

Strengthening the Welland Hospital Site



Proposed Amendments to the HIP

Proposed by the Welland Hospital Site Working Group
November 2009

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Introduction

On July 15, 2008 the Niagara Health System (NHS) issued the Hospital Improvement Plan (HIP) to the Hamilton/Niagara/Haldimand/Brant Local Health Integration Network (HNHB LHIN). This document was revised and accepted by the LHIN Board on December 16, 2008. A two-year accountability agreement was then signed with a proposed implementation plan.

Since the release of the HIP and the proposed Implementation Plan, there were grave concerns with the Welland Site plans. These concerns were articulated to the NHS board in July 2008, to the Chief Executive Officer, Debbie Sevenpifer, Chief of Staff, Dr. W. Shragge and to the Welland medical staff. The Welland medical staff then appointed a Welland Hospital Site Working Group as representatives for the HIP. The working group was formed, in cooperation with the senior team and the City of Welland to review the issues, obtain data, and return with a proposal to amend the HIP.

The Welland Hospital Site Working Group appointed representatives are Dr. Peter Willard, Dr. John Song, Dr. Peter Bonsu, Dr. Khal Salem and Dr. Craig Hogg. A consultant, Angela Carter, President of Angela Carter Enterprise was hired to assist with the development of the proposal.

The viability of the Welland Hospital Site (WHS) as an acute care site is seriously compromised by the HIP. Viability is defined as the ability to support a 24-hour Emergency Room and to manage critically ill patients within this site. Transferring these patients to other hospital sites makes little clinical sense.

The WHS serves the Niagara South area well due to its geographic position. In reviewing the scope of the proposed services, consideration was given to the site name. It was agreed that the name **“Niagara South Site”** would better reflect the geographic area served and consideration should be given to this recommendation as the HIP is implemented.

In our initial deliberation the WHS Working Group reviewed which clinical programmes were necessary to support the Emergency Room (ER). The following programmes were viewed as the three most critical choices:

1. Orthopaedics
2. General Surgery
3. Maternal/Child

These programmes are most critical for the following reasons:

1. Acuity of illness mandates on-site treatment in a 24/7 ER
2. Volume of cases is substantial
3. Transportation leads to higher risk of poor outcome (e.g. GI bleed, pediatric airway emergency, pelvic fracture)
4. They form part of the Hospital On-Call Coverage (HOCC) Program, Physicians Services Framework Agreement (2004) Specialty Group Level II.

Additional programmes would aid in maintaining surgical volumes, clinical skills, and volumes for inter-dependent specialties (Internal Medicine/Hospitalists). In particular, a significant component of the regional Urology services inpatient caseload (see Appendix I) would promote a thriving acute care service at the WHS.

Every consideration was given to the rationale behind the HIP in proposing the changes herein to strengthen the WHS. Each clinical unit has presented its case for change to the current HIP. In alignment with the NHS vision, mission, values & guiding principles, the WHS Working Group is committed to a proactive, facilitative approach to expressing their opinions and ideas.

First and foremost, the WHS Working Group considered and worked within the NHS Board of Trustees Framework for Quality Measurement, which defines quality based on the following nine domains:

1. **Effective** – Providing health services to patients that are proven through scientific knowledge as effective
2. **Efficient** – Making the best use of resources and avoiding waste, including waste of equipment, supplies, ideas and energy

3. **Equitable** – Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status
4. **Safe** – Keeping people safe
5. **Patient Centred** – Putting clients and families first
6. **Timely** – Reducing waits for both those who receive and those who give care
7. **Work Life Focus** – Supporting wellness in the work environment
8. **Population Focus** – Working with communities to anticipate and meet needs
9. **Continuity of Service Focus** – Experiencing coordinated and seamless services

The process in which the recommendations are expressed by the WHS Working Group will respect the protocol set out by the NHS and the LHIN. We believe that the NHS and the LHIN will honour their commitment to an open, consultative process with serious consideration of the proposed recommendations.

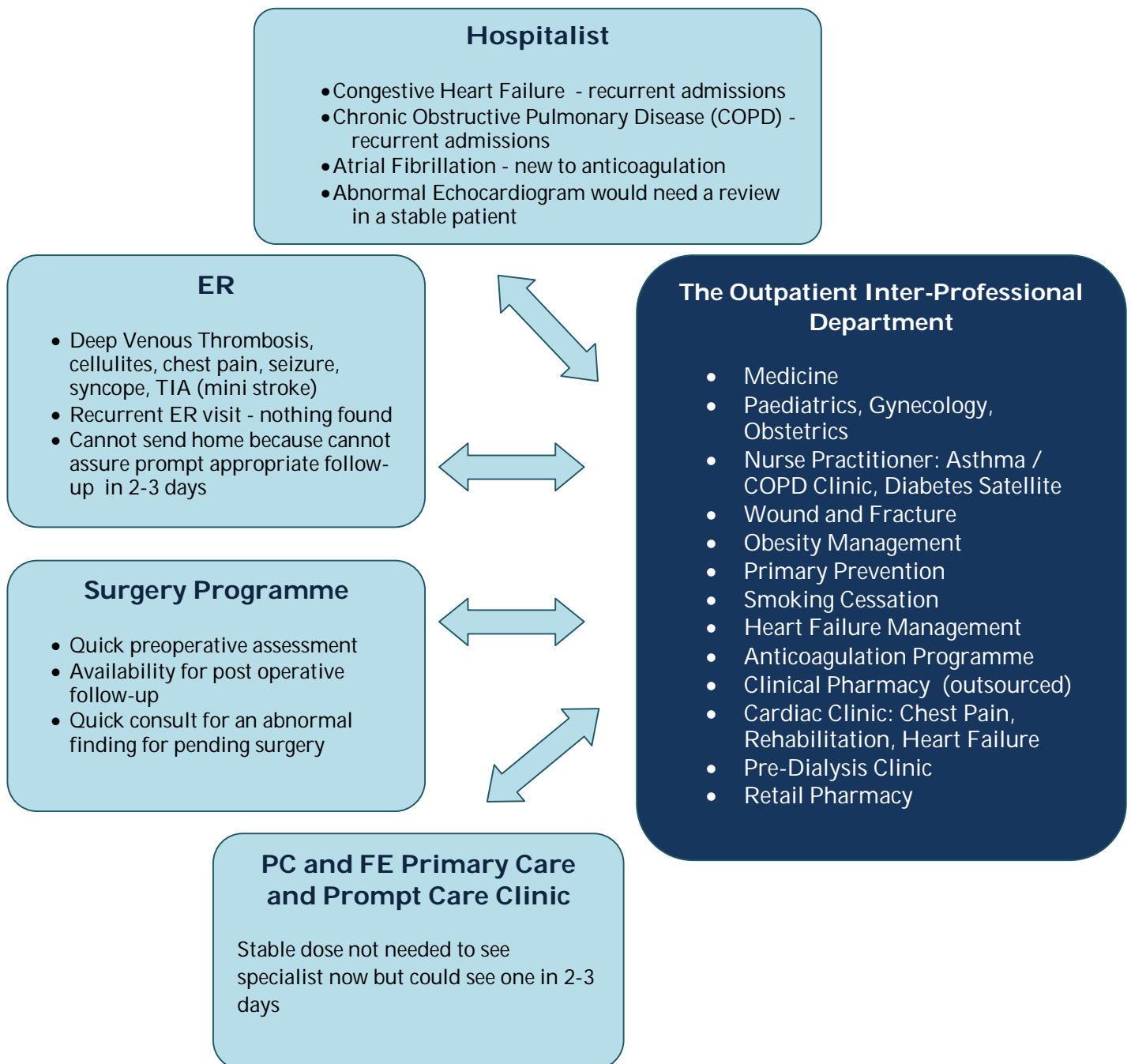
MEDICINE



Dr. Khal Salem

Centre of Excellence Model

The centre of excellence model being proposed here reflects a non-traditional way of thinking about patient care. The model expands on the concept of centralization of patient care by establishing an outpatient, inter-professional health delivery system, within a hospital setting. The centre has potential integration with various specialties and ancillary supportive services. From the client perspective, this “one-stop centre” model allows for a seamless flow of movement between essential services for non-acute care.



