Centre, Toronto Public Health, tertiary health centres)<br>• planned 24 hour discharge for normal vaginal deliveries<br>• planned 48-72 hour discharge for Caesarean sections patient centred care focused on the women's birth plan and choice of pain management (i.e. epidural, nitrous oxide, hydrotherapy, and other medications)<br>• electronic documentation in obstetrics and NICU (RVC site only)<br><br>All three Scarborough hospitals rely on the community family physicians for obstetrical and paediatric referrals.<br><br>The nursing staff at RVHS and TSH are cross-trained within the Maternal Child program which offers increased flexibility in assigning resources according to patient needs. Staff movement between the two TSH campuses assists with aligning resources with patient demands. |

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| **Innovations Planned and/or Underway**<br>*What changes are planned or in-progress to improve the service/ program?(e.g. new model of care, investment in new technology)* | **RVC**<br>• Development of a Maternal Fetal Medicine (MFM) program in partnership with Sunnybrook Health Sciences Centre; recruitment is underway for an MFM specialist.<br>• Updating minimally invasive surgery<br>• Expansion of the urogynecology program<br>• Expansion of the electronic documentation and monitoring system (ObTraceVue) currently in place in obstetrics to the NICU<br>• Marketing initiatives to increase obstetrical volumes<br>• Development of a paediatric constipation clinic in partnership with SickKids<br>• Shift to a paediatric only inpatient unit (currently the paediatric unit services adult medical patients when adult units are full)<br>• Expansion of urology<br>• Paed Link<br>**TSH**<br>• RPN training for support during c-section deliveries<br>• Application of the "Studer Bundle" best practices which include hourly patient rounding, multidisciplinary team huddles twice daily, post-discharge telephone follow-up calls, face-to-face transfer of accountabilities (obstetrics only)<br>• Public relations campaign (Birchmount campus) to increase volumes<br>• Water births<br>• Pursuit of World Health Organization (WHO) Baby Friendly designation<br>• Implementation of a Patient Navigator role for obstetrics<br>• Marketing initatives |
| **Key Metrics**<br>*Identify and describe the key metrics that capture the quality and performance of the services/programs* | Both hospitals monitor a range of quality and performance metrics including:<br>• Obstetrics<br>  ○ Patient satisfaction<br>  ○ Mortality rate<br>  ○ Morbidity rate<br>  ○ Readmission rate<br>  ○ C-section rate<br>  ○ Induction rate<br>  ○ Vaginal birth after c-section (VBAC)<br>  ○ Breastfeeding rates |

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| **Key Metrics (continued)** | • Paediatrics<br>  ○ Patient satisfaction<br>  ○ Newborn readmission rate<br>  ○ Infection rates<br>  ○ Length of Stay inpatient paediatrics and NICU<br>  ○ Inborn admission rates for NICU<br>  ○ Time from arrival in the emergency department to transfer to an inpatient paediatric bed<br>  ○ Paediatric readmission<br><br>Both hospitals participate in the reporting of data to the provincial Better Outcomes Registry & Network (BORN) and the Provincial Council of Maternal and Child Health. |
| **Other Information**<br>*Provide additional service/program information (if required)* | no other information provided |

## 1.2. Patient Profile

*Use the following table to document the high-level patient profile related to the services/programs.*

| | |
|---|---|
| **Patient Value Statement**<br>*Identify the purpose of the service/program area and the value-added benefit that it offers from the perspective of the patient.* | The patients and families that receive care in our obstetrics and paediatrics program value treatment and interactions that include:<br>• Respect<br>• Feeling respected for their cultural and religious beliefs<br>• Being informed and involved in their care plan (or their child's care plan) in a way that makes them feel like they are a welcome part of the caregiving team<br>• Culturally sensitive care and communication<br>• Informed choice<br>• Progressive treatments and interventions<br>• Pain management<br>• Welcoming provision of service regardless of what hospital the patient 'belongs to' or has used in the past<br>• Timely access to services and health care professionals<br>• Good care close to home |
| **Patient Characteristics**<br>*Describe the key patient characteristics; consider factors such as demographics, geography, complexity, etc.* | • The obstetrics program serves women of child-bearing age and their families. This includes many young/teenage mothers.<br>• The paediatrics program serves newborns, children, teenagers and their families.<br>• Both the obstetrics and paediatric populations are diverse in terms of language, culture and race.<br>• Other than English, Tamil is the top language of patients at RVC and TSH-General Campus while Cantonese is the top language of patients at TSH-Birchmount campus.<br>• Certain services have high proportions of patients from specific demographic groups (e.g. the paediatric sickle cell clinic at RVC serves a largely Black population)<br>• Both programs serve a significant number of patients and families that are newcomers to Canada. In addition to language issues many of these patients may not have OHIP coverage.<br>• Many of patients/families face socio-economic challenges as 6 out of 10 high priority areas identified for the City of Toronto are located in Scarborough. |

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| **Population Need**<br>*Describe the key factors driving population need; consider factors such as social determinants of health, incidence/ prevalence rates, demand (e.g. wait lists, people travelling outside CE LHIN for service/program), etc.* | • "Despite the range of obstetrical and paediatric services offered there are still a number of unmet needs for our community.<br>• Some patients travel outside of Scarborough to access services. This may include travel to access specialized/tertiary services that are not available locally or travel to access services that meet the special needs of newcomers.<br>• There are no paediatric palliative services in Scarborough.<br>• There are wait lists for clinics and midwifery services.<br>• The ability to meet patient needs is also impacted by patient compliance.<br>• A regional model of maternal/child care does not currently exist in Scarborough.<br>• Developmental assessment and therapy services |

