Integration Proposal

Lakeridge Health and Rouge Valley Health System Integration

An Integration Proposal Submitted to the Central East Local Health Integration Network by the Boards of Lakeridge Health and Rouge Valley Health System

July 2016

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1. Executive Summary

"I believe that a system that best meets the needs of patients in an equitable way is one that is truly population-focused, and that is deeply integrated at the local level."

- Dr. Eric Hoskins, Minister of Health and Long-Term Care, Remarks, HealthAchieve Conference, November 2015.

Background

Rouge Valley Health System (RVHS) and Lakeridge Health (LH) understand the importance of local health system integration. It is not only embedded as part of their organizational histories, but a key driver of current collaborations and partnerships between the two hospitals. However, more recently, given the unprecedented challenges in the health care system, it is recognized that local system transformation is needed to drive and sustain quality, accessible and equitable health services in the Durham community. Since 2013, deliberate integration efforts within the region have focused on this need for bold change - to rethink and reorganize how health care is governed and delivered for better patient outcomes.

Following the unsuccessful *Leading for Patients* facilitated integration process between RVHS and The Scarborough Hospital (TSH) in 2013-14, the momentum for change and will for local system transformation remains unabated. In 2015, Dr. Eric Hoskins, the Minister of Health and Long-Term Care created the Scarborough/West Durham Expert Panel (Panel) to "develop a plan to address how hospitals in the region can work together to deliver acute health care programs and services in a way that meets the needs of local residents.[1]" The Panel was also to provide recommendations on program and service integration, as well as infrastructure needs. Based on the resulting Panel report and recommendations publically released in December 2015, the Minister wrote a letter, in May 2016, to the Board Chairs of RVHS, TSH, and LH confirming his endorsement of the recommendations and, specifically, highlighting the path forward with regard to governance structure:

> *I am mindful that the local communities are very motivated to move forward with the development of modernized and integrated hospital care in a timely manner and have limited tolerance for further delays. A representative and empowered governance model is the prerequisite for necessary local investments. Given the urgency of this matter, I invite you to come forward at your earliest opportunity with notices of integration to the Central East Local Health Integration Network, consistent with section 27 of the Local Health System Integration Act (LHSIA).*
>
> *I am supportive of a reconfiguration of the existing corporate structures and hospital sites as follows:*
>
> - *The Birchmount and TSH General sites of The Scarborough Hospital (TSH) and the Centenary site of the Rouge Valley Health System (RVHS) to be operated by a single new hospital corporation.*

[1] Ministry of Health and Long-Term Care, News Release, April 10, 2015.

- *The Ajax Pickering site of RVHS to be operated by Lakeridge Health, with assurance that the governance framework appropriately recognizes the addition of the Ajax Pickering site to Lakeridge Health.*

The first integration noted above, as it relates to the Scarborough community, will be completed through a statutory amalgamation (i.e., merger), and the resulting new hospital corporation is referred to as "Amalco" throughout this document. The second integration, as it relates to the Durham community, will be completed through an asset transfer by which Lakeridge Health (LH) will be responsible to govern and manage the Ajax Pickering site of the Rouge Valley Health System.

With clear direction from the Minister, and a continued commitment to achieve new levels of quality, access and value for patients, RVHS and LH have embarked on the early stages of this integration journey designed to transform local health care services for all Durham residents. Through the leadership and guidance of the LH RVHS Integration Steering Committee (ISC), there is shared motivation to action the Minister's direction judiciously and commitment to the following guiding principles:

- Collaboration and Engagement - We believe that collaboration and engagement will lead us to better solutions.
- Accessibility - We believe in providing accessible patient care to our community.
- Sustainability - We believe that we must find new solutions to sustain our health care system.
- Excellence - We believe that we must never waver from our responsibilities to provide quality patient care and to be accountable to our stakeholders.

Guided by the principles above, the LH RVHS integration will ensure health services are responsive to the needs of the population, appropriate access is provided, an outstanding experience for patients and their caregivers is delivered, and resources are used efficiently so that these services are sustainable into the future. Health care integration in the region, supported by physical improvements including strengthening and expansion of current services and development of a new comprehensive acute care facility, will pave the way for a Durham health care system that puts patients first.

The LH RVHS Integration: Investing in Success

There is no doubt, integration is simply hard work. The integration of RVHS and LH is a complex process that will require initial and ongoing investments in order to realize the long term benefits and enable improved care for the Durham community. The working groups have considered several matters raised in the *Leading for Patients* report and conducted additional analyses to develop a financial model that represents the best interests of both organizations in the integration.

The net financial impact of the LH RVHS Integration is estimated to be between - $0.3M and $0.3M in savings. However, the Integration also requires $18.8M in one-time investments.

Key findings from the working groups include:

A) Efficiencies

- There are **minimal operating efficiencies** that will result from integration. A master plan that will result in improved capital infrastructure will create opportunities for operating efficiencies and will allow for more effective deployment of scarce capital resources.

- There is **no material effect on the funding formulas** through the Health Based Allocation Methodology (HBAM) and Quality Based Procedure (QBPs) as a result of integration

B) Investments Required to Support Integration

At a high-level, or "order of magnitude", the following summarizes the financial investments required for the foundational work that will be critical in the Implementation Phase for transformation management, IM/IT integration, transaction costs, and workforce considerations.

- Transformation Management – Given the importance and complexity of this work, the new leadership team will require a formal transformation management structure, with a senior level, multi-disciplinary team to successfully execute on the integration. **The total one-time investment over a 3-year period required is estimated to be $1.9M**.
- IM/IT Integration – There are five requirements for integration: consolidate enterprise hospital information systems (HIS); consolidate departmental clinical systems; consolidate back office systems; merge networks and email systems; and merge telecommunication systems. **The total one-time investment required over 12-18 months is estimated to be $13.6M.** Funding commitments from the MOHLTC for IM/IT will need to be clarified due to the significant investment required for these mission critical IM/IT requirements.
- Transaction Costs – This includes the cost of legal, due diligence, and communications and engagement activities leading up to November 1, 2016. **The total one-time investment required is estimated to be $1.1M.**
- Workforce Restructuring and Harmonization of Compensation and Benefits – The overall cost to align salaries to the higher level across both organizations, and manage the employees who do not remain with the organization post-integration. **The total investment required for restructuring is $2.2M, and $0.29M for harmonization (not including pay equity).**

C) Cost Allocation (i.e. division of operating costs between two future organizations – LH and Amalco)

- **Total expenses for LH will be approximately $576.9M post-integration**. This projection is based on a cost sharing principle agreed upon between the three organizations. The relative split of operating costs between the two future organizations is approximately 34.8% LH and 65.2% Amalco.
- Allocation of assets and liabilities between LH and Amalco will be determined during the next phase, specifically through the due diligence work.

In addition, as stated in the Panel report, the development of a master plan for the Durham community must be completed within 12 months post-integration. This master plan will guide future capital development that is based upon the growing and changing needs of the population and will take into account the full spectrum of health care required to meet the needs of the Durham community well into the future.

Through the detailed planning that the hospitals have undertaken to date, the organizations acknowledge and understand the significance of change that is forthcoming. In order to best support this change and position Amalco and LH for success, it will be crucial to develop an approach to HBAM calculations that considers restructuring costs, to ensure adequate financial support related to overall integration costs and IM/IT costs is available, and to understand and address the implications of the organizations' current financial positions (e.g. significant working capital issues that RVHS has going into the integration). All three hospitals look forward to working with the CE LHIN and the MOHLTC on the path forward.

Of course, investing for success in not just about money. It's about building for the future and ensuring equitable, high-quality, and accessible patient care is enhanced for our community. Important investments must be made in listening to, engaging with and supporting our staff, physicians and communities. As such, a comprehensive

Human Resource (HR) Transition Plan will be developed to ensure that the integrated organization is stable, and that staff are supported through the process. Due consideration will be given to establishing an understanding of the number of staff, skills and abilities the LH RVHS integrated site requires compared to the current state. Additionally, key HR Transition Plan activities aimed at supporting staff include developing recruitment/retention strategies, designating resources to support the existing workforce during the transition, establishing a union/management consultation strategy to ensure appropriate communication throughout the process, and establishing an ongoing communication plan (internal and external).

We understand the complexity – and for many, the emotion – of the journey ahead for our key stakeholders. There is much diversity in knowledge, perspectives and opinions about the LH and RVHS Integration. On the path forward, we remain committed to informing and engaging our stakeholders in a meaningful way to help further develop a high-performing hospital system for the Durham community.

Summary

Throughout this integration planning process, discussions on the benefits of the LH RVHS Integration included the consideration of risks. Key risks and mitigation strategies were related to effectively engaging internal and external stakeholders, ensuring access is improved through the development of the new acute care facility and the strengthening and expansion of current services, sustaining a successful integration through careful and achievable planning, and achieving excellence in care through robust standardization and performance management.

This Integration Proposal follows from the recommendations described in the 2015 report by the Scarborough/West Durham Panel and the subsequent May, 2016 letter from Minister Hoskins and requests the CE LHIN to consider this as a voluntary integration proposal under s. 27 of the Local Health System Integration Act, 2006, and to the Ministry of Health and Long-Term Care (the "Ministry") pursuant to s. 4 of the Public Hospitals Act. This proposal represents an important milestone in the integration journey ahead for RVHS and LH. With a commitment to the target integration date of November 1, 2016, the LH RVHS ISC has established and activated a comprehensive work plan for the balance of the Integration Planning Phase, including due diligence activities, governance and professional staff integration plans, HR transition planning and stakeholder engagement.

