Town Hall Meeting- Update on Zero Based Budgeting

February 10, 2009

On October 20, 2008, the Board of Directors made certain decisions arising from the Zero Based Budgeting exercise that started in the Spring 2008.

Since Windsor Regional Hospital announced its ZBB decisions the four other hospitals in our LHIN have started their own process in order to find efficiencies, enhance patient care and balance their operating budgets. Many more across the province have started similar processes. In fact, some are using the same process we created.

This past week Minister of Health David Caplan stated "We want hospitals to fund their operation with the existing resources and we do not want them to run a deficit,"

The decisions the Board of Directors made in the ZBB process were not easy to make. However, by being proactive in their process and decision making Windsor Regional has been identified as one of the best operated, managed and staffed hospitals in the Province of Ontario by the Minister of Finance. He made this statement to the media and to our Board Chair and myself.

The decisions for ZBB came from suggestions from staff.

In implementing these decisions we have adhered to the following principles:

One – Reduce the impact on patients and families as much as possible

Two – Reduce the impact on staff as much as possible

Three – Implement the decisions by the end of this fiscal year, March 31, 2009

It has now been approximately 4 months since the first nine decisions were made. The most recent 10th change being made approximately a month ago with the organizational changes.

I thought it was appropriate to meet with all of you to briefly discuss the progress of each initiative as well as answer questions that have been submitted to me in advance. I decided to ask for questions in advance because I appreciate it may be difficult to ask questions in a large venue. I am trying different ways to ensure that your questions, concerns and issues are addressed as best as I possibly can on behalf of the board of directors and the executive committee.

Unfortunately since we met in October and most recently in January the economic situation locally, provincially, nationally and internationally is not getting any better. It is getting worse.

Unemployment is in double digits locally and heading that way nationally. We all now know someone who has lost their job or about to go bankrupt. Hospitals in Michigan are laying off staff in the hundreds, freezing and in some cases rolling back wages and benefits for everyone – including their employed physicians.

Ontario healthcare is not immune to the economic realities of today

Three examples

1. Extendicare pulling out of the construction and operation of three long term care facilities based upon economics. One in Windsor that we desperately need
2. Our own hospital foundation losing over $1 million is funds as a result of the stock market reductions – that is pretty good considering some foundations across the province lost 30-40 % of their value – we lost 10%
3. Hospitals have moved ahead with capital improvements – one in Toronto got $1 million in gift in the form of stock that they could not sell. Went ahead with construction. Stock now worth less than $100,000.

Notwithstanding this - as each of us know though, demand for healthcare services is not reducing. In fact, it is increasing.

As stated in my February report our emergency department volumes are increasing each year and the patients are getting sicker.

The Board of Directors appreciate and recognize each of you continuing your amazing professionalism and caring during this difficult time. In fact, I am getting more compliments from patients then ever before. You really are living our mission of outstanding care with compassion.

As I stated before – we needed to get our house in order before we could ask for further resources from the LHIN and Ministry.

I can inform you that since announcing our ZBB decisions – members of the Board of Directors, Executive Committee Members and I have been meeting with local MPP's, Ministry Officials and LHIN officials to advocate for additional resources. .

Although I have no new funding to announce today I can inform you that - they are listening!

As previously stated the Minister of Finance has identified that Windsor Regional Hospital is one of the best operated, managed and staffed hospitals in the Province of Ontario. This fact will begin to pay dividends shortly.

With respect to the nine ZBB initiatives, they are well on their way in completing their implementation plans.

Briefly I will highlight each of them

One – NICU

- Team meets weekly to discuss process of moving as close to budgeted beds as possible
- Have developed and implemented transitional plan
- As we
- Provincial maternal newborn advisory committee coming down this week – our own Dr. Broga was one of the nine people provincially appointed to this committee
- On Friday we had 17 babies in NICU and 4 in Peads. If not for these babies in Peads we would have had 21 in NICU.

Two – Pain Clinic

- Services not being provided effective April 1, 2009
- On going communication staff meeting(s) to outline "transition plan"
- Pre and post decision package meetings with or Executive and Anesthesiologists
- "Transition Plan"
    - No new referrals to pain clinic after Jan 1st 2009
    - All patients currently being treated will continue with treatment until April 1, 2009
    - Staff who currently work in the pain clinic and start their day at 0630 will being their shifts at 0730 following closure of the clinic
- Letters to both pain clinic patients and physicians who refer patients to the pain clinic have been receiving letters outlining the fact the services are being stopped, the rationale for the change and contact information for pain clinics that are in operation
- Currently working with the chief of Anesthesiology to put a regional pain program proposal together and submit to the LHIN (CKHA with some modifications and local support)