## 1.3. SWOT Analysis

*This section should summarize the SWOT analysis using the following table. For each Strength, Weakness, Opportunity and Threat identified, indicate the organization(s) to which it applies by placing an X in the appropriate box.*

| | RVHS | TSH |
|---|---|---|
| **Strengths** | | |
| • Multicultural staff with diverse language capacity | X | X |
| • Diverse range of subspecialties | X | X |
| • Staff/Physicians dedicated, committed, highly skilled and focused on quality | X | X |
| • Unique programs | X | X |
| • Gynecology doing minimally invasive surgeries | X | X |
| • Exemplary accreditation results | X | X |
| • Strong Urogynecology program (specialized service) | X | |
| • Good interdisciplinary relations | X | X |
| • Stakeholder commitment to excellences | X | X |
| • Physical plant – new Birthing Centre and NICU, large paediatric space | X | |
| • Electronic Medical Record and central monitoring for Obstetrics | X | |
| • Obstetrical and NICU level IIc | X | |
| • Clinical service, space and bed capacity within cluster | X | X |
| • All three sites have a pleasing feel to them | X | X |
| • Paediatric friendly space at both organizations | X | X |
| • Obstetrics at TSH-General is large and recently renovated | | X |
| • Stable complement of obstetricians and paediatricians | X | X |
| • Physicians have affiliation with the University of Toronto for teaching residents | X (paediatrics) | X |
| • Huge strength amongst physician group if they all come together | X | X |
| • Strong Interventional Radiology program | | X (General) |
| • Midwifery program | x | X (Birchmount) |
| • Excellent translation services | X | X |
| • | | |

| | RVHS | TSH |
|---|---|---|
| • Large paediatric space | X | X |
| • Developmental and Newborn Clinic (Developmental clinic is the only program in Scarborough) | | X |
| • Partnership with ED through Paed Link Program. It is the only program within the GTA. | | X |
| • Early Pregnancy Assessment Clinic – partnership with Emergency Departments to pull patients out of the Emergency Department and for ongoing follow-up | x | X |
| • Pulse Dye Laser Surgery (PDL) – RVC is the only community hospital in Ontario providing this services aside from Ottawa | X | |
| • Scoliosis Surgery – RVC is the only community hospital providing this service in the CELHIN and beyond | X | |
| • Orthognatic Surgery (maxillofacial) – RVC is the only group funded in the LHIN to provide this service | X | |
| • Capacity for expansion exists if needed due to projected growth from population increase or integration of services | X | X |
| **Weaknesses** | | |
| • All 3 units competing with each other and functioning under capacity | X | X |
| • Aging infrastructure and equipment with exception of Birthing Centre at RVC and video towers at RVC | X | X |
| • Corporate electronic documentation system is antiquated | X | X |
| • Resistance to change | X | X |
| • Paediatric medical staffing could be enhanced | | X (Birchmount) |
| • Mandated maintenance of Emergency Departments at all three sites within the Scarborough cluster | X | X |
| • Lack of vision | X | X |
| • Strategic dysfunction | X | X |
| • Lack of physician integration and collaboration across the three sites | X | X |
| • Silos | X | X |
| • Internal competition for resources | X | X |
| • Weak branding of programs and services | X | X |
| • Insufficient development of community partnerships | X | X |
| • Negative branding by own staff will destroy public trust, staff morale. We must counter the negativity | X | X |

| | RVHS | TSH |
|---|---|---|
| • Insufficient labour and delivery volumes to support dedicated anesthesiology coverage to labour and deliver and operating room | X | X |
| • Dilute unique attributes of existing programs related to the populations served | x | x |
| **Opportunities** | | |
| • Consolidation and collaboration would generate efficiencies leading to potential for increased and better utilization of funding | X | X |
| • Opportunity to capture funding under the new funding model | X | X |
| • Improve service delivery model | X | X |
| • Decrease the competition and increase the services | X | X |
| • Decrease the cost per case by collaboration | X | X |
| • Increase midwifery (level of funding) | X | X |
| • Subway can increase patient access | X | X |
| **Threats** | | |
| • Not capturing optimal market share | X | X |
| • Families moving east and north out of the area | X | X |
| • Competition from other hospitals | X | X |
| • Other organizations may increase their use of midwives | X | X |
| • Subway can decrease patient flow away from our doors | X | X |
| • Siloed programs across Scarborough cluster (not a conglomeration) | X | X |
| • Our biggest threat could be "ourselves" if we don't move forward progressively; difficulty making decisions | X | X |
| • Community perception that change equals loss | X | X |
| • Staff who undermine the process | X | X |

## 1.4. Environmental Scan

*This section should contain a summary of key external factors (i.e. influences/trends) that should be considered in the due diligence process. At minimum, Working Groups should consider using a PESTLE framework for identifying external factors – **P**olitical, **E**conomical, **S**ocial, **T**echnological, **L**egal, **E**nvironmental. Note: Complete only for the sections of the framework that are relevant to your Working Group area of focus. For each of the sections that are relevant, focus on the key 2-3 external factors that are most important to consider.*

| | |
|---|---|
| **Political**<br>*Factors that include provincial strategies and/or programs, LHIN priorities/directions and other government trends* | • No strong direction currently<br>• Women's and Children's not a priority in low growth population areas<br>• When services move – perceived as "a loss" to organizations (e.g. "All 3 emergency departments will be open") |
| **Economical**<br>*Factors that include fiscal realities, funding models and other economic trends* | • Impact that any proposed changes have on "the provider of health care"<br>• Fundraising issues<br>• Current budget and funding to the 2 separate organizations<br>• Your market share is where your budget is – the money follows the patients<br>• Quality Based Funding |
| **Social**<br>*Factors that include demographics, socio-cultural trends, social determinants of health and other social/community trends* | • No public voice<br>• Low socio-economic population<br>• Marketing issues – community not clear what we provide<br>• Newcomers/new clients have difficulty accessing and advocating for the service |
| **Technological**<br>*Factors that include information management and information technology trends, globalization, innovations in patient care and other technical trends* | Advances in technology are changing clinical practice, quality, access and how patients interact with health care providers and the health system; examples include:<br>• Patients using the internet to access information and explore health care options<br>• Online booking of health care appointments<br>• Self-registration kiosks for clinics<br>• Dictated notes shared with patient<br>• Automated Parking systems (direct to empty space, easy pay)<br>• Wayfinding in Kiosks<br>• Translation service on demand<br>• Free Wi-Fi that is accessible<br>• Timely test results before patient seen by physician<br>• Electronic referrals by physicians and self<br>• Computerized technology and shared health information (e.g. Electronic Child Health Network (eCHN)) are influencing quality of care |