Health Care Needs

Provincially, there are a number of priorities and needs that were considered in designing the outpatient inter-professional health delivery model. We know that integration is an objective of the LHIN. Inter-professional care is a governmental direction and is funded. Innovation is an economic necessity and there is a need for chronic disease management (Congestive Heart Failure (CHF), COPD, and Atrial Fibrillation) and sub-acute disease management.

From an internal, NHS perspective, we are aiming to decrease the length of hospital stay, enhance outpatient programmes, provide fast, effective access to specialists and facilitate discharges from ER and the hospitalist programme. With the changes to the Port Colborne and Fort Erie sites, services are equitable, fast and may provide enhanced access to specialists care.

Outcome

To set up an outpatient inter-professional health delivery model that would integrate various specialties and ancillary supportive service into a one-stop centre for patient care.

The model is hospital based and funded through resource allocation, inter-professional programmes and physician billing. It is a modified, cost sharing model between the provider and the organization. The model also provides leased space for a pharmacy.

Purpose

Our primary purpose is to implement a pilot model of sub-acute care, close follow-up system and chronic disease management in a hospital based outpatient inter-professional department as opposed to a structured centralized referral process.

The department would integrate the following services provided in Welland:

- | | |
|-------------------------------------|----------------------------|
| a. Specialty services | e. Heart failure follow-up |
| b. Asthma clinic | f. Nephrology follow-up |
| c. Diabetes satellite programme | g. Paediatric programme |
| d. Cardiac rehabilitation programme | h. Wound and fracture care |
| | i. Gynecology services |

Scope of Services

The outpatient, inter-professional model would serve sub-acute and chronic care patients only. It is not designed for acute care or inpatient assessment.

The outpatient, inter-professional department would service internal medicine, paediatrics, obstetrics/gynecology, wound care and fracture care. We envision an asthma educator, diabetes services and a cardiac health and rehabilitation programme. Although these are the main components identified currently, there is certainly potential for other components to be added in the future.

Advantages

1. Quality

- Central referral to a clinic with multiple physicians versus individual outpatient offices with expected patient wait time;
- The convenience of direct referral from ER, Hospitalist programme, Surgical programme, etc;
- Provides an alternative to sub-acute patients that are kept in the hospital or kept in observation for close monitoring. The alternative is an expedited outpatient follow-up in 2-3 days with one of the 3 available physicians;
- Potential to have a role in ER diversion based on the triage nurse assessment;
- Provide opportunity for inter-professional communication resulting in less errors and higher quality;
- Improve attendance of educational rounds;
- COPD programme effective implementation;
- Effective implementation of heart failure programme;
- Anticoagulation programme;
- Difficult case conference discussion;
- Human capital – We learn from each other;
- Indirectly keep up-to-date;
- Improve attendance for local continued medical education.

2. Educational

- Set-up provides an ideal learning environment for medical students and residents;
- Set-up provides for revenue generating research projects;
- Tele-health potential;
- Clinical teaching;
- Set-up allows for research centres.

3. Organizational

- A collaborative team of people working in the same location leads to the following outcomes:



- Greater staff satisfaction leads to cost savings
- Allows for application of the principle of inter-professional care beyond the planning committees, advisories and retreat activities
- Provides the right set up for stakeholder focused group communication
- A way to change organizational culture through unplanned social events (hallway meeting). The 2 principles of culture change are the founder and socializing.
- Groups develop formally rather than informally
- Creates opportunity for converting “resistors” or “bystanders” into champions through effective communication
- Provides an alternative plan to the staff who will be negatively affected by the rapid changes in the system
- Re-establishes the outpatient revenue making investigations (mainly cardiac) that are being lost to the outpatient labs
- An opportunity for job re-design for the staff that will be affected by the Centre of Excellence restructuring, resulting in improved moral

Barriers/Risk

1. Change - why change is necessary and how is it different from the current model.
 - a. fragmentation versus integration
 - b. individual efforts versus consolidation
2. The usual fear of hidden personal agendas
3. Plant and physical space
4. Under-estimating the potential positive impact
5. Innovation and crisis
6. Poor business plan

The Role of the Niagara Health System

There are many roles that the NHS plays in this proposed model. Most importantly is the provision of the physical location for the inter-professional department and the infrastructure to support the model. The NHS offers the possibility of Nurse Practitioner support, the use of Meditech, transcription services, a registration clerk and can act as a billing agent.

Measures

Like any proposed business model, there must be a measurement of success. The following criteria will be used to determine the achievement of goals and outcomes:

1. Quality
2. Patient satisfaction
3. Staff satisfaction
4. Business case quarterly review
5. Wait time
6. LOS

RECOMMENDATION

To establish a Centre of Excellence as an innovative outpatient inter-professional health delivery model that would integrate various specialties and ancillary supportive service. The centre enhances quality of care, provides new educational opportunities, has an infrastructure that encourages communication and teamwork, and promotes inter-professional care. The centre is funded through a modified cost sharing model between the provider and the organization.

ANAESTHESIOLOGY



Dr. C. Hogg

Anaesthesiology

The following is a summary of the implications for the Department of Anaesthesia at the WHS site if the HIP is implemented in its current form.

In presenting the HIP, the assumption has been made that the NHS has one Anaesthesia department that will rotate through all the sites. This assumption is wrong. In the past, Anaesthetists from other sites have been reluctant to move from site to site for either elective lists or on-call coverage. There has been no indication that this will change in the future and physicians are openly resistant to this being imposed on them. This is a statement of fact and not a criticism.

As such, the ramifications of the HIP for Welland Anaesthetists are based on the fact that we are a stand alone department.

The first result of the HIP will be a loss of income for staff Anaesthetists at the Welland site. The HIP proposal will have the Welland Operating Room (OR) doing only Ophthalmology, Urology and General Surgery. The majority of the after hours work comes from Obstetrics and Orthopaedics. After hours work can account for 30-35% of our income. Loss of these services will result in a significant reduction of billings for our department.

There would be a significant reduction in Anaesthetic consultations and acute pain service requirements if Orthopaedics and Obstetrics were lost. Very few Ophthalmology patients require consultations. The proposed changes in the OHIP schedule of fees for cataract surgery will see a 50% reduction in billing for these services. This loss will be borne exclusively by the Welland Anaesthesia group under the HIP proposal.

The second result of the HIP will be an erosion of our group's Anaesthetic skills. We will no longer be able to maintain competence in Obstetrics and Paediatric Anaesthesia. We will also lose confidence in different regional techniques often used in Orthopaedic Surgery. By travelling to other sites we could avoid this, however, for previously stated reasons, no one will be available to free us from our elective responsibilities in Welland to travel to other sites to maintain our competence.

Another result of the HIP will be a significant reduction in after hours work. This reduction will decrease the incentive to provide after hours coverage for Anaesthesia. After hours coverage will not be sustainable under the proposed HIP changes to the WHS. This will have a significant impact on the hospital's ability to maintain an Intensive Care Unit (ICU) and Emergency Department.