This Integration Proposal, including the resolution in *Section 8 – Recommendation*, is submitted by the LH and RVHS Boards of Directors and signals their eagerness in working collaboratively to ensure the Durham community has access to a stronger health care system tailored to their needs. With this proposal, two organizations with rich histories and unique communities have come together – as partners – to create a revitalized and strengthened organization that will better serve the Durham community. Both hospitals are confident they will contribute further developing a hospital system that is positioned to succeed in improving quality and safety, enhancing access to services, and delivering patient-centered care to the Durham community.

2. Introduction

Integration Context

Lakeridge Health (LH), Rouge Valley Health System (RVHS), and The Scarborough Hospital (TSH) have a long history of working together to improve health care in the Scarborough and Durham communities. As the residents of these communities look ahead to the stronger and revitalized health system of the future, it is crucial to consider the integration context that has brought the three hospital corporations to this stage of collaboration and partnership.

Over the years, these three hospital corporations have been dedicated to building a strong partnership which has resulted in, for example, the integration of various regional programs, such as cardiology, cancer and vision care. Further, in 2013-14, *Leading for Patients* – a facilitated integration process of the Central East LHIN – brought RVHS and TSH together as partners to explore the benefits of a potential merger, also known as an amalgamation. After significant collaborative efforts and planning discussions, robust analysis, and comprehensive community engagement, *Leading for Patients* showed support for a RVHS-TSH merger. The value proposition was clear – a merger would strengthen the delivery of accessible, high quality health care services for the Scarborough and Durham communities. However, these efforts did not lead to a merger in 2014, as planned.

In 2015, Dr. Eric Hoskins, Minister of Health and Long-Term Care, created the Scarborough/ Durham Expert Panel (Panel) comprised of senior health care leaders and community representatives to "address how hospitals in the region can work together to deliver acute health care programs and services in a way that meets the needs of local residents. "[2] The Panel was also to provide recommendations on program and service integration, as well as infrastructure needs.

The Panel's final report and recommendations were released publicly by the Minister in December 2015, and included twelve recommendations spanning the Scarborough and Durham communities. The Panel made the following recommendations as they relate to the Durham community:

- The construction of a new comprehensive hospital in Durham to meet the needs of our growing community.
- Expanding existing regional and integrated programs to achieve comprehensive and equitable delivery of patient services for Scarborough and Durham residents including, but not limited to, mental health and addictions, obstetrics and neonatal care, stroke and palliative care, cardiology, and oncology.[3]

In May of 2016, Dr. Hoskins wrote a letter to the Board Chairs of RVHS, TSH, and LH in follow-up to the Panel report and recommendations restating his endorsement and, specifically, highlighting the path forward with regard to governance and structure:

> *I am mindful that the local communities are very motivated to move forward with the development of modernized and integrated hospital care in a timely manner and have limited tolerance for further delays. A representative and empowered governance model is the prerequisite for necessary local investments. Given the urgency of this matter, I invite you to come forward at your earliest opportunity with notices of*

[2] Ministry of Health and Long-Term Care, News Release, April 10, 2015.

[3] McLellan, B., Barbato, T., Campbell, J., Chung, R., Clarke, I., DiEmmanuelle, M., Ronson, J., & Whiteside, C. (2015). Report of The Scarborough/West Durham Panel. Retrieved from Ontario Ministry of Health and Long-Term Care website: http://www.health.gov.on.ca/en/news/bulletin/2015/docs/scarborough_west_durham_panel_20151218.pdf

integration to the Central East Local Health Integration Network, consistent with section 27 of the Local Health System Integration Act (LHSIA).

I am supportive of a reconfiguration of the existing corporate structures and hospital sites as follows:

- *The Birchmount and TSH General sites of The Scarborough Hospital (TSH) and the Centenary site of the Rouge Valley Health System (RVHS) to be operated by a single new hospital corporation.*
- *The Ajax Pickering site of RVHS to be operated by Lakeridge Health, with assurance that the governance framework appropriately recognizes the addition of the Ajax Pickering site to Lakeridge Health.*

Upon receipt of this letter, and the appointment of Mr. Mark Rochon as the Minister's Special Advisor and Facilitator to support the integration, RVHS and LH governance, executive and medical leadership acted promptly to begin the early stages of the important work described in the second bullet above ("LH RVHS Integration"). With the support of the two boards (see *Section 8 - Recommendation*), this document (the Integration Proposal) is being submitted as a notice of integration to the Central East Local Health Integration Network (CE LHIN). The first bullet above ("the RVHS TSH Integration") will be the subject of a separate, but complementary Integration Proposal.

The LH RVHS Integration

As described above, the LH RVHS Integration involves transferring the assets of the Ajax Pickering site of RVHS to Lakeridge Health, with assurances that the governance framework appropriately recognizes the addition of the Ajax Pickering site to Lakeridge Health.

Putting Patients First

The Panel did an in-depth study. The rationale for the LH RVHS Integration is outlined in some depth in the Panel report:

- *Enables planning of integrated systems of care both within and between regional care systems that reflect the characteristics and requirements of the different communities they service;*
- *Streamlines capital planning processes and makes more effective use of capital investments;*
- *Enables funding to follow the patient and future bundled payment initiatives;*
- *Enables regional health service planning and rationalization in the content of a critical mass of patients required to adequately support a system of shared health services; and,*
- *Aligns corporate boundaries with geographic, transit and road system boundaries to facilitate comprehensive patient care, including flow.*

- McLellan, B., Barbato, T., Campbell, J., Chung, R., Clarke, I., DiEmmanuelle, M., Ronson, J., & Whiteside, C. (2015). Report of The Scarborough/West Durham Panel.

In addition to the above, the LH RVHS Integration will strengthen relationships with academic institutions and enhance the ability to retain and attract the best talent to deliver high quality health care to Durham residents. The Panel envisioned that integrating care in Durham will enable integrated planning and delivery of patient care that will respond to the unique and diverse needs of the Durham community. This will ensure the patient experiences a seamless care journey that is responsive to their needs. As an integrated hospital system, the LH RVHS Integration will ensure the right care is delivered to the patient at the right time and in the right place – primary and community care will be better coordinated, navigation will be improved, patients will be able to access a broader range of services, and clinical programs will be strengthened and enhanced.

Finally, the development of a master facility plan for the Durham community will guide future capital development that is based upon the growing and changing needs of the population. As stated in the Panel report, with the support of the Ministry and the CE LHIN, planning must begin for the siting and construction of a new comprehensive acute care hospital, taking into account the full spectrum of health care required to meet the needs of the Durham community well into the future.

Approach to Integration Planning

RVHS and LH Boards of Directors are aligned to implement the Minister's direction and begin the integration journey designed to transform local health care services for the Durham community. An integral first step was the establishment of the LH RVHS Integration Steering Committee (ISC).

The members of the ISC include representatives from both hospitals who are guiding and overseeing the integration activities that are required to implement the governance related recommendations contained in the Panel report and the Minister's directions as set out in his May 2016 letter. With the support of the Special Advisor and Facilitator, Mr. Mark Rochon, the ISC will:

- Establish a work plan and schedule for the key deliverables;
- Oversee the legal and financial due diligence process;
- Oversee the development of a Integration Proposal for review, consideration, and approval by the Boards and submission to the CE LHIN (this document);
- Oversee the preparation and submissions of legal documents to give effect to the LH RVHS Integration as identified in the Minister's letter;
- Recommend a governance structure and processes for the LH RVHS Integration that takes into consideration the addition of the RVHS Ajax Pickering site to LH;
- Develop a community engagement framework to guide further activities, as may be deemed necessary by the ISC;
- Conduct appropriate community engagement and communication activities, taking into consideration the engagement activities already completed by the Panel and through the *Leading for Patients* integration process;
- Develop a Human Resources Transition Plan; and,
- Develop a Professional Staff Integration Plan.

The ISC has set a target date of November 1, 2016 to complete the integration. It is important to note, however, that the role of the ISC is advisory only. Although the ISC will be overseeing the above activities, the authority to approve the LH RVHS Integration remains with the Boards of Directors of RVHS and LH.

Guiding Principles

Early in the integration process, the ISC jointly developed the following Guiding Principles to set the tone for the path forward as they plan for the integration and make recommendations to their respective hospital boards on how to improve health care in Durham. It is clear from the principles below that the ISC wishes to further develop an integrated system of health services that is responsive to the needs of the population, provides appropriate access, delivers an outstanding experience for patients and their caregivers, and uses resources efficiently so that these services are sustainable into the future.

Guided by the following principles, the ISC plans to be leaders in health care transformation.

Collaboration and Engagement

We believe that collaboration and engagement will lead us to better solutions. We will collaborate and engage with our community and patients, as well as other health service providers to enhance care outcomes and increase service efficiencies. We will be transparent and honest in our relationships. In doing so, we will share information and knowledge, promote teamwork and fairness, and ultimately work towards providing patients with timely, effective, and efficient care.

Accessibility

We believe in providing accessible patient care to our community. Services and patient care are accessible if they are delivered in a timely manner, are seamless for patients to navigate, and address other barriers such as culture, language and transportation. User-friendly patient care can be achieved through streamlined processes throughout the continuum of care. We strive to ensure timely diagnosis, treatment, and follow-up care.