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| **Technological (continued)** | • Electronic health records – accessible via desktop and mobile with auto-transfer of documentation to physicians<br>• Electronic whiteboards<br>• Electronic education<br>• Telemedicine; Ontario Telemedicine Network (OTN) provides linkages with teaching/tertiary hospitals<br>• Central telemetry<br>• Minimal invasive surgical suites<br>• Robotics<br>• Pneumatic system<br>• Physician-specific metrics in real time<br>• Surgical Information Systems (SIS) – tracks patients throughout all phases of perioperative care in real time.<br>• Novari's Access to Care system gives surgeons and specialists the ability to electronically book surgical and other cases at the hospital and automates mandatory provincial wait times reporting. |
| **Legal**<br>*Factors that include relevant legislation and other legal trends* | • *Excellent Care for All Act* (2010)<br>• Privacy legislation<br>• The Managing Obstetrical Risk Efficiently (MOREOB) Program<br>• Cap on settlement on legal claims |
| **Environmental**<br>*Factors that include attitudes towards "green" or ecological products/resources, corporate social responsibility trends and other environmental trends* | • Efforts to move towards a paperless work environment<br>• Increased focus on recycling |

## 1.5. Leading Practices

*This section should contain a summary of leading practices, as relevant to the area of focus. Note: KPMG support will be provided for the leading practice review.*

*The Leading Practice Summary provided by KPMG is included for reference in the Appendix of the Workbook. The Summary is a high-level review of leading practice themes and is intended to be a conversation-starter for the purpose of assisting in the due diligence process in order to determine what benefits a merger of the two hospital corporations will provide to the Scarborough community.*

*The Leading Practice Summary is only one source to obtain ideas and insights related to leading practices. The Working Group is also encouraged to draw on their own knowledge, experiences and sources to complete the following section.*

| | |
|---|---|
| **Additional Leading Practices for Consideration**<br>*Identify any additional leading practices based on the Working Groups knowledge, experience and sources.* | • Standardized use of evidence based guidelines for common paediatric conditions<br>• Electronic Documentation with integration for equipment<br>• Computerized order entry<br>• Electronic Child Health Network (eCHN) uploads (sharing patient results and images with eCHN) |
| **Leading Practices Already Implemented**<br>*Based on the Leading Practice Summary and the additional leading practices listed above, identify those that are already in place at RVHS and/or TSH.* | • Standardized use of evidence based guidelines for common paediatric conditions<br>• Electronic Documentation with integration for equipment |
| **Benefits of a Potential Merger**<br>*Identify the leading practices that could be adopted and/or enhanced through a potential merger of the two hospitals?* | • |

# 2. Opportunity Assessment

## 2.1. Overview of Opportunities

*This section should provide an overview of the portfolio of potential opportunities identified by the Working Group. Opportunities should be numbered for ease of reference to Detailed Opportunity Assessment section.*

| Reference | Opportunity - Paediatrics |
|---|---|
| P1 | Central East LHIN Regional Paediatric Program<br>• Stronger clinics and enhancement of small programs (i.e. complex care, palliative care, obesity, expanded developmental care)<br>• Create new programs in specialized areas<br>• Create paediatric after hours clinic/urgent care<br>• Partner with other organizations for special populations<br>• Expand paediatric mental health program |
| P2 | Consistent Use of Best Practices<br>• Including point of excellence for better servicing special populations (i.e. sickle cell) |
| P3 | Promotion of Increased Use of Ambulatory Care Program Benchmarks<br>• Ambulatory care paediatric services promoted at provincial level |
| P4 | One Site<br>• One institution (short-term)<br>• One physical campus (longer term) |
| P5 | Building the Brand<br>• Collective fundraising efforts<br>• Stronger public relations and branding |
| P6 | Seamless Access<br>• Common seamless referral and intake system<br>• Patient Navigator role<br>• Cross-site bed management system |

| Reference | Opportunity - Obstetrics |
|---|---|
| O1 | Centre(s) of Excellence<br>• Increased volumes – may have opportunity to have dedicated anaesthesia to the program, stronger bargaining for more resources (by site or at one site)<br>By Site – no real benefit<br>At One Site – centre of excellence, recapture market share<br>• Lacking basic services in our community, therefore the opportunity to expand and increase services for women's health in obstetrics (e.g. amniocentesis, genetic termination, high risk<br>• Opportunity to expand urogynecology program by combining hospitals/gynecology/oncology<br>• Gynecology opportunities – Early pregnancy complications, inpatient opportunity<br>• Regionalization /network of paediatrics, gynecology, women's health<br>• Electronic documentation so access to patient information throughout merged organization (e.g. add – GP care, midwifery, paediatrics)<br>• Decrease competition within the catchment area with a merged organization – can support the patient through the continuum of care<br>• Greater economies of scale |
| O2 | Midwifery<br>• Growth of midwifery – opportunity to expand/evaluate and improve birth numbers/care provider |
| O3 | Obstetrical Group<br>• Redeployment/manpower strategy with obstetrical group – on call group allows improved hours/patient safety (decrease of 24 hour on-call to 12 hour shift)<br>• Offer more culturally sensitive types of service, multicultural service. |
| O4 | Outpatient site or services |