These above mentioned considerations will be a significant barrier to physician retention and recruitment to the Welland Anaesthesia department. Any physician contemplating a move in the next 5-10 years will not stay in Welland to see their skill eroded. Some physicians may not be able to tolerate a 30-35% reduction in their income and choose to seek employment elsewhere. These factors are also a real deterrent to recruiting other Anaesthetists to the Welland site.

We are currently dealing with maternity leave coverage for six months that started August 1, 2009. We anticipate the requirement of a new full-time Anaesthetist for start in September 2010. The HIP proposal will impair our ability to recruit for these manpower needs.

The only way to maintain a viable Anaesthesia department providing full after hour's coverage at the Welland site is to maintain the Welland site as a full service hospital for South Niagara retaining in particular Maternal/Child and Orthopaedics. The department is not sustainable if the HIP is implemented as proposed.

ORTHOPAEDICS



Dr. John Song

Orthopaedic Surgery and the HIP

The HIP proposes radical restructuring of the current NHS to improve the quality of health care for all Niagara citizens. Among its proposals, is a reorganizing of the delivery of Orthopaedic Services which essentially will see the relocation of this service from the WHS to the Greater Niagara Site (GNS). It is not clear from the HIP document why this is necessary, how it will improve the delivery of Orthopaedic Services to all Niagara citizens, or what shortcomings that exist in the present 3-model site will be addressed with this proposal. One can only deduce the rationale for this proposal as follows:

The HIP rationale to move Orthopaedics out of the WHS is:

- 1) Cost saving
- 2) Critical mass
- 3) Quality of care

The HIP claims to reduce cost by:

- a) Standardizing equipment
- b) Eliminating duplication
- c) More efficient use of surgical blocks

The HIP claims that critical mass can be achieved by consolidating to 2 sites from 3 to:

- a) Improve quality of care
- b) Enhance specialist expertise
- c) Improve education and training
- d) Establish Orthopaedics centre of excellence

The HIP claims as its core principle, that it will achieve these without compromising patient access or lengthening wait times and maintaining all aspects of quality care (HIP document July 15, 2008 p. 215)

The Case to Keep Orthopaedics at the WHS

Improvement in the delivery of Orthopaedic Services to all Niagara citizens depends on maintaining an integral Orthopaedic Service at the Welland site, be it as part of a 2-site model, but ideally as part of a 3-site model. Presented below is our case to keep Orthopaedics at the WHS based on the rationale currently presented in the HIP.

Cost Saving

a) Standardizing Equipment

Currently a process is underway (Request for Proposal Ad Hoc Standardization Committee) to achieve significant cost savings to the NHS by standardizing the suppliers of Orthopaedic equipment. The contracts awarded will provide cost benefits to the NHS regardless of whether it is a 2-site, 3-site, or even 10- site model.

b) Eliminating Duplication

- Equipment is in duplicate by necessity for large volume and/or highly acute emergency cases. Eliminating such duplication, without a proper analysis of the infrastructure requirements of the Orthopaedic programme will jeopardize patient care. No such study has been conducted at the NHS.
- Equipment already owned in duplicate in the NHS is not costing any money. No cost savings will be achieved by moving a site's Orthopaedic service.
- Some equipment, such as the C-arm image intensifier, is not exclusive to the Orthopaedic service. It is also used by Urology and Cardiology. Eliminating the need for duplicating such equipment cannot be accomplished simply by moving one service from a site.

c) More efficient use of surgical block

- The Orthopaedic Service at the Welland site is very efficient compared to the other sites (number of cases per number of nurses per OR day) even though the other sites insist on specialized teams of "Orthopaedic" nurses only.
- Having a local hospital gives the OR flexibility to call in patients on short notice to fill unexpected gaps or cancellations, maximizing utilization.

- Superbugs at one site may cause closure of its surgical programmes, which will be disastrous if there are only 2 Orthopaedic facilities. Historically it has been the Welland Orthopaedic service "bailing out" the other sites for closures due to maintenance or call disruptions.

What is the cost savings?

Keeping Orthopaedics as it is with 3 sites: **\$0 for renovation**

Moving Orthopaedics from the WHS to other sites: **\$ millions to accommodate 4+ Orthopaedic days /week in OR, significant volume of trauma cases and volume of outpatient visits**

Critical Mass

There is no clear definition of critical mass in the HIP. The HIP mentions that the St. Catharines Hospital Site (SCHS) and Greater Niagara Hospital Site (GNHS) are capable of sustaining critical mass. By omitting mention of the WHS there is a deliberately misleading implication that the WHS is not capable. If critical mass status is volume dependent, then the HIP should also include the WHS as having sustainable critical mass. It is a false assumption that by making fewer, larger centres providing Orthopaedic Surgery, improvements will be achieved in quality of care, specialist expertise, education and training and establishing an Orthopaedic centre of excellence

1. Quality of Care

- 1.1 Quality of care is already high within the NHS - SCHS, GNHS and WHS: Patients at all three sites express a high level of satisfaction with the treatment they receive at their local hospital. Conversely, patients express a high level of concern and dissatisfaction at the notion that they may have to travel to receive consultations, lab investigations, surgery and follow-up.
- 1.2 No other measure of quality of care has been presented in the NHS comparing wait times, infection rates, re-admission rates and length of hospital stay data, comparing the 3 sites to provincial averages,. The WHS is superior and thus has the best "quality of care."

2. Specialist Expertise

- 2.1 A very high level of sub-specialization exists in the NHS across the 3 sites. Examples include hip resurfacing, ankle replacement and reverse shoulder replacements, which are not typically found in other similar sized communities. This fortunate sophistication did not occur accidentally nor was it dependent on the "critical mass" the HIP would claim is necessary.
- 2.2 There is an excellent record of recruiting and retaining new surgeons. Manpower has not been a problem with filling in retirement vacancies in the last 10+ years in spite of severe national and global manpower shortages of Orthopaedic Surgeons.
- 2.3 The explanation would be that the current model, 3 smaller sites, is superior to the larger, fewer site model, in attracting and cultivating specialist expertise. There is "reverse critical mass" in this model, which is very attractive for new trainees, who feel they can still dictate the scope and special interest of their "small town" practice, while being connected to the larger membership of the "big city" regional group.

3. Education and Training

- 3.1 McMaster medical students and trainees will not benefit from exposure to larger site hospitals; they already get enough of that at the Hamilton Hospitals. A good education experience at the NHS will depend on the group's specialist expertise, not on an arbitrary standard of "critical mass". As stated in 2.3 above, the group's ongoing high level of specialist expertise will continue to be related to the 3-site model.
- 3.2 The WHS Orthopaedic service has been a leader in education. The culture of the entire WHS medical staff has promoted an exceptional learning environment, as well as demonstrating, by example, the collegial and consultative relationships between very different employee groups that effectively problem solve. As a testament, no other site has hosted resident doctors, nor has any other site trained a single Orthopaedic Technician hired in the last 10 years at the NHS.