Three and Four – Bed Utilization and Flex Beds

Three (3) components of this decision package: close 14 flex beds, develop and implement a clinical utilization team and "smooth" the or schedule

All three components to be implemented April 1, 2009

Close 14 Flex Beds (medicine and surgery)

- To be accomplished following implementation of the clinical utilization plan
- Physical space to be eliminated so we can not use for patient care in the future (to the extent possible)
- No lay-offs on medicine or surgery units as a result of vacant positions
- Re-do surge and/or over-capacity protocol

Clinical Utilization Team

- **Overall goal is to improve utilization of in-patient beds and ensure documentation supports best care possible and reflects care provided**
- Working with HCM and John Sexton who has implemented CU program in Ontario
- Develop "clinical utilization team" including utilization review nurses, social workers, physician and nursing leadership

Also creating a utilization committee whose primary responsibility is monitor, track and trend progress with improvements being implemented……..increased accountability for physicians and staff

Or smoothing

- The goal is to more equally distribute the number of elective surgeries requiring in-patient beds: either step down or non-critical care beds
- No staffing changes anticipated (either increases or decreases)

Telemetry

The existing 13 bed telemetry unit is moving from 3 west to 6 north.
The number of beds is increasing from 13 – 16.
Staffing issues being addressed

Training and support for medicine nurses caring for telemetry patients being planned

Urgent internal medicine and urgent cardiology clinics to be opened on 3 west in the spring of 09

Five – 14 Psychogeriatric Beds

- Meetings held with the staff, unions, the patients and families and with psychiatrist
- A steering committee created with the LHIN, HDGH, CMHA, WRH and Psychiatrists represented to look at alternatives of care. Has met and will continue to meet.

- Scheduled to officially close April 31st, due to union notification period
- Will officially stop admissions to the unit on March 1st. Average length of stay is 30 days.
- A letter has been sent to all stakeholders as notification of this plan.

Six – Psychology Services at Western

- One psychologist resigned as of the end of January
- Position descriptions developed for the Neuropsychologist and the generalist psychology position.
- On target for transition the first of April
- Physicians and staff have been notified of the change in psychology role to one of consult

Seven – RT Services at Western

Moving forward on schedule to reduce to twelve hour shifts effective April 1st.

- RN and RPN education on target
- BCLS and AED training planned
- Roles identified and clarified
- New job description being created for respiratory therapist
- AED's purchased and locations identified.
- Learning packages and teaching of clinical practice staff has been completed
- Unit staff training plan has been completed and staff will receive training before the end of march
- Staff will practice new skills as training is completed while RRT available 24 -7 should questions/ concerns arise
- "Code Policy" has been discussed and revisions to go to code blue committee on Feb. 11th
- Role of RRT at western is being revised and refined.

Eight – DI Enhancements

Di team have been marketing the DI services to various physician groups in order to increase referrals

- The appointment booking process has been simplified to minimize additional burden on physician office staff
- Volumes are above year to date last year but the impact of recent changes will be more evident come the end of March 2009

Nine – Vented Beds at Western

- Meetings scheduled for discussion with CCAC and LHIN for February.
- Staffing pattern has been developed for after we have only three and then two chronic vent patients
- Working with one patient to either wean from vent or prepare for homecare with support.
- Education plan has been developed to educate families on the ventilator use and care.
- Connected with the ventilator equipment pool (VEP) program in Kingston for needs of future patients.
- Working to have plan in place and be down to two chronic vent patients be end of fiscal year 2010.

Ten – Organizational Changes

- Changes announced
- Will become effective by end of February
- Currently examining levels below manager

Now addressing the questions that were asked in advance.

I first want to thank all of you that submitted questions. Again, I have no way of determining who submitted the questions unless you specifically identified yourself. I have combined some of the questions because they were identical or had a very similar theme.

If you feel I did not answer your question please do not hesitate to call, email or ask me to talk to you. I will make myself available to talk – I will ask that the email submission form be kept open for the next few days in order to address any follow up questions you may have.

Question – do we expect any further staff reductions or terminations?

- Currently our funding for this upcoming year is 1.95%
- We have one collective agreement settled into this year – ONA for 3% increase
- Similar to other hospitals all other C.A.'s are open
- 65% of our costs are wages and benefits
- We are obligated to have a balanced budget for 2009-2010
- We are projecting an approximate $3.5 million deficit as it stands now. I had rec'd a question stating the deficit was $16 million – it is not. Also we do have a $60 million dollar working capital deficit - $700 million provincially – these are monies we invested into capital and operating deficits that accumulated over the past 10-15 years. It is

monies that we do not have to invest in future equipment needs and create cash flow issues for the hospital where it has to borrow using lines of credit to finance its operations. Again this has been going on for 10 years. Etc.