Sustainability

We believe that we must find new solutions to sustain our health care system. Services are sustainable if they respond to the community's health care priorities while achieving best use of public funds. Sustainability requires our hospital corporations to pursue partnerships with each other and with other health providers whenever it is appropriate and possible. Sustainability also requires engaged stakeholders and the appropriate human and technical resources to provide high quality services.

Excellence

We believe that we must never waver from our responsibilities to provide quality patient care and to be accountable to our stakeholders. Quality has many dimensions, and for this planning exercise we define it to include effectiveness, safety and high standards. Services are considered effective if they lead to best possible patient care outcomes, safe if they are responsive to patients' needs while minimizing risks, and of a high standard if they use leading practices, the right information and the most appropriate technology. To be accountable, our hospital corporations must report to their stakeholders, in a transparent fashion, the performance achieved relating to our stated goals and targets.

Purpose and Structure of the Integration Proposal

The purpose of this Integration Proposal is to respond to the recommendations described in Panel report and the subsequent letter from the Minister outlining his request for RVHS and LH to come forward with notices of integration to the CE LHIN. This proposal takes into account work completed as part of *Leading for Patients*, the Panel recommendations, as well as updated and refreshed analyses, all anchored in the Guiding Principles, to understand the current state and future implications of the LH RVHS Integration.

The content of this Integration Proposal was developed through consultations and analyses prepared by three Working Groups (Human Resources; Finance; and Community Engagement and Communications) that include staff representatives from RVHS, TSH and LH. The hospital staff on each Working Group has been dedicated in moving their work forward and focused on analysing the current state and articulating the related implications and benefits of the LH RVHS Integration. Recognizing the importance of this work to community members and patients, patient and family advisors have been included as members of the Community Engagement and Communications Working Group. As the ISC has committed to ensuring the community and patient voice is strong in planning for the LH RVHS Integration, it is important that these advisors are present on this working group to inform a community engagement and communications plan.

This proposal consists of the following sections:

- Human Resource Implications
- Financial Implications
- Community Engagement and Communications Plan
- Risks and Mitigation Strategies
- Plan Forward
- Recommendation

3. Human Resource Implications

As LH and RVHS prepare for the LH RVHS Integration, it is essential to consider how the two workforces can be brought together in a thoughtful and practical way to enable the success of the integration and the realization of anticipated benefits.

LH and RVHS have many similarities in their Human Resources (HR) structures and processes, workforce demographics, people indicators and labour relations environments. LH and RVHS have minor differences in organizational culture and HR policies, procedures and practices. While there are similarities, integration will still require the planning and implementation of a number of important human resource integration considerations.

This section provides an overview of the planning principles and assumptions, current state of workforce at both organizations and preliminary implications, as well as considerations for a HR transition plan.

Principles and Assumptions

In order to facilitate an effective and optimal workforce integration process, a set of key workforce integration principles were developed to guide planning efforts along the integration path. In developing these principles, the HR Working Group embraced the future prospects with confidence to lead the change. Summary of workforce integration principles include:

- Fostering an **open and transparent** workforce integration process by involving all hospital staff and medical staff throughout the journey and making decisions with a clear, ethical decision-making framework;
- Ensuring **fairness and equity** and where possible provide choice to staff;
- Treating employees, volunteers, and medical staff with **respect and timely support;** and,
- **Minimizing labour disruption** by exploring opportunities (e.g. redeployment) for staff.

Please refer to Appendix A for a detailed list of the principles.

To understand the HR implications for the purpose of this Integration Proposal, key assumptions were developed by the HR Working Group as follows:

- In the next detailed planning phase of integration, scope of analysis will extend to volunteers of both organizations and include workforce metrics and, as such, have not been included in the Integration Proposal submission;
- Basic demographic information of professional medical staff has been included for context to disclose order of magnitude change - all other medical staff matters (e.g. by-laws, privileges etc.) will be addressed by the Professional Staff Working Group in the months ahead;
- The scope of this proposal is intended to include matters resulting in new cost considerations;
- It is not anticipated that there will be a significant cost to harmonize benefits related to the LH RVHS Integration. However, Long Term Disability (LTD) costs are currently higher at one organization which may impact the overall premium rates for LTD in the Integration. LTD will be further analyzed during the integration planning phase;
- The development of a new compensation structure for the corporation will necessitate the completion of a Pay Equity exercise in order to ensure compliance with Pay Equity legislation; and,
- Due to the nature of the RVHS TSH and LH RVHS Integration, and the split of resources, the three organizations have decided on a practical cost allocation methodology for severance costs. Although there

is no anticipated severances as a direct result of the LH RVHS Integration, costs attributed to severances will be structured according to this cost allocation methodology developed through data analysis – 34.8% LH, 65.2% Amalco.

Current HR Landscape

The workforce at both organizations includes employees, volunteers and medical staff. For the purpose of this Integration Proposal, only employees and medical staff have been considered. (As noted previously, detailed HR analyses will include volunteers as integration planning continues.)

Both organizations are focused on ensuring an optimal employee experience throughout the entire employment lifecycle through the development and implementation of effective strategies, policies and processes. The HR plans align with the overall strategy of the respective organizations and influence and impact organizational quality and fiscal results.

Internally, HR strategies and services directly impact the employee experience through the provision of qualified resources to provide care, wellness programs, competitive compensation programs, occupational health and safety and other HR infrastructure supports. As such, HR services have a significant indirect impact on the patient experience, given employees are the direct providers of patient care through their staff support functions. Additionally, the scope of HR services extends externally to the community and patients through its Diversity and Accessibility functions. The safety function ensures a safe and healthy facility for our patients, visitors and staff, and programming to support injured workers who are providing patient care.

HR services at both organizations are comprised of the following functional areas:

- Compensation and Benefits
- Salary Administration
- Employee Relations
- Labour Relations
- Recruitment
- HR Information Systems
- HR Administrative Services
- Occupational Health, Safety & Wellness
- Learning and Organizational Development
- Health Sciences Libraries
- Diversity (at RVHS) and Accessibility
- Payroll (shared service)

Employees

As with any change, the current sentiment among members of the workforce is that of concern about their future within the LH RVHS Integration. To manage workforce uncertainty, a clear plan and consistent communication will be necessary to ensure everyone is up-to-date and well informed on the critical components of the integration. Strategic communication will need to ensure appropriate messages are conveyed and reinforce a key message that the LH RVHS Integration offers opportunities for staff (i.e. redeployment within a larger workforce group) and will consider the various resourcing needs of the hospitals. Historically, both hospitals have mitigated staffing impacts through vacancy elimination and voluntary exit

packages, and have followed the provisions of their respective collective agreements, a practice that will continue during and after the LH RVHS Integration.

Table 1: RVHS Employee Demographics (headcount as at June 15, 2016)

RVHS Group	Shared	RVC	RVA	Total	Full Time	Part Time	Casual	Average Tenure of Service	Average Age
ONA	24	646	347	**1017**	590	275	152	13	46
CUPE	42	695	399	**1136**	530	487	119	11	45
OPSEU	1	357	179	**537**	298	156	83	12	44
SEIU		16		**16**	10	6		11	39
CEP		3		**3**	1	2		5	61
Non Union	96	11	7	**114**	101	8	5	7	45
Management	70	27	17	**114**	109	5		12	45
Executive	9			**9**	8	1		7	56
Total	**242**	**1755**	**949**	**2946**	**1647**	**940**	**359**		

Table 2: LH Employee Demographics (headcount as at June 15, 2016)

LH Group	Bowmanville	Corporate Office	Oshawa	Port Perry	Whitby	Total	Full Time	Part Time	Casual	Average Tenure of Service	Average Age
CUPE	172	16	1226	55	117	**1586**	803	665	118	12	43
ONA	130		1005	65	59	**1259**	711	411	137	12	42
OPSEU	37		293	17	7	**354**	185	148	21	13	44
OPSEU Pinewood			93	1		**94**	61	17	16	9	38
PIPSC			8			**8**	8			6	44
ONA - Allied	5	1	101		5	**112**	62	36	14	9	40
Non Union	20	31	442	5	28	**526**	353	74	99	9	41
Management	12	24	168	1	6	**211**	199	7	5	12	47
Executive			5			**5**	5			8	53
Total	**376**	**72**	**3341**	**144**	**222**	**4155**	**2387**	**1358**	**410**		

Both RVHS and LH operate in largely unionized environments. At RVHS, approximately 91% of employees are unionized. At LH, approximately 82% of employees are unionized. There are five unions in place at RVHS – ONA, CUPE, OPSEU, SEIU and CEP. There are 6 Unions at LH- ONA, ONA-Allied, CUPE Clerical, and CUPE Service, OPSEU, OPSEU Pinewood and PIPSC. Local Collective agreement renewal dates vary, so bargaining is either beginning or in progress Table 3 outlines the union footprint and bargaining dates. Both organizations have positive and respectful working relationships with their unions.

Table 3: Union Footprint and Collective Bargaining Agreement Expiration

Union	Expiration Date
RVHS	
UNIFOR	September 28, 2013
ONA	March 31, 2017
CUPE	September 28, 2017
SEIU	December 31, 2018
OPSEU	March 31, 2016
LH	
CUPE	September 28, 2017
OPSEU CL	March 31, 2017
OPSEU TECH	March 31, 2016
ONA	March 31, 2017

In an integrated state, a range of possible labour relations scenarios exist as prescribed under the Local Health System Integration Act, 2006 (LHSIA), and the Public Sector Labour Relations Transition Act, 1997 (PSLRTA). Working with the unions may result in some legal and other costs (estimated at $25,000) to the new organization – these costs are included in the labour transitioning costs in Table 9, refer to *Section 4 – Financial Implications*. This estimate is based on an assumption of five days of proceedings at the Ontario Labour Relations Board, one day for each of the five union groups involved.