4. Orthopaedic Centre of Excellence

- 4.1 The HIP does not identify what upgrades are necessary for the Orthopaedic programme to become a "centre of excellence", except that having 2 sites instead of 3 will somehow create this. A centre of excellence is not a "bricks and mortar" concept. All 3 sites contribute to the NHS virtual "centre of excellence." There is no advantage in a 2-site versus 3-site model.
- 4.2 Today's technology has negated the need for physical proximity to teach and learn. Internet and teleconferencing allows participation in lectures and rounds from remote sites. Picture Archiving and Communications System (PACS) provides system wide imaging. It is no longer necessary to have a "critical mass" of educators under a single roof to be a centre of excellence.
- 4.3 Most citizens of Niagara do not desire treatment at a HIP-type "centre of excellence." There is preferred treatment at local community hospitals which already provide "centre of excellence" caliber sub-specialty and quality care.
- 4.4 To be truly a "centre of excellence" for the citizens of Niagara, the NHS would have to offer the full spectrum of Orthopaedic Surgery. Spine Surgery is the only sub-specialty not represented in the NHS and continues to account for the overwhelming majority of out-of-region referrals. The NHS Orthopaedic group requested recruiting a Spine Surgeon in 2006, but was refused, even though one was available and had a desire to come here. Among the 3 sites, only the WHS has the capacity to accommodate this.

Quality of Care

The HIP will have a negative impact on quality of care by impeding access and lengthening wait times. Meanwhile, the HIP will be responsible for collateral effects which will place a strain on patient families, communities and social resources, not considered within the limited, narrow focus of the HIP.

1) Access

- a. Currently 3 Orthopaedic sites are providing emergency care Monday- Thursday in the Niagara Region. Reducing one third of these resources will amount to a 50% cut back in service. The HIP will result in longer wait times for trauma patients, increased complication and morbidity rates, longer hospital stays and higher cost to the NHS.
- b. Having "downgraded" the Douglas Memorial Hospital (DMHS) and Port Colborne Hospital (PCHS) sites it is even more critical to maintain Orthopaedic surgical access to South Niagara.
- c. Locating the Orthopaedic Service at the WHS instead of the GNHS will be geographically more accessible than the GNHS for the same catchment area.

2) Waitlist

- a. There is no physical capacity to accommodate the additional volume of the entire WHS service at the other sites. As seen with Urology and Ophthalmology, there will be an unavoidable net loss of resources (OR blocks, clinic blocks, beds) which will affect wait times.
- b. Demographic analysis would compel any foreseeing administration to plan only of expanding the capacity of the Orthopaedic programme, rather than downsizing or consolidating, to meet the demands of the aging baby boomers. The new St. Catharines General Hospital has no increased capacity for this future level of Orthopaedic demands. The GNHS is crowded and has little room to grow. Only the WHS has the physical space to accommodate the additional structures needed to serve this looming health care crisis.
- c. Orthopaedic ER patients at the WHS will have to be transferred to other ER sites in the region. The additional burden will result in longer wait times not only for the Orthopaedic patients, but for ALL patients at those ER departments. Additionally, patients from the Urgent Care sites, already stripped of full service hospitals, will be made to travel yet further to receive care that was previously accessible in Niagara South.

1) Collateral Effects

Additional collateral effects detrimental to all citizens of Niagara have been identified with the implementation of the HIP:

- a. To help with volume allocation, the HIP suggests moving the site for inpatient care only, while maintaining outpatient services at the original site. This is not acceptable. Outpatient volumes are too high and codependence between outpatient clinics and inpatient treatment is too important to have these at separate sites. The entire body of the NHS Orthopaedic Surgeons has already unanimously rejected any plan that requires any of its members to conduct their practice this way.
- b. Time spent in transportation will be increased for patients from the Niagara South tier. This is critical time in the acute perioperative care period that has the most profound impact on patient outcomes.
 - i. There will be delays to surgery as patients wait to be transferred from the South Niagara ER or urgent care centres,
 - ii. Interruptions in post-operative care as patients are transferred back to their home hospital and
 - iii. Barriers to follow-up appointments which are critical in detecting the development of surgical complications.
- c. The HIP depends on key "enablers" one of which is a public transit system. As yet there is no financially viable way of providing this. Cost of transport to and from distant sites for appointments and surgery (hundreds of dollars per trip) are being downloaded to patients and the public. This is occurring even now on a small scale, as patients with broken hips are diverted from the SCHS to WHS due to bed pressures. These are hidden fees the citizens of Niagara are and will be paying for personally or through taxes and have been deliberately evaded by the administration while promoting the HIP. The socioeconomic cost for the resultant delays in treatment (loss in wages, longer dependence on social programmes, prolonged suffering and disability) are similarly dismissed because the perceived budgetary impact on the NHS itself is felt to be minimal.

- d. The HIP is misguided in assuming the WHS will continue to serve the Niagara South region with all other services after removing the Orthopaedics programme. The co-dependencies of all specialties are so strong that, like dominoes, the rest of the hospital services will slowly decay, as described in other parts of this report. Anaesthesia will be most immediately affected, and then the ER department, which will no longer have full Anaesthesia or Orthopaedic support, followed by General Surgery and Internal Medicine. From that point, the demise will be steady and unstoppable, as the role of the WHS will be reduced ultimately to the equivalent of an Urgent Care Clinic unable to handle anything else but the most basic and non-acute Urology and Ophthalmology problems.

Summary & Recommendation

The benefits alleged by the HIP to move the WHS Orthopaedic service to another site are at best questionable, and on most claims, regarding cost savings, quality of care and critical mass, will clearly have only negative effects on the delivery of Orthopaedic care to the citizens of Niagara. Orthopaedic service must remain at the WHS. Service to Niagara South has been severely whittled away already and the additional burden to its citizens needing Orthopaedic care would be a grievous mistake. Niagara South needs a full service general hospital. The Welland Hospital site has numerous advantages to offer:

- Higher quality of care
- Good accessibility
- More attractive to sub-specialists
- Room to expand WHS to include spine surgery
- Room to expand to serve a larger part of the Niagara Region
- Ability to improve the level of excellence at the NHS

If the NHS feels adamant it is unable to sustain its mandate unless it consolidates to 2 Orthopaedic sites, the Welland Hospital Site should certainly be one of them.

MATERNAL/CHILD PROGRAMME



Dr. P Bonsu

Background

In August 2006, prior to the HIP document being released, the Maternal/Child programme had recommended and endorsed the department consolidation to a one-site model. At the time, the reasons for this recommendation and endorsement were as follows:

- 1) A genuine desire for the NHS to save money as the system was running out of funds.
- 2) The chief of staff had reiterated on more than two occasions that the new hospital being built was for St. Catharines and Thorold with consolidation of cancer services and cardiac catheterization.
- 3) The regional Obstetrical department passed a resolution endorsing a one-site move, NOT to any of the existing sites, but to a centrally located site easily accessible to all citizens of Niagara.
- 4) A Maternal/Child programme meeting also passed a resolution which endorsed a one site solution to save money. This was ***not*** to St. Catharines in particular as a regional site. This was altered without the knowledge or the full participation of the Maternal/Child department at the WHS and GNHS
- 5) The amalgamation was never discussed at regional paediatric meetings or at the local sites. We were categorically told not to discuss it outside of the meeting room.

The new focus on quality of care and developing centres of excellence does not really apply to Maternal/Child currently to require consolidation to one site. The most important advancement in Paediatric inpatient care in the past two decades has been accessibility to a centre where the child and parents can get access to health care in a timely fashion and be able to stay together as a family as necessary. We feel very strongly that we cannot jeopardize this advancement. As proposed in the HIP, the one-site model is going to be a regression and would compromise the successes we have seen in integrating the parents into the care plan for the child's health. This will ultimately have a negative impact on the patient's recovery time and the trauma experienced by the child.