- The remainder of the 250 ZBB initiatives will be taking place in next 12 months – some involve slight staffing reductions
- Also as stated have asked management teams to look at all non-union positions below manager by end of February – I do not know what they will result in
- However, our goal is to reduce impact on staff as much as possible.
- Similar to the first nine ZBB initiatives – through retirements, normal resignations, leaves, etc. We have some 300 positions a year become open – as a result very hopeful any further reductions will be minimal and also can be handled primarily through attrition
- However – I do not know where collective agreements are going to land or if provincial funding will stay the same – a negative answer to either of those could change the landscape for many hospitals including WRH
- Another late related question was asked why are we showing up at job fairs if we are laying off staff? I really need everyone to think beyond today. We are not managing to today's issues. We need to think about the future. I will discuss this later but at the end of the day very few people will be without a job as a result of all the changes – because of normal retirements (that are going to increase) we have some 300 vacant positions a year we have to fill.

Question - With the anticipated layoff of experienced NICU nurses, do you have a plan to retain their expertise within the corporation? Is there any realistic expectation that the government will fund these extra 10 NICU beds?

- First part – yes as a result of retirement, bumping and normal resignations and leaves we plan on saving as many of these NICU nurses as possible – all nurses for that matter.
- As a result of C.A. processes we had to issue some 102 layoff notices – yet we also posted some 76 new positions.
- We are still moving through the process – however it looks like we are very close to maintaining all staff subject to them wanting to work in other areas until their previous positions become open again
- Another similar question asked about all the RN postings and why is that happening – we are obligated to do that during layoffs – it is a good thing though – it allows internal movement and may free up positions rather than bumping – if you see a position posted you like - apply for it –
- Second part – we are hopeful. The committee that will decide the maternal newborn resources in the province is coming down to WRH

this week. Also, Dr Mary Broga, the VP of Family Mental Health was just appointed as one of nine members on this committee.

- As I stated we are financially efficient in this area and we have very good clinical outcomes in this area. Therefore, we are a good investment for the province.
- A committee made up of the Chiefs of PEADs, OBGYN and Medical Director of NICU, COS, myself, CNE and Directors and Managers have put together a business case and sent to Ministry and LHIN to validate our position.

Question: Non union changes – I rec'd a lot of questions about the changes in one document – I will try to answer most of them as follows

- If we wanted to only freeze wages why demote people? Why not just freeze wages

- I would ask that you read the report and the text of my speech in January. I will not repeat it except to say we have created an org chart based upon best practice and moving the org chart closer to the patient where it belongs. It was not motivated to freeze wages.

- Why are we harassing staff to make donations then turn around and freeze their wages and why do we spend money on billboards and advertising?

- We have a massive western redevelopment project that starts in the late spring. We are obligated – legislated - to raise 10% of the value of the project – that is close to $10 million dollars. In today's environment that will be difficult. However, we have no choice.
- Over the past ten years as a result of having to fund projects and equipment we have created a $60 million dollar working capital deficit. We are working with the ministry to address this. Hospitals have combine some $800 million dollars of this W.C. deficit
- We are reaching out to everyone to raise these needed funds – through billboards and advertising and yourself – if you feel you are being harassed then do not contribute.
- Many staff are giving only what they can comfortably – that may be $1 a pay.
- We are not keeping tabs of who does not contribute. To date we have some $80,000 dollars contributed by staff – that is amazing and you should be complemented
- However, also the billboards have another value – to showcase our staff and also we are going to have a lot of retirements over the next 5 years – we have to keep that in mind – we have to plan for the next five years – not just tomorrow or today

- How can we say non union people were not demoted

- I never said that some were not demoted. Some were demoted. No doubt about it
- However, we tried to maintain as many jobs as possible
- We are hopeful title changes can be overcome once we appreciate as a group where we are going as an organization

A late related question I got was how many management staff did we reduce and why is union staff taking the brunt of the changes – it is okay to cut union but not non union staff?

- I would differ with the inference this questions is drawing. Non union staff make up 7% of our staff. We reduced 9 non union staff. Also, you all have the org charts I would ask that you talk to the non union staff and ask if they share your same feelings about not being impacted.

Question – In his Zero Based Budgeting report Mr. Musyj is obviously proud that the average age of the WRH employee is dropping. Are older employees being offered buyouts to produce the obvious drop in age?