In addition, there are currently 27 employees who work at both RVH Ajax site and LH; this is a potential risk because of the Employment Standards Act (ESA) maximum number of hours worked with a single employer regulation. A mitigation strategy will be required to manage this risk in consultation with the unions, if applicable.

Medical Staff

The majority of medical staff, with the exception of pathologists at RVHS, are independent professionals who are not employed by the hospitals, but are appointed and granted privileges by the Board of Directors to provide patient care within their licensed scope of practice. Groups that are granted privileges include physicians, dentists, midwives, and extended class nurses. Professional staff are organized through structures where there is an appointed department chief or medical leader who supervises the practice of medicine, dentistry or midwifery; these leaders report directly to the Chief of Staff, who reports to the Board of Directors and bears accountability for the overall management and quality of care provided by these credentialed members.

The management of all medical or professional staff is coordinated through each hospital's Medical Administration. Working with the Chiefs of each department, both offices administer credentialing and re-credentialing processes to facilitate the appointment and reappointment of professional staff members, as well as the delineation of procedural privileges for active, courtesy, temporary and locum staff.

Table 4: RVHS Ajax Pickering Physician Profile

Departments	Active	Associate	Courtesy	Total	Average Tenure at RVHS (Yrs)	Average Age (Yrs)
Cardiology*	14	4	9	27	13	48
Diagnostic Imaging*	19	0	0	19	16	54
Emergency	12	1	0	13	14	47
General Practice	22	2	14	38	22	56
Medicine	15	0	7	22	11	51
Obstetrics & Gynecology	7	0	0	7	11	51
Paediatrics	5	0	3	8	14	56
Pathology*	4	0	0	4	12	52
Psychiatry*	14	9	4	27	11	57
Surgery	32	4	3	39	14	50
Total	**144**	**20**	**40**	**204**	**15**	**52**
Midwifery* *(not included in above numbers)*	0	10	0	10	46	8
Total	**154**	**20**	**40**	**214**		

NOTE:

'*' cross-sited departments and members practice at both campuses

Source: Physician Database, 2016-06-22, Medical Administration

Table 5: LH Physician Profile

Departments	Active	Associate	Courtesy	Clinical Assistant	Locum Tenens	Supportive	Total	Average Tenure at RVHS (yrs)	Average Age (yrs)
Anesthesia	23	0	1	0	0	0	24	13	51
Diagnostic Imaging & Nuclear Medicine	16	0	4	0	0	3	23	17	54
Emergency & Critical Care	31	14	16	14	0	2	77	6	40
Family Medicine	53	1	6	0	0	49	109	19	53
Laboratory Medicine	4	0	60	0	0	0	64	4	52
Medicine	56	7	11	0	0	8	82	12	50
Obstetrics & Gynecology (includes midwives)	21	7	1	0	3	0	32	7	43
Oncology	30	4	6	0	0	0	40	9	46
Pediatrics & Neonatology	7	2	2	0	0	1	12	6	48
Psychiatry	16	0	1	0	0	0	17	16	59
Surgery	50	2	24	0	0	0	76	19	54
Total	**307**	**37**	**132**	**14**	**3**	**63**	**556**		

Source: Physician Database, 2016-07-08, Medical Administration

The Medical Administration and Medical Staff Offices provide administrative support and coordination to the Chief of Staff and Chief Executive Officers for the management of medical risk. In addition, they support the fulfillment or implementation of strategic goals and various patient care delivery initiatives by liaising with various clinical programs or services within the organization. They play a facilitative role in ensuring that the impacts of change on the credentialed professional staff are understood and considered, and ensure that medical leaders and physicians are represented in strategic initiatives and communicated with, as appropriate. Other significant functions that are supported by Medical Administration and Medical Staff Offices include:

- Fulfillment of HR-related processes for credentialed professional staff such as professional staff human resources planning, recruitment and orientation of new physicians;
- Providing administrative support and coordination to the department chiefs to ensure emergency patient coverage;
- Addressing disciplinary issues and complaint resolution;
- Supporting medical education for professional staff;
- Management of remuneration for medical staff—both leadership and non-leadership related, such as the provincial Hospital On-Call Coverage Program; and,
- Providing information to both the general public as well as to other community-based professionals about medical services that are available in the hospital.

The changes associated with the integration that will impact medical staff also need to be separately addressed. The HR Working Group will continue to work on developing a strategy for shared positions, the grandfathering of staff, and overall alignment of LH and RVHS staff resources. The Professional Staff Working Group will address matters such as privileging and credentialing, medical leadership model, the medical staff integration plan, and professional staff by-laws for LH. Different from the RVHS TSH Integration, the professional staff integration will be a gradual process as the organization is heading to a transitional state.

Medical Leadership Framework

As mentioned, there are differences in the medical leadership framework between both organizations. The new environment resulting from the LH RVHS Integration will require a leadership model that best meets the needs of the integrated organization at that time, as determined by the Board, Chief of Staff and Chief Executive Officer of LH. Further, it will need to be in compliance with medical by-laws, which will be reviewed and may be revised to support the LH RVHS Integration, as required. Note that any revised by-laws would be developed in consultation with medical leaders, and approved by the Board.

The emerging leadership framework will need to take into consideration future organizational structures and clinical programs that are in place, and factor in the location of programs and services. Further analysis focusing on the medical staff structure and compensation will be required to address the integration of the RVHS Ajax Pickering site and the transition process. It is important to ensure that resources are aligned across both sites along with key processes of privileging and credentialing. These considerations will be addressed by the Professional Staff Working Group.

HR Transition Plan

Both organizations appear to have similar cultures. Strong community affiliations currently exist across all sites. Aligning culture for the newly integrated organization will require:

- A clear vision;
- Consistent communication and messaging;
- Leadership driving and role modelling the change; and,
- Involving the workforce in establishing core values, standards of behavior, customer service principles and performance expectations.

This aligned culture should then be engrained in the workforce through a transition plan, outlined below, and incorporated in recruitment and onboarding strategies. Consideration should be given to cross-pollination of the workforce across all sites of LH as a strategy towards fostering an aligned culture.

The Organizational Development function at both organizations will play a key role in working with leadership to design and implement effective change management strategies for the workforce, in addition to providing support to the leadership to enable them to lead through change. These strategies should be established in a proactive manner and implemented expeditiously following a decision to pursue the LH RVHS Integration, and these initiatives have already started at both organizations. For both the RHVS TSH Integration and the LH RVHS Integration, there may be opportunity to allocate staff between the two organizations to optimize health human resources and support their respective talent retention plans.

A comprehensive HR Transition Plan will be developed to ensure that the integrated organizations are stable. Following the submission of the Integration Proposal, a Human Resource Transition Plan (HR Transition Plan) will be developed to guide LH in the necessary workforce integration activities, including talent management strategies, change management strategies and culture alignment. More specifically, the HR Transition Plan will include:

- A transition plan for all employee groups impacted by the integration, including the 242 employees that are currently shared across both RVHS sites;
- A review and realignment of the leadership model for the integrated organization will be undertaken;
- A talent retention plan to address workforce concerns and ensure communication throughout the transition;
- Perform a culture comparability assessment of RVHS and LH;
- Mitigation strategies to address foreseeable and unforeseeable challenges with a goal of avoiding labour and service disruptions; and to assist in the avoidance of labour disruption challenges; and,
- Change management strategies and recommendations for a transition management structure.

An overall plan that takes into account the unique staffing needs of each service area in the organization, as determined by the leadership teams for the respective areas, will be developed. Although many priorities, an immediate priority will be the development of the transition plan for the 242 staff shared across the two RVHS sites so HR implications related to these staff can be addressed prior to the transaction date. The issue of appropriate management span of control must be addressed in order to ensure adequate leadership resources, particularly at the staff level.

HR policies, procedures and practices between both organizations are largely aligned with minor differences. As part of this analysis, the following HR strategies for LH RVHS Integration would need to be put in place.

- Redeployment
- Recruitment and Retention
- Compensation and Benefits
- Learning and Development
- Wellness and Safety
- Diversity and Accessibility
- Labour Relations

A critical path will be developed to guide proper workforce planning **post-integration**, which will include the following elements:

- Implement an active change management process to ensure that the workforce of the LH RVHS Integration is able to achieve its objectives;
- Align leadership structure and ensure clear roles and responsibilities;
- Determine service/department specific workforce structures, considering individual needs of each area;
- Review and assess appropriate departmental data and information to support decision-making;
- Implement strategies for recruitment and retention;
- Designate resources to ensure adequate support to the existing workforce during transition;
- Continue union/management consultation strategy to ensure appropriate communication throughout the process;
- Continue ongoing communication plan (internal and external);
- Determine compensation philosophy and strategy for the LH RVHS Integration; and,
- Develop key performance indicators to measure success of activities related to the integration.

Investments to Support Workforce Integration

Workforce Restructuring: $2.2M

Workforce restructuring costs for staff who do not remain with Amalco, post RVHS TSH Integration, are estimated at 35% of executive and 15% of back office administrative compensation costs. Total estimated cost of workforce restructuring using this formula is $6.16M. Therefore, applying the 34.8% (LH), 65.2% (Amalco) cost allocation methodology, the portion of this cost attributable to LH is $2.2M.