Niagara South Centre of Excellence

A Niagara South Centre of Excellence should be located at the WHS for the following reasons:

- WHS is centrally located in southern Niagara, comprised of Port Colborne, Fort Erie, Dunnville, Fonthill/Pelham, Wainfleet, and Welland. A total population of about 130,000 means there are enough people to service this site.
- Because of its geographic position, services will be timelier for the local population.
- Welland can be easily accessed by public transportation from these communities and more research is currently being done to develop increased transportation to meet the perceived needs.
- WHS has a relatively new emergency department, operating room and Paediatrics department. Very little financial investment is needed to develop a new infrastructure at this site thereby saving the NHS a great deal of money.
- We make it equitable by reducing wait times in the emergency.
- There is an excellent working relationship between staff and physicians at the WHS.
- WHS has excellent patient satisfactory surveys, testifying to our safe and effective management of patients.
- With the large unit, we have the capacity to accommodate more patients.
- Our staff has been cross-oriented to cover both Obstetrics and Paediatrics making staff coverage much easier.

Do we have the numbers to support Welland? Indeed we do.

As mentioned earlier, there is a large enough population base (130,000) to warrant a Niagara South Centre of Excellence at the WHS.

Figure 1 shows the statistics for ER visits across the major sites. The Paediatric emergency numbers are approximately 14,000 including Port Colborne and Fort Erie which is large enough to support Paediatric services at the WHS site.

Emergency Department Visits

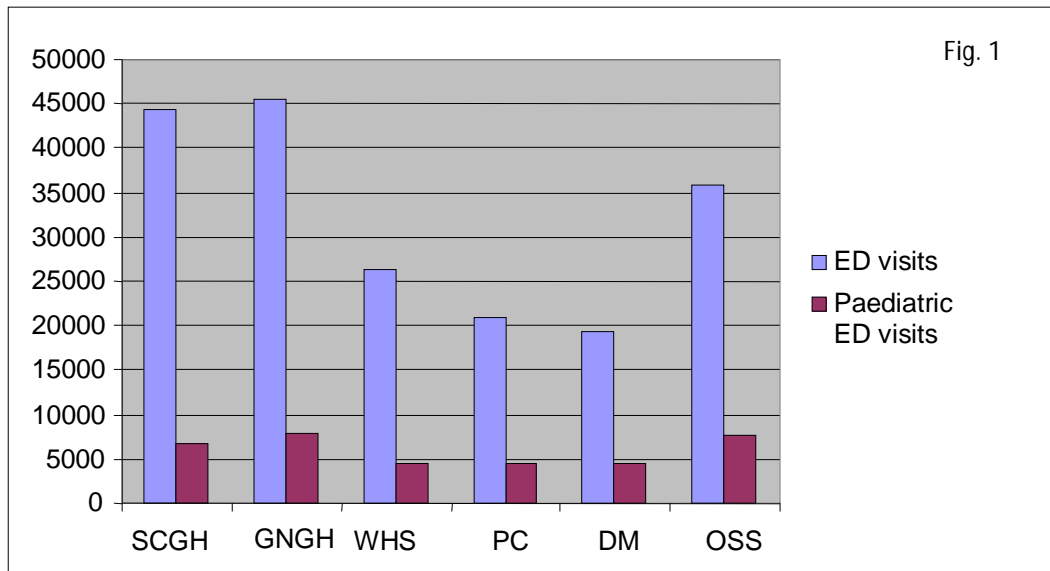


Fig. 1

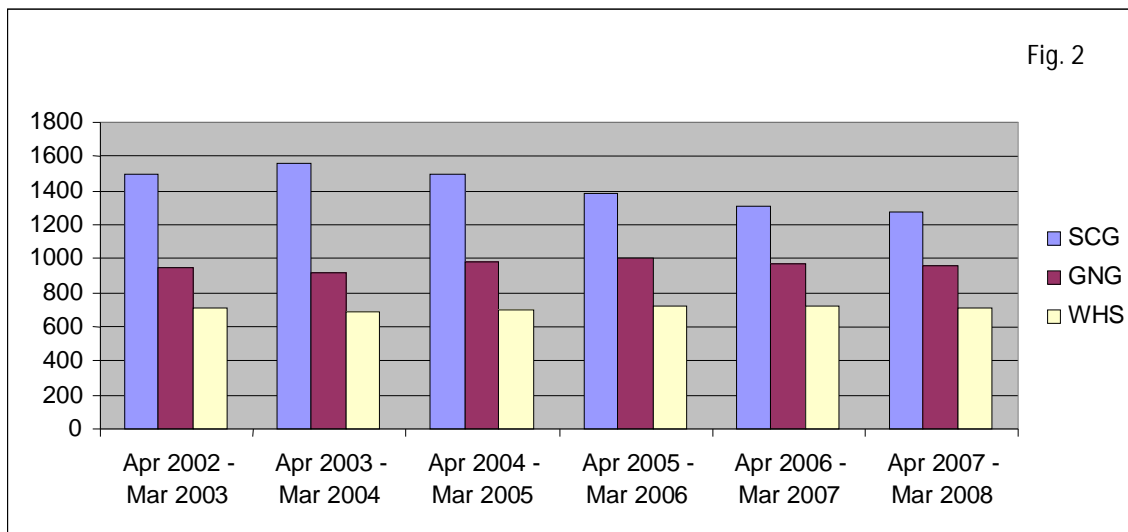
Key factors to consider:

- There is a 75% occupancy rate for inpatient beds and there is still room for expansion to accommodate more patients.
- These numbers will almost all be coming to WHS once the PCS and DMS are closed.
- The numbers for both the HIP proposed one-site model and our proposed two-site model do not support the volume needed to meet the minimum expectations for increased expertise. The two site model offers a plan that creates less congestion, timelier response and a higher quality of care.
- Quality of care can be maintained by:
 - Keeping the patients closer to home making it easier for parents and families to take care of their loved ones.
 - Decreased travel time for access to health care.
 - Quicker response for ED calls and providing services in the community.

With the proposed model, it is safer and less risky for the NHS, physicians, staff and patients. The proximity is closer and there is a reduced need to “rush” to get places in a timely manner. There will also be increased satisfaction for both care givers and those receiving care.

Across the board, there was a general decrease in deliveries, from 2002 – 2008, with the exception of Niagara Falls which has increased slightly because of increased access for midwives (as seen in Fig. 2). WHS has remained relatively stable over the past five years with essentially two Obstetricians working.