## 2.2. Opportunity Assessment

*For each of the opportunities identified in Section 2.1, complete the table on the following page.*

*Facilitation Tip: Prior to assessing the potential opportunities, work together as a Working Group brainstorming the possibilities. Encourage Working Group members to consider different ideas and different types of integration scenarios (e.g. consolidation, outsourcing).*

## Opportunity P1: CE LHIN Regional Paediatric Program

**Overview:**

| | |
|---|---|
| **Description** | • Regional Paediatric Program<br>  ○ Expand and continue stronger clinics (post-partum, breastfeeding, paed link, newborn and paediatric follow-up clinics)<br>  ○ Create new programs in specialized area<br>  ○ Partner with other organization<br>  ○ Create a paediatric after-hours clinic<br>  ○ Central East LHIN-wide program<br>  ○ Expand paediatric mental health |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • Comprehensive care closer to home<br>• One stop shop |
| **Community** | • Easier access<br>• Healthier community<br>• Culturally sensitive care |
| **Organization** | • Increased catchment<br>• Increased operational and process efficiencies through economies of scale and tight connections across the services<br>• Increased market share |

| | |
|---|---|
| | • Stronger position to access funding – funding follows patient |
| **Clinicians & Staff** | • Increased education (growth and development)<br>• Recruitment and retention<br>• Increased development of skills through critical mass<br>• Increased clinical competency<br>• Variety of services to be provided (opportunity) |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| • Inability to access capital and operating costs | • Re-investment of savings<br>• Fundraising<br>• Advocacy<br>• Business planning includes primary care |
| • Loss of focus on hospital based primary services | • Vision for comprehensive program<br>• Linkages with primary care and community<br>• Comprehensive services to include primary care |
| • Insufficient Physician availability | • Health Human Resource planning<br>• Talent management<br>• Links to post grad programs |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Medium-term (1-2 years)** |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • Market share<br>• Staff satisfaction |

| | |
|---|---|
| | • Patient satisfaction<br>• Recruitment and retention rates<br>• Number of referrals<br>• Number of subspecialty consults<br>• Wait times |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)**<br>*Identify the key financial investments (e.g. one-time costs) required to realize the benefits.* | • |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial impact (stated in the $100,000).*<br>*Is this opportunity a financial investment or savings?* | • |

## Opportunity P2: Consistent Use of Best Practices

**Overview:**

| | |
|---|---|
| **Description** | • Consistent use of quality/best practices |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • high quality of care<br>• shorter length of stay<br>• better outcomes<br>• decreased wait times |
| **Community** | • healthier community<br>• increased community confidence<br>• increased access<br>• decreased wait times<br>• optimizing resources |
| **Organization** | • better resource utilization<br>• cost effective care<br>• decreased errors<br>• meeting accreditation standards<br>• meeting clinical benchmarks |
| **Clinicians & Staff** | • consistent practices |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| • unless there is a system in place to monitor practices we could become | • regular review of order sets to ensure practices |

| outdated | are current |
|---|---|
| • non-compliance with best practices | • strong quality assurance<br>• case reviews |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Short-term (up to 1 year)** |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • Compliance to protocols/order sets<br>• Reduced length of stay<br>• Reduced conservable days |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)**<br>*Identify the key financial investments (e.g. one-time costs) required to realize the benefits.* | • |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial impact (stated in the $100,000).*<br>*Is this opportunity a financial investment* | • |

| | |
|---|---|
| *or savings?* | |

## Opportunity P3: Promotion of Use of Ambulatory Care Programs

**Overview:**

| | |
|---|---|
| **Description** | • Stronger position from which to promote greater use of paediatric ambulatory care benchmarks at the CE LHIN and provincial level |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • Timely access to stable program with specialized services<br>• Alignment of provider and organizational incentives to best practices |
| **Community** | • Access to paediatric services |
| **Organization** | • Alignment of provider and organizational incentives to best practices<br>• Sustainable program<br>• Stable funding |
| **Clinicians & Staff** | • Stable program leads to increased recruitment and retention |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| • Potential loss of inpatient funding - Hospital Based Allocation Model (HBAM) | • Advocate with Provincial Council for Maternal and Child Health (PCMCH)<br>• Utilizing evidence based statistics demonstrating admission avoidance |
| • Time, resources and attention required to achieve greater use of ambulatory care benchmarks | • Advocate by using Ontario Medical Association and Physician links |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Medium-term (1-2 years)** |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • Adoption of paediatric ambulatory care benchmarks at the CE LHIN level<br>• Adoption of paediatric ambulatory care benchmarks at the provincial level |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)**<br>*Identify the key financial investments (e.g. one-time costs) required to realize the benefits.* | • |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial impact (stated in the $100,000).*<br>*Is this opportunity a financial investment or savings?* | • |

## Opportunity P4: One Site

**Overview:**

| | |
|---|---|
| **Description** | • Build one physical facility that would house a comprehensive range of paediatric services |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • One stop shop (no transportation required to different sites)<br>• Increased patient satisfaction<br>• Increased accessibility – e.g. potential for referrals tobe seen in the same day |
| **Community** | • New state of the art facility |
| **Organization** | • Increased efficiency – decreased maintenance and overhead costs<br>• New equipment |
| **Clinicians & Staff** | • Increased staff satisfaction, recruitment and retention<br>• State of the art equipment |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| | • |
| • Underfunding of new facility | • Strong fundraising |
| • Unachievable volume targets or other conditions of funding | • Marketing and reputation |
| • | • |
| Changes to Emergency Department access | • Increased urgent care centres<br>• Stand alone Emergency |

| | |
|---|---|
| | department with horizontal transfer to inpatient bed |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Long-term (3-5 years)** |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • Market share<br>• Patient satisfaction<br>• Staff satisfaction |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)**<br>*Identify the key financial investments (e.g. one-time costs) required to realize the benefits.* | • |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial impact (stated in the $100,000).*<br>*Is this opportunity a financial investment* | • |