Workforce Harmonization of Compensation & Benefits: $0.29M

Both RVHS and LH have largely comparable compensation and benefits structures that are competitive with benchmark hospitals within the OHA Region 3. There are, however, differences in some compensation scales for similar individual non-union positions. The estimated cost of harmonizing scales across both organizations, is estimated to be $290,000. This amount represents the cost to align salaries to the higher level across both organizations. It is not anticipated that there will be a significant cost to harmonize benefits for the LH RVHS Integration as LH and RVHS have comparable benefits plans and experience ratings. The LH RVHS Integration will establish a new compensation philosophy that will influence the direction taken post-integration.

Pay Equity: $1.4-2.0M

The development of a new compensation structure will necessitate the completion of a Pay Equity exercise in order to ensure compliance with Pay Equity legislation. In anticipation of potential future cost impacts related to Pay Equity, a cost range is estimated at $1.4M-$2M. The estimated cost required for pay equity is calculated as 0.5% of total wages.

Table 6: Workforce Harmonization and Pay Equity Cost Estimates

LH RVHS Integration	Restructuring One Time Cost ($000's)	Harmonization Ongoing Cost ($000's)	Pay Equity Potential Future Ongoing Cost ($000's)
	$ 2,200	$ 290	$1,400 - 2,000

4. Financial Implications

The Panel made recommendations on investments that are required to sustain safe, accessible and equitable health services. The LH RVHS Integration provides opportunities to build integrated systems of care that support a seamless care experience for patients. To understand the order of magnitude of investments required and financial implications to support integrating the Durham hospital sites, the Finance Working Group leveraged the financial analyses that informed the *Leading for Patients* report and conducted new analyses to reflect the current context of the integration.

Financial Snapshot

It is evident that, while both hospitals expect to reduce their long term debts, the fiscal realities of current health care funding and increasing demand for services will continue to increase pressure on existing resources.

Table 7: Current Financial Position of RVHS and LH

Financial Liquidity ($000s)	2014/15		2015/16		2016/17	
	RVHS	LH	RVHS	LH	RVHS	LH
Average Age of Equipment	12.9	18.5	14.0	18.2	11.6	13.1
Average Age of Buildings and Building Improvements	10.4	11.9	10.9	11.7	13.8	12.4
Working Funds Deficit ($000s)	$ (16,049)	$ 57,548	$ (28,112)	$ 69,946	$ (28,607)	$ (9,092)
Current Ratio	0.76	1.87	0.48	2.07	0.50	1.01
Long Term Debt as % of Total Revenue	4.6%	10.2%	1.6%	9.6%	1.6%	8.9%

Source: Finance Working Group

From the financial analyses completed in 2013 for the *Leading for Patients* report, it is evident that the LH RVHS Integration will also require a number of strategic investments to enable successful integration. Previous analyses and consultation suggests that, with the proper investments, an integrated hospital system would generate meaningful benefits, including:

- Integrated operational planning of hospital services for the Durham community;
- Potential to enhance and expand local access to regional programs and advanced clinical services;
- Combined physical and human resources, sharing capacity and expertise to deliver consistent, high quality services;
- Opportunities to generate short to mid-term operating cost savings, particularly in administration and some back office areas; and,
- A comprehensive plan for long-term facilities renewal (a facility master plan) with associated service expansion and potential for additional operating cost savings.

Financial Projections

Financial projections provided in this proposal are high-level estimates and are to be used for the purpose of understanding key financial impacts in terms of:

- **Efficiencies** – these efficiencies represent targeted and estimated savings related to the outcomes of the integration.

- **Investments Required to Support Integration** – these investments represent several upfront considerations to address the unique needs of integration activities.

Table 8 below summarizes financial projections, leveraging previous analyses to determine estimated costs of one time and ongoing expenditures required for successful integration, as well as savings.

Table 8: Summary of Financial Projections

Opportunity Category	Estimated Incremental Costs ($000's)	Estimated Annual Savings ($000's)	Estimated Incremental Annual Funding ($000's)	Estimated One-Time Investments ($000's)
Efficiencies				
1 Operating efficiencies*		$990		
2 HBAM efficiencies**		$2,700	($700)	
Investments Required to Support Integration				
3 Transformation management				($1,900)
4 IM/IT integration	($1,000)***			($13,600)
5 Transaction				($1,100)
6 Workforce restructuring				($2,200)
7 Workforce harmonization of compensation of benefits	($290)			
8 Pay Equity	($1,400 – 2,000)			
Total	($2,690-3,290)	$3,690	($700)	($18,800)
Net Financial Impact			($300) - $300	($18,800)

**Targeted cost savings from administrative functional centres (35% of executive and 15% of back office administrative compensation costs).*

*** Estimated cost savings informed by HBAM model. HBAM efficiencies are based on 2014/15 OCDM data and excludes executive restructuring or operating efficiencies.*

**** Incremental software licensing costs*

The net financial impact of the LH RVHS Integration is estimated to be between - $0.3M and $0.3M in savings. However, the Integration also requires $18.8M in one-time investments.

Efficiencies

To understand the potential efficiencies (operating and HBAM) to be realized, further detailed analysis was conducted and is described in more detail below:

1. Operating: $0.99M

Operating efficiencies is the targeted cost savings from administrative functional centres (i.e. overhead costs). Given the HBAM model does not account for savings in executive restructuring and overhead costs, a separate analysis was conducted to understand the operating efficiencies that will be realized. Using this approach, targeted savings on overhead is expected to be 35% of executive and 15% of back office administrative compensation costs resulting in **estimated annual savings of $0.99M**.

2. Health Based Allocation Methodology (HBAM): $2.7M

Given the nature of the LH RVHS Integration, it is essential that LH anticipate and plan for the impact on hospital funding, particularly relating to Health Services Funding Reform (HSFR). HSFR has two components including: 1) organizational level funding using the Health Based Allocation Model (HBAM) and 2) specific patient procedures funding based on a "price X volume" approach, referred to as Quality-Based Procedures (QBP). HBAM efficiencies

in this proposal represent the estimated cost savings and excludes executive restructuring and operating efficiencies.

HBAM Implications

To determine HBAM efficiencies, the current HBAM methodology[4] was used. Based on 2014/15 Ontario Case Distribution Methodology (OCDM) data, the two RVHS sites have varying levels of HBAM efficiency. *LH is considered efficient and RVHS Ajax Pickering (RVA) is considered inefficient under HBAM.* Several factors affect the difference in HBAM variance across the two sites:

- RVC has a lower cost per weighted case[5] compared to RVA;
- RVA has a higher average case weight than RVC reflecting a combination of better documentation and higher patient acuity at RVA; and,
- The percent of acute tertiary cases is higher at RVC relative to RVA, partially due to the cardiac program at RVC.

Based on HBAM cost variance, LH is considered efficient and RVA is considered inefficient. LH is projected to become slightly less efficient post-integration with its cost variance increasing from -0.4% to +0.6%. This +0.6% cost variances translates into **approximately $2.7M in potential cost savings** (0.6% of $475M budget).

To determine the effect of integration on HBAM incremental funding the HBAM overall variance (including unit cost efficiency, service efficiency, and population growth forecast) was considered. HBAM overall variance is expected to increase from -1.6% to -0.9% (i.e. actual expenses will be 0.9% below HBAM expected expenses). This translates into a $2.0M decrease in incremental funding for LH. Since HBAM is applied to 36% of the hospital's funding, the $2.0M translates to **$0.7M less in HBAM incremental funding**.

It is important to note that the one-time restructuring costs to be incurred as a result of the LH RVHS Integration are unique to this transaction. As such, and considering LH will be sharing this cost, a specific exception to exclude these one-time expenses for the purpose of the LH RVHS integration (e.g. a modified HBAM funding formula) is requested to ensure the most appropriate funding calculations are applied.

QBP Implications

QBP volumes will be distributed proportional to patient activity. Overall, 40% of RVHS's LHIN managed QBPs, 40% of Endoscopy and 42% of cancer QBP funded volumes are associated to LH RVHS Integration. Corresponding QBP expenses have been divided to the two sites based on departmental level allocation of expenses. The proportion of RVHS's QBP baseline expense is similar to the proportion of RVHS's QBP funding transferred to each RVHS site. The financial modelling, therefore, suggests **the integration should not have a significant net effect on QBP incremental funding.**

Future incremental funding amounts for existing LHIN-managed QBPs will be based on year-to-year changes in volumes and case mix in each respective RVHS site. Future incremental funding amounts for new QBPs will be based on the difference between the facility's actual unit cost and a funded price based on a provincial benchmark.

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[4] HBAM methodology considers the HBAM variance which is a measure of a hospital's cost and service efficiency relative to the provincial average and population growth forecast.

[5] A weighted case is a measure of patient volume, adjusted to reflect patient resource intensity. An inpatient hospital stay is considered a case. A case with a resource intensity that is similar to the provincial average translates into one weighted case.

The cost per weighted case is the MOHLTC's standard measure a hospital's operating expenses divided by the number of patients, or days, weighted to reflect patient resource intensity. The cost per weighted case (or weighted day) is specific to each the hospital settings: acute, Emergency Department, rehabilitation, complex continuing care and mental health inpatient.

The incremental funding difference for new QBPs is expected to be small as the acute unit cost for LH Integration is similar to HBAM. Refer to Appendix C for additional details.