Deliveries per Hospital



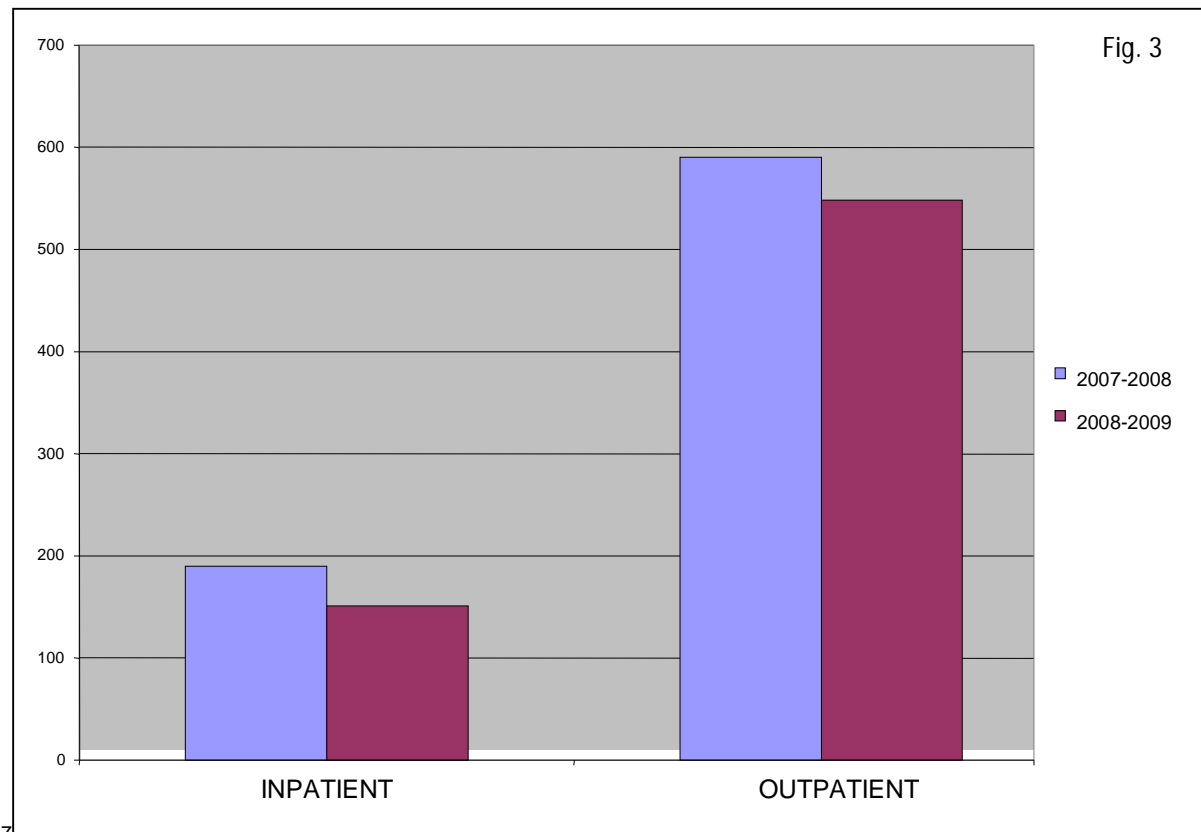
The Canadian Journal of Obstetrics and Gynecology [2001:108:904-9009] states the competence in obstetrical deliveries does not depend on the number of births attended to annually. Moving all deliveries to one location does not improve the obstetrical proficiency of doctors or enhance the quality of care of mothers. We currently give the best quality of care within the existing structure. Our patient satisfaction survey results confirm this finding.

In August 2009, we acquired a third Obstetrician which will increase our volume. This will then provide us with enough numbers to support our maternity programme with three Obstetricians and thus decrease the locum cost provided by the NHS for Welland.

Figure 3 below shows the number of gynecological procedures done at the WHS, both inpatient and outpatient procedures. These numbers will certainly be increased with the third Obstetrician and Gynecologist. As well, it will reduce the work load of the single-site hospital in St. Catharines.

This will also support Anaesthesiology which is critical to maintain the department economically, which, otherwise, could not survive.

Gynecological Procedures



WHS Paediatric Department

WHS Paediatrics department has a full complement of physicians and thus will not incur a locum cost for the NHS. The department also provides support for Obstetrics, Orthopaedics, General Surgery, Emergency Department, and Ear, Nose & Throat. Paediatricians provide timely services to all these departments.

The emergency department needs our immediate and continued availability to deal with emergencies. This will be jeopardized in the current HIP. As proposed in the HIP, Paediatricians will be moving to St Catharines without any emergency coverage for the hospital and other departments. This is risky and unsafe for patients and the NHS. Care will not be timely and access for care will be delayed.

With only one Obstetrician following the same patient in the HIP as it is, we are at risk of losing the personal, patient-centred care and effective delivery of service that is so critical in patient satisfaction.

There is no real change in the level and quality of care within the proposed model. The WHS currently has level II nursery care and in the proposed HIP the nursery care will remain at level II. Health care will continue to be equitable now and in the new hospital as proposed. So why consolidate?

Figure 4 shows the number of emergency department transfers from DMS to WHS. These numbers are disproportionately going to WHS. By moving all of these numbers to St. Catharines there would be congestion at that site. By maintaining WHS as a centre of excellence, we help to alleviate this congestion, pressure and volume. This addresses the concerns of safety, quality and accessibility.

Emergency Transfers - DMS to WHS

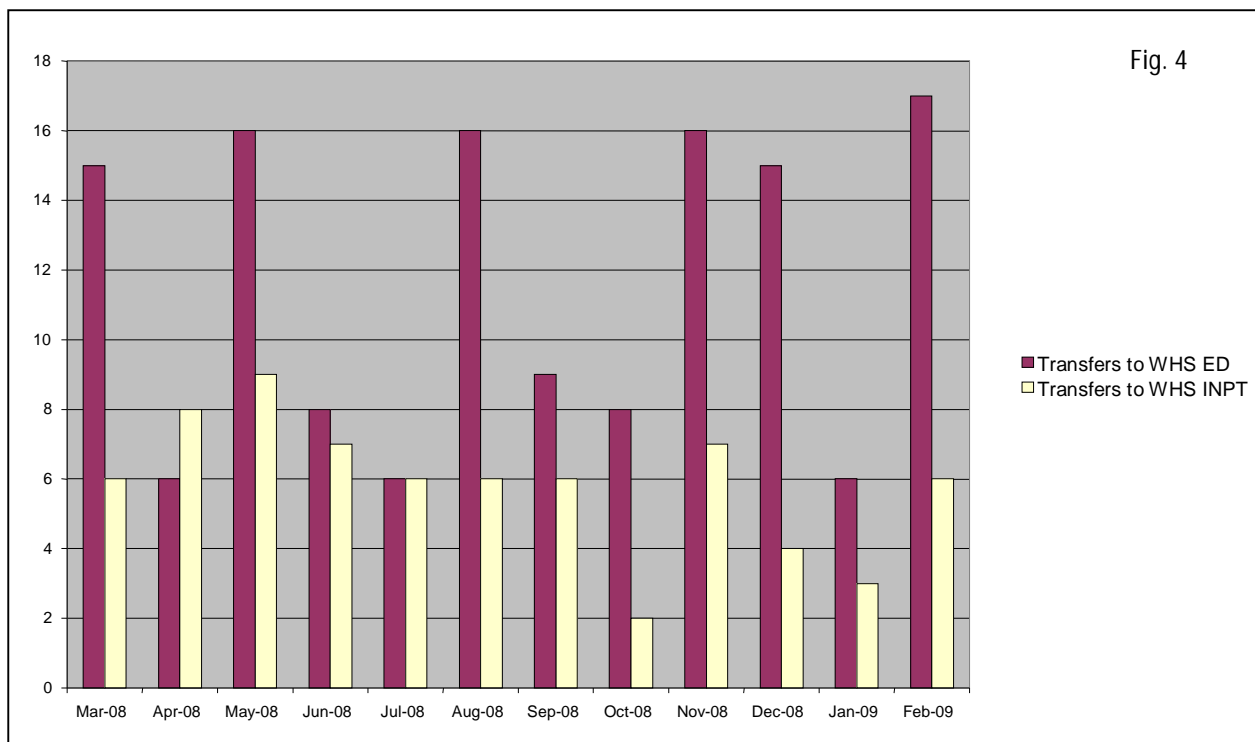


Fig. 4

Figure 5 shows the transfers to GNHS emergency department and transfers to GNHS Inpatient care.