| | |
|---|---|
| *or savings?* | |

## Opportunity P5: Building the Brand

**Overview:**

| | |
|---|---|
| **Description** | • Build a new stronger brand and promote the organization through greater public relations and marketing including more effective collective fundraising efforts<br>• Utilizing a two-phased approach will begin by raising community awareness of currently available programs and services. In the second phase, advertising will be done for additional integrated programs and services. |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • Instill confidence and pride<br>• Increase awareness of services available |
| **Community** | • Confidence in the brand |
| **Organization** | • Increased market share<br>• Increase recruitment of physicians and staff |
| **Clinicians & Staff** | • Pride and confidence in the brand<br>• Increased morale |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| • Not meeting expectations created by the brand | • Focus groups |
| • Confusing the public with different phrases | • Use appropriate resources<br>• Widespread consultation<br>• PR group to send out a clear, well thought out and culturally sensitive |

| | |
|---|---|
| | message<br>• Open, honest and culturally sensitive messaging |
| • High PR campaign costs | • Robust Request For Proposal process or manage with internal resources' |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Short-term (up to 1 year)** – phase 1<br>• **Medium-term (1-2 years)** – phase 2 |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • Market share<br>• Patient satisfaction<br>• Increased dollars raised through fundraising |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)**<br>*Identify the key financial investments (e.g. one-time costs) required to realize the benefits.* | • |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial* | • |

| | |
|---|---|
| *impact (stated in the $100,000).*<br><br>*Is this opportunity a financial investment or savings?* | |

## Opportunity P6: Seamless Access

**Overview:**

| | |
|---|---|
| **Description** | • Development of a common seamless referral system enabled by technology, creation of a patient navigator role<br>• Development of a cross-site bed management system |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • Empowered patients<br>• Decreased wait times<br>• Increased patient satisfaction<br>• Increased awareness of available services<br>• Easier system navigation<br>• Informed choices as to where to receive care |
| **Community** | • Easier access<br>• Increased health promotion/preventative programs<br>• Improved linkages with community services<br>• Seamless resources |
| **Organization** | • Decreased errors<br>• Better utilization of resources<br>• Streamlined processes and resources<br>• Appropriate utilization of services |
| **Clinicians & Staff** | • Increased appropriate referrals |

| | |
|---|---|
| | • Increased staff satisfaction<br>• Increased effectiveness |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| • Decreased patient satisfaction if transferred to another site for services | • Strong communication regarding expectation |
| • Lack of consistent high quality care across different sites/hospitals | • Technology<br>• Shared Electronic Health Record |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Medium-term (1-2 years)** |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • patient satisfaction<br>• number of new referrals<br>• bed occupancy<br>• ER wait times<br>• wait times for outpatient services<br>• number of transfers |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)**<br>*Identify the key* | • |

| | |
|---|---|
| *financial investments (e.g. one-time costs) required to realize the benefits.* | |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial impact (stated in the $100,000).*<br>*Is this opportunity a financial investment or savings?* | • |

## Opportunity O1: Centre(s) of Excellence

**Overview:**

| | |
|---|---|
| **Description** | • Quality programs that are accessible to Scarborough families. Leading area of excellence in the province.<br>• Enhanced patient experience<br>• More comprehensive women's and children's care<br>• Current leading practices could be evolved to improve best practices |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • Accessibility<br>• Continuity of care |
| **Community** | • Increased quality<br>• Public perception that we are providing the "gold standard" as an alternative to "downtown" hospitals<br>• Build a program that the community wants<br>• 360° review of providers ensuring good clinical outcomes |
| **Organization** | • Operational and process efficiencies through economies of scale and tighter connections across the different services<br>• Enhanced relationships amongst physician groups<br>• Improved staff and physician morale<br>• Program sustainability<br>• Partnerships with external agencies<br>• Pride in the workplace<br>• Recruitment and retention |
| **Clinicians & Staff** | |

| | |
|---|---|
| | • Right Care, Right Place, Right Time |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| • Lack of organizational infrastructure | • |
| • Resources not in alignment with increasing volumes | • |
| • Intrapersonal conflicts | • Strong leadership, SMART goals, accountability |
| • Community perception that change equals loss | • Community engagement, marketing |
| • Continued internal competition and decreased efficiencies | • |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Short-term (up to 1 year) –** (patient satisfaction, improved marketing)<br>• **Long-term (3-5 years) –** (development of a regional centre of excellence) |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • patient satisfaction<br>• increased number of physician referral sources<br>• quality metrics (to be determined)<br>• provider satisfaction<br>• recruitment and retention<br>• financial metrics (length of stay, cost per case, etc) |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)**<br>*Identify the key financial investments (e.g. one-time costs) required to realize the benefits.* | • |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial impact (stated in the $100,000).*<br>*Is this opportunity a financial investment or savings?* | • |

## Opportunity O2: Midwifery

**Overview:**

| | |
|---|---|
| **Description** | • Growth of midwifery when and where needed |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • Providing more birthing options (e.g.. water births)<br>• Increased opportunity for alternate provider |
| **Community** | • Leveraging opportunities within the community |
| **Organization** | • |
| **Clinicians & Staff** | • Cross privileging to all sites |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| • Distance amongst sites and client homes | • One large collaborative midwifery group |
| • Privileges may not be available for all midwifery staff who wish to have privileges | • One large collaborative midwifery group<br>• Aim for no elimination of midwifery privileges |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Medium-term (1-2 years)** |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)**<br>*Identify the key financial investments (e.g. one-time costs) required to realize the benefits.* | • |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial impact (stated in the $100,000).*<br>*Is this opportunity a financial investment or savings?* | • |