Investments Required to Support Integration

Key investments are required to support necessary activities occurring before, during, and after the integration in order to enable the two organizations to come together and operate effectively. The major components include transformation management, information technology integration and transaction (note: workforce restructuring, workforce harmonization of compensation and benefits and pay equity details are provided in the *Section 4 – Human Resources Implications* of this report.)

To determine the investment required, the Finance Working Group leveraged the detailed analyses completed in the *Leading for Patients* report, as the complexity of the integration of LH and RVHS is believed to be *similar* in nature.

3. Transformation Management: $1.9M

Transformation will involve a review and refresh of governance and leadership structure for LH. A significant focus of the new leadership team over the first three years will be to bring together and reorganize the two organizations in order to realize the benefits of integration. The revised leadership team will, therefore, need a formal transformation management structure and resources to successfully execute on the integration, while also leading LH to achieving its strategic and operational plans and commitments to the Central East LHIN over the first three years.

A transformation management structure would essentially function as a Project Management Office, accountable to the senior leadership team, with a mandate to coordinate and support the multiple projects required for LH to function effectively. Projects will include workforce restructuring, implementation of new collective agreements with labour unions, back office services integration and Lean-driven process improvement to generate operating efficiencies. Given the importance and complexity of this work, this would be a senior level, multi-disciplinary team, with strong project management support.

Resources would augment existing staff and have subject matter expertise in:

- Change management
- Project management
- Communications
- Process improvement and redesign (LEAN)
- Labour transitioning
- Organizational development and training
- Decision support
- Financial planning and modelling.

The workload and resource intensity of this team would be heaviest in Year 1 as there are several activities that must be completed in parallel soon after the integration to allow the combined organization to function and realize some early efficiencies. Fewer resources will be needed in Years 2 and 3 as the initial critical work is completed and organizational capacity builds.

Table 9: Summary of Estimated LH RVHS Integration Transformation Management Costs (post-Nov 1, 2016)

Resource Requirements ($000's)	Year 1		Year 2		Year 3		
	FTE*	LH RVHS Integration	FTE*	LH RVHS Integration	FTE*	LH RVHS Integration	Total
Process improvement and redesign (LEAN)	1	$100	1	$100	0	$0	**$200**
Change management	1	$100	1	$100	0	$0	**$200**
Project management	1	$100	1	$100	1	$100	**$300**
Labour transitioning**	1	$100	1	$100	0	$0	**$200**
Organizational development and training	1	$80	1	$80	1	$80	**$240**
Decision support, financial planning and financial modeling	1	$80	1	$80	1	$80	**$240**
Subtotal compensation	6	**$560**	6	**$560**	4	**$260**	**$1,380**
Staff backfill for orientation/ Education/training Y1: 1,000 FTEs x 10hrs x $30/hr Y2: 1,000 FTEs x 5 hrs x $30/hr		$300		$150		$0	**$450**
Non-compensation costs (supplies, computers, telephony, etc.)		$23		$17		$10	**$50**
Communications and Engagement	TBD	$50		$25		$25	**$100**
TOTAL		**$933**		**$752**		**$295**	**$1,980**

** Full Time Equivalent*
*** Labour transitioning costs are for the resources (HR staff and legal) needed to execute the transition*

In the implementation phase, clinical transformation will be a priority and, as such, significant work will be undertaken to achieve clinical standardization. Although not included in the table above, both hospitals recognize that this will be an important investment for the success of the integration.

4. IM/IT Integration: $13.6M one-time investment and $1M incremental cost

IM/IT Integration There are immediate Information Management and Information Technology (IM/IT) investments needed to enable the LH RVHS integration. The investments required are strictly to migrate the hospital sites to one of the common systems that is already in place, with the exception of any end of life systems that may require going to market for a new system. **These investments are mission critical to ensure patient safety and minimize business risk by enabling integration and sharing of patient information between the sites. Given the magnitude and complexity IM/IT integration, as part of the Integration Planning Phase, a third-party review will be immediately sought to validate the approach and cost estimates**.

The hospitals are fortunate in that many of the systems and applications they currently use are supplied by the same vendors (approximately 50% overlap), including the core enterprise Health Information System (HIS). However, none of the systems and databases are linked nor configured the same way. Core systems that are supplied by different vendors include finance, human resources and operating room systems. In some instances, convergence to a single system or replacement to accommodate the larger organization's business needs may be required.

> Critical elements of a highly integrated system can be defined as…"interprofessional teams of providers collaborate to provide a coordinated continuum of services to individual patients, supported by information technologies that link provider and settings."

To ensure LH meets the need of an integrated hospital system (as per the Panel report) and understands the financial impact of integrating IM/IT, the Finance Working Group formed a subcommittee with hospital representatives. To develop the high-level IM/IT integration cost estimates, the subcommittee:

- Leveraged the memorandum dated December 11, 2013 entitled *Information Management & Information Technology Investments to Enable the Merger of RVHS and TSH* as a starting point to calculate the impact of integration on IM/IT costs for the three hospitals; and,
- Followed the direction of the Panel report to consolidate information systems from the three hospitals to the two hospital corporations.

The subcommittee members developed the following principles and assumptions to guide discussions and planning:

- Consider an *existing* software application/system rather than purchasing new systems, with the possible exception of a Human Resources Information System (HRIS) that is end-of-life or non-existent. However, if the existing system is end-of-life and it would be less expensive to select a new application, the preferred option would be to procure a new system;
- Harmonize the existing systems of the current three hospitals (LH, RVHS, TSH) to the two resultant hospital corporations post-integration to the greatest extent possible;
- Maintain functionality that is in place (i.e. no loss of functionality or systems at a hospital site as a result of integration);
- Assume that the RVHS Ajax Pickering site will adopt LH systems, unless LH does not have the functionality (e.g. staff scheduling or obstetrical information system);
- Biomedical equipment harmonization and integration has not been included in this analysis; and,
- Costs are high-level estimates, and as a result, an independent third party analysis is recommended to further refine these estimates.

Costs have been allocated to the same categories contained in the *Information Management & Information Technology Investments* report to enable the LH RVHS Integration.

The **five requirements for integration** are:

1. Consolidate Enterprise Hospital Information Systems (HIS)
2. Consolidate Departmental Clinical Systems
3. Consolidate Back Office Systems
4. Merge Networks and eMail Systems
5. Merge Telecommunication Systems

The categories, or requirements, defined as being foundational, enable the integrated hospitals to operate, (i.e. "must do" items). **The total investment required for the five requirements for LH is estimated to be $13.6M.** Funding commitments from the MOHLTC for IM/IT will need to be clarified due to the significant investment required for these mission critical IM/IT requirements.

Table 10 provides a summary of the one-time investments and incremental cost required for IM/IT integration. For detailed description and cost breakdown of each IM/IT requirement to support the integration, please refer to Appendix D.

Table 10: Summary of Estimated Cost by IM/IT Requirements

Requirement	Estimated Cost ($000's)
Consolidate Enterprise Clinical Information Systems (CIS)	$2,400
Consolidate Departmental Clinical Systems	$5,150
Consolidate Back Office Systems	$3,800
Merge Networks and eMail Systems	$1,000
Merge Telecommunication Systems	$1,200
One-time Investments Subtotal	**$13,550**

In the short-term to medium term, it is believed that there are no material savings associated with consolidating IM/IT systems. All IM/IT human resources will be required to consolidate and ensure system interoperability over next 12-18 months. **Incremental operating costs to support software licensing expenses are estimated to be $1.0M.**

5. Transaction Costs: $1.1M

Transaction costs includes the cost of legal, due diligence, transition planning activities, and communications and engagement activities leading up to November 1, 2016. The cost allocation methodology will be applied for due diligence (engaging an external auditor), as one auditor will be performing this function for both the LH RVHS and RVHS TSH transactions. Transition planning activities include detailed operational planning (such as face to face meetings between like programs and departments in both organizations to build relationships and understand the operations of the Ajax Pickering site) with LH and RVHS to ensure readiness for their transaction. Resources for transition planning include increased staff for LH's Strategy and Decision Support teams as well as consultant support. **The total one-time investment required is estimated to be approximately $1.1M**. Table 11 outlines expected resources requirements for the pre-integration period.

Table 11: Resource Requirements for the Pre-integration Period

Resource Requirements July-November 2016	
Legal	$335,000
Due Diligence	$83,000
Transition Planning	$150,000
Communications and Engagement	$500,000
TOTAL	**$1,100,000**

6. Workforce Restructuring: $2.2M

These are the costs required for staff who do not remain with the new organization post-integration - costs are estimated to be 35% of executive and 15% of back office administrative compensation costs. For additional information please refer to *Section 4 - Human Resource Implications*.

7. Workforce Harmonization of Compensation and Benefits: $0.29M

These are the estimated costs of harmonizing pay scales across both organizations. This amount represents the cost to align salaries to the higher level across both organizations. For additional information, please refer to *Section 4 - Human Resource Implications*.

8. Pay Equity: $1.4-2M

A Pay Equity exercise will need to be conducted in order to ensure compliance with Pay Equity legislation. This is an estimation of potential future cost impacts related to Pay Equity. For additional information, please refer to *Section 4 - Human Resource Implications*.

Cost Allocation

Preyra Consulting Group (PSG) supported the Finance Working Group to determine the estimated cost and revenue allocations (i.e. division of expenses and revenue streams of RVHS hospital sites) and determine the potential effects of integration on HBAM/QBP funding.