- The average age of our employees is telling. A hospital or employer does not want staff to be all of the same age group. A dynamic workforce is made up of many age ranges, cultures and sexes.
- This allows for many different perspectives to come to the forefront for any issue facing us.
- I am proud when I am seeing a more leveled out workforce on the basis of age. That way if all of our workforce is of the same age we do not stand to lose them at the same time – be them younger or older
- However, there are massive benefits to older and younger employees in a workforce working together
- Buyouts may cause the average age to drop some however it is minimal. However to answer another question – unless mandated by collective agreements – buy outs are costly and we lose some experienced staff with buyouts

Question: How are adult and children mental health services going to be organized, implemented and delivered

- We are currently developing the service delivery model. We have agreed with the Directors and Managers of both the children and adult mental health programs to organize our current services using a brokerage model. While there will still be programs for children and adults separately, we hope to include family into the clinical intervention plan. This week, we are having a full day planning session

to look at how best to organize the services and programs. This planning includes administration, medical chiefs and board members. Once this has been completed we will reach out to all staff and third parties for input.

- You will be hearing more about this in the months to come

Question – How do you think the changes will impact staff morale – Do we see sick time and WSIB going up – Will patient care be compromised ?

- We are hopeful that with the proactive approach that we have taken that we minimized the staffing impact of the changes and also more importantly enhanced patient care by reducing the areas and stress for which are not funded or they may be staff and patient safety issues.
- Sitting back and waiting for a massive deficit to develop is not the answer. Then there will be massive and decisive action that does not look at reducing the impact on patients, families and staff and does not take 6 months to implement to allow for normal retirements, resignations and leaves to occur.
- By implementing the ZBB changes the way we have we have minimized the impact – I know that is hard to understand if you have been directly impacted however i can tell you by doing to the way we have we have saved close to 100 jobs.
- Our sick time has been reducing each month since October 2008. However, it is still above provincial averages. It was above those averages even more when one could argue we were not making changes.
- The reduction in sick time is a credit to the work ethic and morale of our staff. Also, we are actively addressing individuals that are abusing sick time to the detriment of their fellow worker. This does nothing but add to the number of changes we have to make. I am hopeful this trend will continue
- The changes embrace best practice and will enhance patient care – they are not meant to have a negative impact on patient care – the opposite should occur
- One example I want to give you – we talked about this during ZBB – if we are not proactive – things will occur for which we have no control – an actual isolette would breakdown in the NICU – we were trending financially that we could not actually replace the isolette - would that have been poor management and impacted staff morale and patient care – no plan to address the reduction in patients but one day we would have to react to not being able to take care of patients that are in our building – then what ???
- That is just one example

Question : Have we looked into the cost of keeping vented patients in ICU rather than a dedicated unit ?

- The vented patient initiative did just this. It is not patient, staff or financially viable to keep chronic vented patients in the ICU. We have limited capacity in the ICU and need these beds for acutely ill patients.
- The concept of a dedicated unit is possible. However, by default WRH historically was responsible for the care of chronic vented patients without funding. The closest dedicated chronic funded and operated unit is in Ottawa.
- We have made a request to the LHIN that if we are to have a chronic vent dedicated facility then we need funded to do so. Also research indicates that chronic vented patients do best in a home setting with appropriate support

Question - As a long-serving staff member in the ICU I would like to know why it is now deemed necessary to cross-train between ICU and CCU. You have here two groups of people who are already under some stress in the workplace and this is to be added to for no good reason. The staff remaining in these areas have no wish to work in different specialties and that is what these areas are. The cost alone of retraining the staff should give management pause for thought. Added to this is the possibility of mixing patient populations that should never be side by side. Patients recovering from an Acute MI should not be next to a busy, sometimes noisy ICU patient with the need for constant interventions. This all may come across as complaining in the face of change but I have worked through some changes in my time at WRH and I feel this enforcing staff to work in areas they do not excel in needs more thought ?

- The Zero Based Budget was done to stream line patient flow and optimize the financial picture for WRH. No change is made in isolation without impact on other areas. With telemetry moving to 6 north the move would leave CCU with no staffing support for an area with 5 beds, so there is need to support the staff and patients.

- In review of the CCIS data that assisted in the decision making process, it was noted that currently CCU patients are cared for in ICU either when there are no CCU beds or if staffing is a problem, and the reverse is also true that ICU patients are cared for in CCU when either there are no ICU beds or staffing is a problem. The decision was made to best support staff and patients. The geographic area of CCU and the 5 CCU beds would not change and combined ICU/CCU staff will be assigned to the patients in a rotating fashion to maintain competency for all patients cared for in the ICU/CCU.