## Opportunity O3: Obstetrical Group

**Overview:**

| | |
|---|---|
| **Description** | • One large clinical group |
| **Anticipated Alignment to Guiding Principles**<br>*Shade the relevant guiding principle(s)* | • **Collaboration**<br>• **Accessibility**<br>• **Sustainability**<br>• **Excellence** |

**Potential Benefits and Risks:**

| **Potential Benefits**<br>*Identify the most significant potential benefits. Where relevant, consider the following perspectives when identifying benefits: Patient, Community, Organization, Clinicians & Staff.* | |
|---|---|
| **Patient** | • Patient specific and culturally sensitive care with an enhanced opportunity to provide physicians who speak languages other than English |
| **Community** | • Diversity among the medical team that better matches the community<br>• Opportunity to increase affiliation with teaching hospitals<br>• Development of a high risk program supported by maternal fetal medicine<br>• Patients can access specialized care within their home community (diabetes, hypertension, etc) |
| **Organization** | • Development of specialty services<br>• Partnership/networking improves which increases market share |
| **Clinicians & Staff** | • Full integration provides an opportunity to increase research<br>• Improved quality of worklife by shifting to a 12 hour on call shift rather than 24 hours<br>• Full back-up in times of high volumes |

| **Potential Risks**<br>*Identify the key risks that must be considered (e.g. high impact and high probability). For each risk identified, provide a proposed risk mitigation strategy.* | |
|---|---|
| **Risk** | **Mitigation Strategy** |
| • May lose medical staff (i.e. decreased accessibility due to location) | • "strategy to ensure location coverage is considered" |
| • Medical staff providing care at multiple sites may impact continuity of care and cause confusion in the identification of the most responsible physician | • On-call and most responsible physician process to be clearly defined for nursing staff |
| • Cultural clash between some current practitioners | • Strong leadership and structured change management<br>• Team management approach<br>• Accountability and responsibility and ownership by practitioners |

**Benefit Realization:**

| | |
|---|---|
| **Estimated Timeline**<br>*Shade the estimated timeline (choose only one)* | • **Long-term (3-5 years)** |

| | |
|---|---|
| **Key Metrics to Measure Benefits** | • **To be completed** |

**Feasibility Assessment:**

| | |
|---|---|
| **Key Metrics to Estimate High-Level Financial Impact** | • |

| | |
|---|---|
| **Required Investments – Operating and Capital (if applicable)** | • |

| | |
|---|---|
| *Identify the key financial investments (e.g. one-time costs) required to realize the benefits.* | |

| | |
|---|---|
| **Analysis** | • |

| | |
|---|---|
| **Anticipated Financial Impact**<br>*Indicate the order or magnitude financial impact (stated in the $100,000).*<br>*Is this opportunity a financial investment or savings?* | • |

## 2.3. Stakeholder Engagement Information

*This section should summarize the input considered from stakeholder engagement activities. Content in this section should be drawn from the Working Group's* ***Stakeholder Engagement Summary.*** *(Refer to the Guiding Framework for expectations).*

*Note: This section will be completed before final submission of the Workbook. Working Groups are to use the Stakeholder Engagement Summary as a tool to document and consider stakeholder input/feedback collected during the due diligence process.*

# 3. Recommended Integration Opportunities

## 3.1. Alignment to Guiding Principles

*For each of the recommended opportunities, complete the table on the following page. Specifically, for each of the recommended integration opportunities, Working Groups must clearly articulate a rationale that describes the degree to which the integration opportunity supports each of the Guiding Principles. In building this rationale, the Working Groups will use the most relevant measures/indicators based on the service/program.*

## Recommendation 1: [Insert Recommendation Statement]

**Description:**

Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text Body text

**Alignment to Guiding Principles:**

| | **COLLABORATION**<br>***We believe that collaboration will lead us to better solutions.*** | **ACCESSIBILITY**<br>***We believe in providing accessible patient care to our community.*** | **SUSTAINABILITY**<br>***We believe that we must find new solutions to sustain our health care system.*** | **EXCELLENCE**<br>***We believe that we must never waver from our responsibilities to provide quality patient care and to be accountable to our stakeholders.*** |
|---|---|---|---|---|
| **Rationale** | • | • | • | • |
| **Measures/ Indicators** | • | • | • | • |

# 4. Workbook Sign-Off

*Identify the individuals that were involved in the completion of the Workbook.*

NOTE: The following individuals participated in the completion of this workbook. It was agreed at the outset that individuals who are unable to attend meetings are welcome to send a delegate. It was the responsibility of the working group member and the delegate to keep each other up-to-date on working group discussions. In addition, draft workbooks were posted for broad stakeholder review and feedback after each meeting. It is understood that all working group members are supportive of the information contained in the workbook.

| Organization - Program | Team Member: |
|---|---|
| Rouge Valley Health System | Signature<br>Michele Jordan (Executive Sponsor)<br>August 13, 2013; |
| Rouge Valley Health System – Women's and Children's Program | Signature<br>Susan Fyfe (Co-Lead)<br>August 13, 2013 |
| The Scarborough Hospital – Women's and Children's Program | Signature<br>Barbara Scott (Co-Lead)<br>August 13, 2013 |
| Rouge Valley Health System | Signature<br>Savannah Clancey (recorder)<br>August 13, 2013; |
| Rouge Valley Health System – Obstetrics and Gynecology | Signature<br>Dr. Terry Logaridis, Program Chief<br>August 13, 2013 |
| Rouge Valley Health System – Obstetrics and Gynecology | Signature<br>Dr. David Samra<br>August 13, 2013 |
| Rouge Valley Health System – Obstetrics and Gynecology | Signature<br>Dr. Colette Rutherford<br>August 13, 2013 |
| Rouge Valley Health System - Paediatrics | Signature<br>Dr. Karen Chang, Program Chief<br>August 13, 2013 |
| Rouge Valley Health System - Paediatrics | Signature<br>Dr. Hubert Wong<br>August 13, 2013 |
| Rouge Valley Health System - Paediatrics | Signature<br>Dr. Yehuda Nofech-Mozes<br>(delegate sent on August 13, 2013 |
| Rouge Valley Health System - Midwifery | Signature<br>Carolyn Prior, Midwifery Lead |