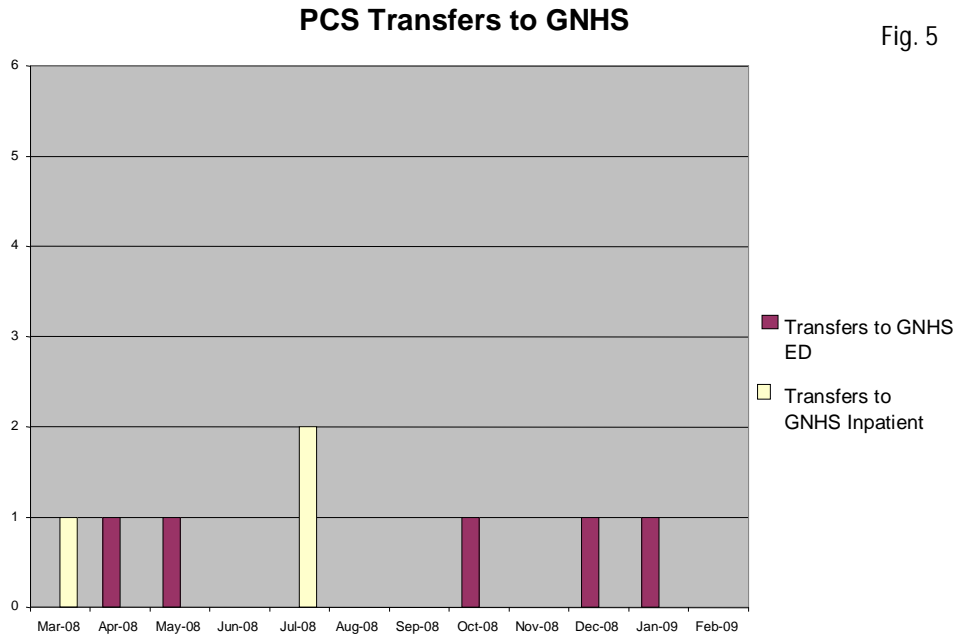
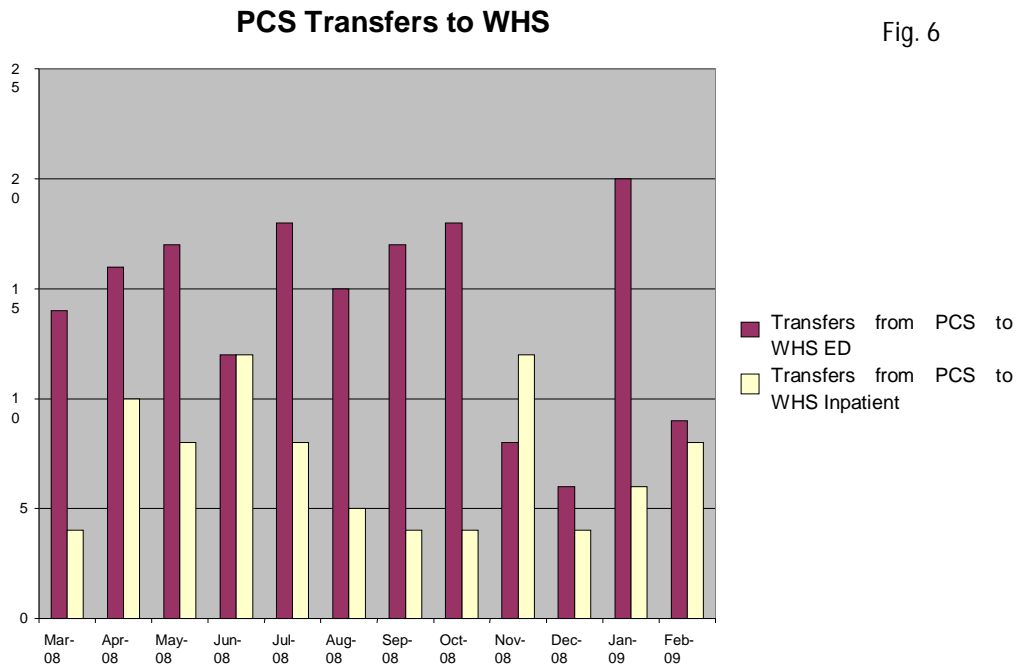


Figure 6 shows the transfers from PCS to WHS emergency department and transfers from PC to WHS Inpatient care.



Current Position

A Centre of Excellence is a place where people like to go to get their care where the best possible outcome is attained and where resources are available. It is a centre where the volume is enough for the subspecialists to gain expertise to treat the illness and where the knowledge gained allows for research and teaching of medical students. A centre of excellence improves accessibility and service delivery to the community and enhances relations in the community.

Improving quality of health care has six components:

- Safety
- Effectiveness
- Patient-Centred
- Timely
- Efficient
- Equitable

Safety is enhanced for patients, nurses and physicians through closer proximity. The ability to maintain the family unit throughout the care plan is critical in an equitable, patient-centred approach. This, in addition to the excellent staff at the WHS, contributes to a more effective and efficient patient care process.

With the HIP programme as is set out, by the year 2013, the programmes left at the WHS will include the emergency department, acute medical beds with level II intensive care beds, complex continuing care, the hospitalist programme, general surgery, laboratory and diagnostic imaging, and adult/stroke paediatric decision unit in the emergency.

We wish to state that on this basis, the WHS cannot stand on its own as an acute care hospital, and there is no convincing evidence set out to support improving quality of care or making Maternal/Child a centre of excellence at one site.

Other Factors

We (WHS) decrease the overload at the new hospital in terms of emergency care, supervision and hospital admissions, thus improving patient satisfaction. This would also not add any extra cost to the system.

WHS is at the forefront of the McMaster teaching programme for medical students. We are the only group to willingly participate in this programme. Our plan is to enhance this to accommodate more students, improve our relationship with the University and help attract new and younger doctors to the community. We are better positioned to support the new Health Centre currently being planned by the City of Welland and McMaster.

Most importantly we cater to the French speaking community in the Niagara region. Considering that the number of Franco Ontarians in Welland exceeds the provincial average it is critical that we maintain the level of support within the community that has worked very hard at preserving the services available in their foreign language. Moving to one St. Catharines site will greatly affect that. There are many francophone services available in Welland including a French community clinic and French speaking physicians.

Future Opportunity for New & Existing Programmes

There are many future opportunities for new and existing programmes that support the Maternal/Child programme. We intend to expand, enhance and consolidate the following programmes:

- Diabetic clinics
- Asthma clinics
- Teaching programme from McMaster

These units must interact for a teaching centre to be complete.

We also have the intention of initiating new programmes to enhance community well being. These include:

- Obesity treatment involving Internal Medicine, Paediatrics, and General Surgery
- Constipation
- Learning and behavior management with cognitive behaviour therapy

Summary and Recommendation

To quote Suzanne Strasberg, the president of the Ontario Medical Association (OMA),

“In rural Ontario, many emergency rooms are being turned into Urgent Care Centres or in some cases closing entire hospitals to the detriment of the local community.”

OMA Journal, June 2009.

We do not want this to happen to the Niagara Region. While we respect what the NHS is doing and the rationale behind the HIP, we feel very strongly that some proposed changes compromise the quality and safety of the Maternal/Child programme and patient care.

The WHS has the capacity to handle the volume of the Niagara South population and meets all of the criteria set out for quality of health care. In comparison to the proposed one-site model presented in the HIP, the two-site centre of excellence will:

1. Enhance **safety** of patients, nurses and physicians through closer proximity, by reducing wait times and having quicker response times for ED calls;
2. Provide for **effective** use of resources and greater **efficiency** without adding any additional costs to the NHS;
3. Have an increased focus on **patient-centred care** with a realistic volume, the right staff to handle the ethnic diversity and the continued focus on our patient satisfaction surveys;
4. Provide more **timely** access to services by being physically located within geographically accessible communities, particularly for Port Colborne and Fort Erie;
5. Provide an **equitable** quality of care because of the geographic proximity and the continued commitment to standards of care that are impartial to all.