To determine cost allocation estimates, expenses were allocated across the two RVHS sites using an evidence based method that equitably distributed the RVHS expenses and revenues to the RVHS TSH and LH RVHS integrations[6]. That is, costs were allocated based on clinical activity for direct patient care and related costs and overhead costs were allocated based on allocation formulas determined by the Working Group (See Appendix E). Key assumptions were developed for the cost allocation approach and are that it should be:

- be based on validated and high quality data;
- be based on clinical data and recognize differences in patient acuity across the two RVHS sites;
- maintain current sites and location of services and programs;
- be based on current levels of activity;
- recognize differences in efficiency levels across the two RVHS sites; and,
- consider and compare alternate options where appropriate.

Key assumptions for expense allocation included:

- direct services are be allocated consistently with actual expenses reported at each RVHS site; and,
- overhead services are to be allocated to the RVHS sites based on weighted clinical activity or other specific measures as deemed appropriate. For example, the expenses in the human resources administration department are to be allocated to the sites proportional to the overall distribution of FTEs in direct functional centres.

This cost allocation approach suggests LH will receive 34.8% of RVHS' expenditures and 34.5% of RVHS's revenues. **Total expenses for LH will be approximately $576.9M post-integration.** Please see Appendix I for additional details on the allocation of expenses and revenue.

[6] Expenses were allocated based on clinical activity for direct patient care and related costs and overhead costs were allocated based on allocation formulas determined by the Finance Working Group. Overhead expenses were allocated using one of three methods according to the type of overhead: MIS reporting, proportional to clinical activity-based allocation of all direct expenses, or proportional to direct FTEs. Please refer to appendix X for further details.

Table 12: Summary of 2015/16 Revenues and Expenses Pre and Post Integration

	LH	RVHS**	RVA	% RVA	LH post-Integration
Expenses*	$457.3M	$344.2M	$119.6M***	34.8%	$576.9M****
Revenues	$481.6M	$341.7M	$118.0M	34.5%	$599.6M
Net Surplus/Deficit	$24.3M	-$2.5M	-$1.6M		$22.7M

Source: MIS 2015/16 data

** Expenses are net of recoveries.*[7]

*** RVHS with exclusions removed. Exclusions are expenses and revenues that are not expected to occur in future years. For example, $1M in interest on long term liabilities are excluded because RVHS has already paid off its debt and this expense will not be incurred in future years.*

****% of RVHS expenses that are RVA.*

*****Sum of LH and RVA expenses.*

Immediately following the LH RVHS Integration, referral patterns are expected to continue. However, given that program planning between Amalco and LH will take time and referral patterns may evolve, it is expected that Amalco, LH, together with the CE LHIN, will re-evaluate the appropriateness of resource allocation.

Summary

The integration of RVHS and LH is a complex process that will require initial and ongoing investments in order to realize the long term financial benefits and enable improved care for the Scarborough and Durham communities. The working groups have considered several matters raised in the *Leading for Patients* report and conducted additional analyses to develop a financial model that represents the best interests of both organizations in the integration. Key findings from the working groups are below:

- Analyses have shown that there is **no material effect on the funding formulas** (HBAM or QBP) and the resultant funding as a consequence of this integration;
- There are **minimal operating efficiencies** that will result from integration. A master plan that will result in improved capital infrastructure will create opportunities for operating efficiencies and will allow for more effective deployment of scarce capital resources;
- Amalco, LH and the CE LHIN will need to re-evaluate the **allocation of resources** to ensure the allocation of resources fits with patient flows and is adjusted if required;
- The relative split of operating costs and revenues between the two future organizations is **34.8% LH and 65.2% Amalco**;
- Allocation of assets and liabilities between Amalco and LH will be determined as part of future due diligence work; and,
- A **modified HBAM funding formula** that excludes restructuring costs for this particular integration is requested.

[7] Recoveries are dollars received by the hospital from other organizations for providing specific services, supplies or receiving cash discounts for purchased products.

5. Community Engagement and Communications Plan

The Conversation So Far: What We Know Today

Changing the local health care system to deliver more modern, integrated, and accessible services has been a topic of great importance in the Scarborough and Durham communities for many years. In 2013-14, this opportunity was pursued through a facilitated integration process mandated by the CE LHIN, which resulted in extensive planning and engagement, branded as *Leading for Patients,* which focused on exploring the merits of a possible merger between Rouge Valley Health System (RVHS) and The Scarborough Hospital (TSH). A comprehensive community engagement and communications plan was created, which allowed for input from more than 400 internal and external stakeholders. While LH did not participate in this effort, it is advantageous to recall and leverage the learnings gleaned from the experience.

Figure 1: Key Facts on 2013 Facilitated Integration Stakeholder Engagement

Internal Engagement	External Engagement
• 2 Administrative and Clinical Leadership Sessions (60 participants per session) • Patient Care Working Groups – 199 participants (68 physicians) • Back Office Working Groups – 44 participants • Surgical Programs Session – 67 participants (36 physicians) • 2 Joint Leadership Sessions – 63 participants (32 Board members, 17 Medical Advisory Committee representatives, 14 Senior Leadership Team members) • Union Leadership Session – 13 participants (8 union leaders, 1 external union liaison). • Staff Town Halls – two sessions reaching four hospital sites, videos posted online	• Facilitated Integration website (www.leadingforpatients.ca) – more than 4,700 visits and 15,400 page views • Two Telephone Town Halls – 8,380 on call Sep. 24 and 7,500 for Oct. 8 • Media relations – community newspapers, ethnic media, television and radio resulting in more than 72 stories • Media ads – reached more than two million via newspapers and radio ads to promote Telephone Town Halls • Social media on Twitter and Facebook – more than 140,000 views on Facebook • Reach out to elected officials – weekly calls to MPPs, and regional and municipal councils • Online survey – 126 responses • 22 community roundtables with more than 150 participants

As illustrated in Figure 1, this robust plan employed various tactics (i.e., the public website, *Leading for Patients*; workbooks prepared by various clinical working groups; an online survey; community roundtables; internal town hall meetings; telephone town halls; and outreach to elected officials) to ensure as many stakeholders as possible were consulted, and each had multiple opportunities to be heard. Although the proposed merger did not proceed, a number of key takeaways from the 2013-14 communications and engagement activities emerged. These included:

- **The community is open to the idea of an integration between RVHS and TSH.** Very few participants in stakeholder engagement activities expressed serious opposition to the idea of integrating as long as there was no reductions in patient services that would have a severe impact on the community.
- Stakeholders respond to specific issues that motivate them, and will **likely react to concrete plans for the future.**

- There are unique issues faced by the RVHS Ajax and Pickering site, including skepticism about the future of the site and concerns over maintaining access to services.
- There is a clear need for **sustained and ongoing engagement.** It is important to keep stakeholders engaged, as strengthening trust is essential to the success of any integration planning and can be challenging to maintain.
- Once the integration occurs, it will be important to **communicate early and often.** Communication with stakeholders should remain a two-way process; the hospitals should keep their stakeholders constantly updated on any changes that are being considered, and which changes are being made. They should also welcome feedback and suggestions from their stakeholders, reflect this feedback in public documents, and make it easy to provide this feedback.[8]

In 2015, the integration conversation broadened with the launch of the Panel by the Minister of Health and Long-Term Care Dr. Eric Hoskins. The Panel built on the *Leading for Patients* work and conducted extensive community engagement through various activities, including focus groups (service providers, advocacy groups, community leaders), surveys (patients and family members), and town hall meetings (service providers, advocacy groups, and residents/patients). In addition to community engagement activities, more than 40 stakeholder consultations were completed.

Figure 2: Key Facts on 2015 Panel Stakeholder Engagement

Stakeholder Consultations	Community Engagement
• Boards, Management, Medical Staff Leaders and Foundations of TSH and RVHS • Boards, Management and Medical Staff Leaders at LH • Regional health service provider partners from non-acute care based segments of the care continuum, including emergency services, primary care, community care and long-term/rehabilitation service providers • Leadership of Central East and Toronto Central Community Care Access Centres • Leadership of Central East, Toronto Central, and Central LHINs • Central East LHIN Board • Members of Provincial Parliament from across Scarborough and Durham; and • Scarborough and Durham municipal government leadership.	• Nine focus groups of community groups, community leaders and advocacy groups - 26 participants from Scarborough, 16 participants from Durham • In-hospital survey of patients and/or family members – 35 participants from Scarborough, 17 participants from Durham, 10 other participants (primarily Markham) • 2 town hall meetings – 80+ participants from Scarborough

The community focus groups and town hall meetings that were conducted by the Panel in the summer of 2015 were well attended and interactive. These, along with the surveys, elicited pertinent comments and observations.

Several key messages were consistently heard from stakeholders, including, but not limited to:

- Scarborough and Durham are in many ways **different communities.** Each has its own vulnerable populations, patient flows, growth patterns and care delivery pressures.

[8] Leading for Patients, Stakeholder Engagement Final Report. October 28, 2013.

- A **clear strategic direction** is required for acute program and service delivery across both regions and it must be acted upon soon to achieve the service integration necessary for excellent and equitable care.
- **Existing governance and management structures** do not optimally or comprehensively support integrated service planning and delivery.
- **Capital investment** in these regions is needed to provide equitable access to care for the residents of Scarborough and Durham.[9]

There is an opportunity to build on and apply the community engagement and communications best practices that were undertaken during the *Leading for Patients* work, as well as the recent community engagement and communications consultations done by the Panel to the LH RVHS Integration.