| Organization - Program | Team Member: |
|---|---|
| Rouge Valley Health System - Paediatrics | Signature<br>Elena Nikolsky, Manager<br>August 13, 2013 |
| Rouge Valley Health System - Obstetrics | Signature<br>Deborah MacInnes, Manager Genetics |
| Rouge Valley Health System – Anaesthesia | Signature<br>Dr. Ian Salter<br>August 13, 2013 |
| The Scarborough Hospital - Paediatrics | Signature<br>Dr. Peter Azzopardi, Program Chief/Medical Director |
| The Scarborough Hospital – Obstetrics | Signature<br>Dr. Nathan Roth, Lead<br>August 13, 2013 |
| The Scarborough Hospital – Obstetrics | Signature<br>Dr. Georgina Wilcox, Lead |
| The Scarborough Hospital – Paediatrics | Signature<br>Dr. Tineke Vermaat, Lead<br>August 13, 2013 |
| The Scarborough Hospital – Obstetrics | Signature<br>Janine Jackson, Corporate Perinatal Clinical Resource Leader<br>August 13, 2013 |
| The Scarborough Hospital – Paediatrics | Signature<br>Myrna Henry, Manager |
| The Scarborough Hospital - | Signature<br>Bev St. Martin, Manager<br>August 13, 2013 |
| The Scarborough Hospital – Midwifery | Signature<br>Laurie Hintzen, Chief |
| The Scarborough Hospital - Anaesthesia | Signature<br>Dr. Winston Wong, Chief<br>August 13, 2013 |
| The Scarborough Hospital | Signature<br>Nurallah Rahim, Patient Care Director<br>August 13, 2013 |

# Appendix: Leading Practice Summary (KPMG)

The purpose of this section is to highlight and identify high-level leading practices themes for the purpose of assisting in the due diligence review. The themes that have been identified in this document are from several sources and are meant to provide Working Group members with a broad view of the themes related to leading practices for **Maternal Child**. These sources include KPMG's own experience, global thought leadership and external sources (where identified).

The below tables summarizes leading practices themes for Maternal Child.

| **Leading Practice Themes** | |
|---|---|
| **MORE Program** | • Across Canada, many maternal child programs are participating in Salus Global's Managing Obstetrical Risk Efficiently (MOREOB) Program. This is a comprehensive performance improvement program that creates a culture of patient safety in obstetrical units. Founded on High Reliability Organization principles, the MOREOB Program integrates professional practice standards and guidelines with current and evolving safety concepts, principles and tools. The results are sustainable, proven and measurable -- a decade of experience and more than 13,000 participants confirm it.<br><br>Key elements of the MORE program include:<br><br>• Developing effective teamwork and communication.<br><br>• Eliminating the culture of blame.<br><br>• Embracing learning, knowledge sharing and evaluation.<br><br>• Promoting interprofessional collaboration with trust and respect. |
| **Leading Practices** | • Increasing emphasis on preventive care<br><br>• Focus on family centred care<br><br>• Increased use of technology<br><br>• Increased use of safe home care<br><br>• Range of birthing options – patient choice<br><br>• Centre of Excellence or Institute approach to facilitate inter-disciplinary approach to care focused on patient needs and related services (public health)<br><br>• Cross sector planning and funding for maternal child – e.g. pilot in Quebec targets young pregnant women; consult includes assessment of housing, education, etc; prescriptions can include smoking cessation, voucher for vitamins, paid prescription for iron supplements<br><br>• Regionalization of intensive care |

| Leading Practice Themes | |
|---|---|
| | • Strengthened ambulatory care system<br>• Shorter hospital stays<br>• Advanced Practice roles<br>• Empowerment of consumers<br>• Adoption of clinical practice guidelines – See Canada's MORE program<br>• Provincial level business analytics to support provider, planners, researchers – in Ontario Born has a mandate to be the authoritative source of data.<br>*Ontario is increasing its capacity to plan and deliver maternal-child services through the Better Outcomes Registry & Network Ontario (BORN Ontario - previously the Ontario Perinatal Surveillance System - OPSS).*<br>• Focus on managing transitions in care between providers and sectors |
| **Keeping childbirth dynamic and natural programme** | • NHS Scotland issued the "Keeping childbirth dynamic and natural programme" to facilitate ongoing risk assessment in the community and to ensure evidence-based care by the appropriate professional for all women accessing maternity care across Scotland. The ethos of the programme is that birth is a natural process and unnecessary intervention should be avoided, **shifting to midwife-lead birth or home birth for normal pregnancies**. |
| **Maternity Matters – Choice**[1] | • The UK launched an initiative called Maternity Matters. The initiative focuses on Helping women and their partners choose what is right for them. Encouraging and enabling Self Referral to Maternity services. Engaging with families who are least likely to access maternity care, aiming for equality of outcome for all maternity users and improve the families' experience of maternity care.<br>• To do this, the following actions were taken:<br>  • Establish a vision<br>  • Engage the team<br>  • Develop role of the midwife.<br>  Ensure appropriate case load<br>  • Lean map community teams<br>  • Enhance capabilities and confidence of other midwives<br>  • Include home births, water births etc. |

[1] Maternity Matters NHS Department of Health, 2007.