We strongly recommend that the NHS reconsider the one-site model for Maternal/Child and move forward with a two-site model as proposed within this document.

GENERAL SURGERY



Dr. P Willard

General Surgery

While "untouched" by the HIP, this department has significant interdependency with Orthopaedics, Urology, Internal Medicine, Paediatrics, ER, and the Intensive Care Unit. Our department's track record is one of innovation and progress in the MIS field. Sentinel Node Surgery was pioneered in the LHIN at the WHS and the SCHS (1999-2000). It has become the standard of care in the United States and is becoming the standard of care in Canada. It is routine at the WHS.

The Welland Site has noteworthy success in key areas that are relevant to General Surgery.

- We perform a substantial number (60-70/400) of Video Assisted Surgeries (both advanced and basic) thereby reducing our LOS (by 1-2 days per case for advanced lap, by 3-4 days for basic lap cholecystectomy)
- The Welland Site effectively manages medical beds, never having cancelled surgery for lack of medical beds.
- An excellent retention rate among surgical specialists.

Our interdependence with Anaesthesia is best understood in terms of inpatient surgery, as these more complex cases require strong Anaesthesiologist support and validate the need for full-time Anaesthesiology at this site. The WHS has traditionally had sufficient inpatient volume to barely support four full time Anaesthesiologists, making a difficult but sustainable call group. Any decline in volume strongly threatens the continuation of the site Anaesthesia group.

The table below compares the numbers for Surgery in our key areas of focus considering the pre-HIP, post-HIP and post revised HIP.

Big Picture of Surgery (2006-07)

| | Pre-HIP | Post-HIP | Post Revised HIP |
|------------------------------|---------|----------|------------------|
| Inpatient Cases | 2,470 | 1,724 | 3,412 |
| Inpatient Days | 11,741 | 5,359 | 15,478 |
| Inpatient Beds Needed | 30 | 14.7 | 42.4 |

By augmenting the number of inpatient cases requiring Anaesthesia involvement, we improve local viability of the Anaesthesia department, as well as improving access at our site for Niagara South emergencies.

The HIP in fact augments utilization of the ICU/CMC, which will aid viability of the site. The contribution of Urology to critical care utilization is significant and should be considered in the final model approved by the Steering Committee. From the point of view of General Surgery, we would support the original HIP recommendation of a regional Urology inpatient services on site. From a volume perspective, clinical support and patient access viewpoint, outpatient services at each large site would also seem appropriate.

The loss of inpatient surgery threatens the very same Anaesthesia department which will be needed to support critical care. Moreover, loss of Orthopaedic Emergency Surgery makes the necessity for the 3-11 pm “on-call” operating room (OR) nursing staff questionable through volume losses. With this loss of after-hours work, the need for Anaesthesia availability declines, and eventually the natural outcome is an unsupported ER (for surgical patients—recall PCHS & DMHS).

The Linchpin to our 24/7 ER

Emergency Surgery is the linchpin in maintaining the acuity level of an acute care hospital supporting a 24/7 ER. The attached table reveals that Orthopaedics provides greater than 50% of our after hours surgical volume and Obstetrics provides over 60% of the weekend emergent cases.

WHS Inpatient Afterhours Procedures by Service

Discharges between 01/01/2008 to 31/12/2008

"AFTER HOURS PROCEDURES"

| | Total Cases | Weekday Elective 1500-0700 | Weekday Urgent 1500-0700 | Weekend Elective | Weekend Urgent |
|------------------------------------|-------------|-------------------------------|-----------------------------|------------------|----------------|
| General Surgery | 421 | 6 | 83 | 2 | 51 |
| Internal Medicine | 100 | 5 | 16 | 5 | 17 |
| Obstetrics & Gynecology | 424 | 64 | 26 | 45 | 18 |
| Ophthalmology | 2 | 0 | 0 | 0 | 1 |
| Orthopaedic Surgery | 807 | 40 | 180 | 12 | 124 |
| Otolaryngology | 31 | 3 | 4 | 0 | 1 |
| Plastic Surgery | 35 | 2 | 7 | 0 | 1 |
| Urology | 201 | 8 | 20 | 2 | 8 |
| Grand Total | 2,021 | 128 | 336 | 66 | 221 |

Note: After hours procedures are defined as patient in room times: weekdays 1500-0700 and all day Saturday/Sunday

OUR VISION

We have looked beyond the most immediate needs as part of the HIP Implementation. Our long term vision includes the following programmes and services:

1. Bring Gynecology to the Niagara South Site and recruit infertility specialists.
2. Begin a MIS Simulator programme for staff to acquire credentials as well as training residents.
3. Consider a Bariatric programme (may require an additional general surgeon).
4. Expand the role of the nephrology programme as a hub with vascular access back up from the general surgeons.
5. Develop an efficient hospital based outpatient Internal Medicine Department.
6. Provide better structure to the Cardiac Rehabilitation Programme in Welland as an official hub.
7. Dedicated nurse practitioner support to the Internal Medicine department.

OUR RECOMMENDATIONS

1. To establish a Centre of Excellence as an innovative outpatient inter-professional health delivery model that would integrate various specialties and ancillary supportive service.
2. Encourage growth in the Anaesthesia Group by adding Inpatient Volume (Regional Urology, focused Gynecology, Obstetrics). This in turn will improve ICU support, for the expanded Urology service.
3. We support the HIP recommendation of bringing Regional Urology to the WHS, with the revision that outpatient Urology continue at all major Acute Care sites.
4. Maintain Orthopaedics as is, for emergency surgical volume, and patient access reasons. This is crucial to maintaining viability of the Anaesthesia team, as well.
5. Encourage Maternal/Child unit to become the Niagara South centre, to provide better patient access, continue the teaching programme, and reduce risk exposure of the NHS to poor Maternal/Child outcomes.
6. Promote the links between Internal Medicine & General Surgery by supporting the nephrology programme (vascular/peritoneal access), and initiating a Bariatric programme.
7. To maintain the interdependency of General Surgery with Anaesthesia, Orthopaedics, Urology, Internal Medicine, Paediatrics, ER and ICU.

ACKNOWLEDGEMENTS

The Welland Hospital Working Group would like to extend a special thanks to Mayor Damian Goulbourne and City Council for their support of this project. The collaboration of this working group and the City truly represents the mutual trust and desire to see the Welland Hospital Site thrive as changes are made within the Hospital Improvement Plan.

We would also like to extend our gratitude to all the Physicians who contributed to this report and who have supported the working group throughout this process. Your guidance, support and confidence in the working group have been very much appreciated along the way.

Our aim is to collaborate and communicate within the framework and principles of the Niagara Health System and the HIP. While this report is primarily focused on the clinical perspective to patient care, we know that preserving hospital services within the Welland Site is of utmost importance to the people in our community. It is our hope that both the clinical and community perspectives to preserving and continuing to enhance our services are heard by those who influence the future of our hospital.

APPENDIX 1

Critical Care Utilization by Surgical Services¹

| | Pre-HIP | Post-HIP | Post Revised HIP |
|--|---------|----------|------------------|
| General Surgery | 257 | 257 | 257 |
| Orthopaedics | 72 | 0 | 72 |
| Urology | 91 | 350 | 350 |
| Other Surgery | 85 | 0 | 0 |
| Total ICU Days (With Current Urology) | 505 | 607 | 696 |

¹ICU cases only, step-down and telemetry not included

A bariatric program would undoubtedly augment the General Surgery ICU days, but this could be phased in.