| Leading Practice Themes | |
|---|---|
| | • Optimise role of Maternity Support Worker<br>• Change working practices<br>• Move into Children's centres (in some instances)<br>• A survey showed an outstanding improvement in: mothers' satisfaction from 70% in 2007 – 2008 to 91% in 2008-2009.<br>• Maternity Matters has made a significant difference to the maternity services available. It has given pregnant women enhanced choice and widened access to current facilities, as well as providing novel services that have improved maternity care in the area and I have noticed a high level of patient satisfaction since the scheme has been implemented. |
| **Maternity Support Workers**[2] | • The impact of skill mix, for example the introduction of Maternity Support Workers (MSWs), has the potential to release midwifery time and improve outcomes for women and babies e.g. improved breastfeeding rates. Promoting effective skill mix within the maternity team will be key.<br>• For example, Bexley Care trust in the UK has implemented recommendations and has experienced steady increases in home delivery and midwife-led births. |
| **Midwifery care model** [3] | • Some models of midwife-led care provide a service through a team of midwives sharing a caseload, often called 'team' midwifery. Another model is 'caseload midwifery', where the aim is to offer greater continuity of caregiver throughout the episode of care. Caseload midwifery aims to ensure that the woman receives all her care from one midwife or her/his practice partner. All models of midwife-led care are provided in a multi-disciplinary network of consultation and referral with other care providers. By contrast, medical-led models of care are where an obstetrician or family physician is primarily responsible for care. In shared-care models, responsibility is shared between different healthcare professionals.<br>• A review was conducted by the World Health Organization of midwife-led care and covered midwives providing care antenatally, during labour and postnatally. This was compared with models of medical-led care and shared care, and identified 11 trials, involving 12,276 women.<br>• Midwife-led care was associated with several benefits for mothers and babies, and had no identified adverse effects. The main benefits were a reduction in the use of regional analgesia, with fewer episiotomies or instrumental births. Midwife-led care also increased the woman's chance of being cared for in labour by a midwife she had got to know, and the chance of feeling in control during labour, having a spontaneous vaginal birth and initiating breastfeeding. However, there was no difference in caesarean birthrates. |

[2] Ibid.
[3] http://apps.who.int/rhl/reviews/CD004667.pdf

| Leading Practice Themes | |
|---|---|
| | • Women who were randomised to receive midwife-led care were less likely to lose their baby before 24 weeks' gestation, although there were no differences in the risk of losing the baby after 24 weeks, or overall. In addition, babies of women who were randomised to receive midwife-led care were more likely to have a shorter length of hospital stay.<br><br>• The review concluded that most women should be offered midwife-led models of care, although caution should be exercised in applying this advice to women with substantial medical or obstetric complications. |
| **Decreasing Narcotic-Related Adverse Drug Events in Children's Hospitals**[4] | • Narcotic-related adverse drug events are the most common form of adverse drug events in hospitalized children.<br><br>• The purpose of the project was to implement large-scale improvement to rates of narcotic-related adverse drug events through use of best practice guidelines.<br><br>• Guidelines anticipated to have a high degree of impact included the following:<br><br>  • Control for medication errors of omission: the routine proactive use of laxatives and stool softeners should be used when narcotics are prescribed to help reduce/avoid constipation.<br><br>  • Control for medication errors: limit overrides of automated medication dispensing devices.<br><br>  • Control for medication withdrawal: Adoption of a standardized weaning protocol.<br><br>  • Control for communication errors: Adoption of a standard medication reconciliation process to address medication errors at the time of transfer.<br><br>• Narcotic-related ADE rates decreased 67% between the baseline and postimplementation time frames. |
| **Facilities and Equipment**[5] | • The following facilities, equipment and support services should be available in hospitals that care for children from birth to 18 years old:<br><br>**Facilities**<br><br>  • Single/double rooms that comply with guidelines for infection prevention and can accommodate parents' overnight stays.<br><br>  • Air, oxygen, suction equipment, and electrical outlets at each bed, with access to the hospital emergency power system. |

[4] http://pediatrics.aappublications.org/content/122/4/e861.long

[5] http://pediatrics.aappublications.org/content/101/6/1089.full?sid=a84b1237-7d1e-40da-a155-394576bb811f

| Leading Practice Themes | |
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| | • Placement of beds to allow for observation by nursing staff.<br>• Age-appropriate furniture and cribs/beds that comply with safety guidelines.<br>• Designated area for child life activities.<br>• General site safety such as covered electrical outlets, appropriate window locks and door latches, etc.<br>• Treatment room for patient assessment and procedures.<br><br>**Equipment**<br><br>• Some of the following equipment will also be used to care for adult patients:<br>• Resuscitation cart containing readily accessible, easily identifiable, necessary weight- or length-appropriate emergency drugs and resuscitation equipment with easily readable lists of pediatric drug dosages<br>• Defibrillator designed for pediatric use with paddles for infants and children and easily readable chart with joule dosages<br>• Scales and stadiometer for infants/children<br>• Thermometers and blood pressure measuring device with cuffs appropriate for all infants/ children<br>• Cardiorespiratory monitors<br>• Pulse oximeters<br>• Papoose board for immobilization of infants/toddlers<br>• Backboard for cardiopulmonary resuscitation<br>• Portable lamps for emergency bedside procedures<br>• Motor-driven nebulizers and electric suction machines (if no suction wall units are available)<br>• Twenty-four hour access to electrocardiograph machine<br>• Intravenous, phlebotomy, and lumbar puncture trays designed for children<br>• Wheelchairs, crutches, slings, and splints for all infants/children<br><br>**Support Services**<br><br>All of the following should be available 24 hours a day, with fast response times:<br>• X-ray imaging for thoracic, abdominal, skull, and orthopedic studies (computed tomography if possible)<br>• Lab testing for hematology, blood chemistry, and blood gas studies from small volume blood samples, and basic microbiology and blood banking services (toxicologic and drug levels testing if possible)<br>• Age- and size-appropriate pharmacy services<br>• Information about drug interaction and drug dosing<br>• Child life services; social work services; and respiratory, physical, occupational, and speech therapies as needed |