Our Commitment to Engagement: The Proposed Plan Ahead

In order to move the Minister's direction forward, the hospitals came together in various working groups, including a Community Engagement and Communications Working Group to develop a plan to share details of the integration with their various stakeholders and community members.

This plan, which focuses on the integration of the RVHS Ajax Pickering site with LH, has been developed by the Community Engagement and Communications Working Group, comprised of communications representatives and patient/community representatives from RVHS, TSH, and LH. The ultimate goal of this plan is to effectively communicate with the various stakeholder groups impacted by this integration, and is harmonized with the RVHS-TSH Integration Community Engagement and Communications Plan to ensure consistent messages and strategies. To reach this goal, the following objectives have been established:

- Inform/engage all stakeholders on the LH RVHS Integration activities, developments, and the desired outcomes.
- Inform and update LH and RVHS employees on the progress of the RVHS TSH Integration occurring in parallel.
- Provide timely, open, and transparent multidirectional communications to all community members and other stakeholders.
- Demonstrate the value of the LH RVHS Integration, create and/or maintain excitement, and strengthen ongoing support for the changes ahead.

Additionally, a number of guiding principles will be applied to communications and engagement leading up to the LH RVHS Integration and beyond. These include:

- Strengthening confidence and trust.
- Congruity of messaging and common language in all communications.
- Finding new ways to engage with the community and reflect their needs.
- Emphasizing patient and family choice and accessibility to promote a seamless care experience.
- Reassuring the preservation of quality.
- Recognition of previous engagement work and what still needs to be done.
- Looking beyond the individual sites with a focus on the broader health system.
- Maintaining a sustainable process and approach.

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[9] McLellan, B., Barbato, T., Campbell, J., Chung, R., Clarke, I., DiEmmanuelle, M., Ronson, J., & Whiteside, C. (2015). Report of The Scarborough/West Durham Panel. Retrieved from Ontario Ministry of Health and Long-Term Care website: http://www.health.gov.on.ca/en/news/bulletin/2015/docs/scarborough_west_durham_panel_20151218.pdf

Strategic Considerations

In developing the approach to this Community Engagement and Communications Plan, a number of strategic considerations have been identified, which are essential to ensure a successful, sustainable integration in Durham:

- ***Transparency:*** A critical success factor in strengthening trust and maintaining healthy community stakeholder relationships is transparency. There are many passionate stakeholder groups in the communities with different opinions and attitudes related to the LH RVHS Integration. Various stakeholder groups who may not have been consulted during the Panel's engagement efforts are likely to feel some anxiety, confusion, and frustration over the Panel's recommendations. Transparency in the communications will not only help to address communication gaps with these groups, but will also help to build trust and confidence with all stakeholder groups.
- ***Variation in starting point:*** It is important to acknowledge and account for the variation in baseline information and understanding in the community engagement and communications. For example, a considerable amount of engagement and consultation work has been done in the Scarborough and West Durham communities as a result of the *Leading for Patients* work. However, the East Durham communities have had little to no involvement or visibility in this work and are generally uninformed. Additionally, information regarding LH is limited in the communities in West Durham.
- ***Leveraging patient and family input:*** Each of the hospitals has developed patient and family advisory groups or councils and it will be important to continue to involve these people in ongoing engagement and communications in order to help ensure and enhance meaningful dialogue among the hospitals and the community. In addition, the hospitals have made a commitment to identify patient and family advisors who can support engagement and communications activities. As such, the plan distinctly identifies and highlights this stakeholder group as Advocates/Advisors.
- ***Stakeholder status transitions:*** As the RVHS Ajax Pickering site integrates with LH, it will be important to recognize the change in status of various internal and external stakeholders, and communicate with them appropriately. For instance, prior to the integration, staff and physicians of the RVHS Ajax Pickering site will be internal to RVHS but will be external to LH. Following the integration, they will be internal to LH but external to Amalco.
- ***Community diversity:*** Scarborough and Durham are vibrant, diverse, and growing communities and the communications should be tailored to address the specific concerns and needs of residents.
- ***Myths related to governance:*** As the Minister's decision to integrate the RVHS Ajax Pickering site with LH was different than the Panel's recommendation to create a new Durham hospital corporation, there are rumours and misinformation surrounding how the Ajax Pickering site will fit into the governance structure of LH.
- ***Experience of previous integration*** (Ajax Pickering): It will be important to take into consideration the experience that stakeholders have had with previous integrations, particularly the integration of the Ajax Pickering site with the Centenary site to form RVHS. There are still negative opinions in the community regarding this particular integration.

Building on the previous work experience and familiarity with the communities, the following potential major topics for discussion in community engagement and stakeholder consultation sessions have been identified.

Table 13: Potential Topics for Stakeholder Engagement / Consultation Sessions

Potential Topics for Stakeholder Engagement/Consultation Sessions	
Understanding the integration process and value of LH RVHS integration	Developing a common platform of understanding is foundational to any successful change journey. Resistance from some stakeholder groups may be a result of misinformation or past experiences with attempted integrations. These concerns and misconceptions need to be addressed through engagement, information, and transparency.
Services/Clinical direction setting	Internal and external stakeholders have expressed concerns regarding the perceived loss or changes in services currently offered at their hospital sites. The messages need to focus on the fact that this is not about siting of services, but about coming together to strengthen quality.
Workforce/Impact on jobs	Employees and medical staff have vocalized concerns regarding job security, job changes, and the challenges associated with integrating different work cultures. Concerns have also been raised regarding job cuts and the burden on staff and the broader community.
Medical staff	It will be important to engage with medical staff to understand their concerns and provide information regarding the review and possible revision of the medical leadership model.
Foundations/Donors	Donors to the existing Foundations have concerns about the integrity of historical donations, allocation of existing funds, and the ability to garner donor support. Strengthening trust will be critical to ensure support of the new Foundations.
Volunteers	It will be important to engage with volunteers at both RVHS and LH to understand their concerns and convey the message that their services will continue to be vital to the organizations.
Community and Patient Advisory Council	It is important to convey the strong commitment from the existing Boards of Directors that the future LH RVHS integrated organization will continue to value community and patient engagement; working with the existing community / patient advisory councils, engage the councils in refreshing terms of reference. There may be opportunity to collaborate across the two integrations (LH RVHS and RVHS TSH) and leverage best practices.
Future planning	There may be a potential opportunity to engage with stakeholders to allow them a voice in helping to shape LH post-integration.

Communications Plan

A comprehensive communications and engagement strategy will ensure there are opportunities for dialogue with stakeholder groups throughout the LH RVHS Integration process. The following plan takes into account various stakeholder groups, the purpose, channels, and timing for communications and engagement.

Purpose of Engagement

It is expected that the purpose of engagement with each stakeholder group will evolve over time as the LH RVHS Integration. However, initial emphasis will, generally, be to inform/educate and gather input/advice. In stakeholder engagement planning, it is important to consider that, unlike the 2013 and 2015 conversations, there

is now a formal direction for the LH RVHS Integration (2015 Panel report recommendations and the May 2016 letter from the Minister of Health and Long-Term Care). Therefore, 2016 conversations are starting from a clear vision for the future and, as such, the discussions and questions must both acknowledge and build from this future state. Specifically, in the Integration Planning Phase, stakeholders will be

- *informed and educated* on the parameters guiding the integration, trajectory of the integration process, and the outcomes to be achieved; and
- consultations will *gather input and advice* on how groups would like to be engaged in a number of strategically important organizational planning initiatives that will commence following the integration date, including master planning and clinical services planning, and building effective community advisory groups

Communications and engagement will progress throughout the Integration, leading towards more active involvement from various stakeholders post-Integration. Post-Integration, the emphasis will be on communicating with and engaging stakeholders, enabling them as leaders who can advocate with their communities and contribute to the success of the LH RVHS Integration.

Stakeholders

Stakeholders are individuals, communities, political entities, or organizations that have a vested interest in the outcomes of the LH RVHS Integration. They are either affected by, or can have an effect on, the integration. Anyone whose interests may be positively or negatively impacted, or who may exert influence over the project or its results is considered a stakeholder.[10]

Internal

Hospital Staff are considered to be all staff that work at RVHS and LH.

Hospital Volunteers are considered to be community members who provide volunteer services to the hospitals (e.g. Ajax Auxiliary Group, LH Volunteer Association).

Medical Staff are considered to be all physicians and staff with appointments (e.g. midwives, dentists) who work at the hospitals. This also includes advisory groups such as the RVHS Medical Staff Society and Medical Advisory Committee; and the LH Medical Staff Association and Medical Advisory Committee.

Unions encompass large proportion of staff at both RVHS and LH. At RVHS, approximately 91% of employees are unionized. At LH, approximately 82% of employees are unionized. There are five unions in place at RVHS – ONA, CUPE, OPSEU, SEIU and CEP. There are 6 Unions at LH- ONA, ONA-Allied, CUPE Clerical, and CUPE Service, OPSEU, OPSEU Pinewood and PIPSC.

Boards of Directors of RVHS, TSH, and LH have a vested interest in each organization, and also influence key decision making due to their accountabilities and responsibilities as the governors of the existing organizations.

Corporate Members of RVHS, TSH and LH have a vested interest in each organization. Specifically, legal process requires that, following Board approval, RVHS and TSH Members will approve the integrations; LH will require a members 'meeting to pass new by-laws.

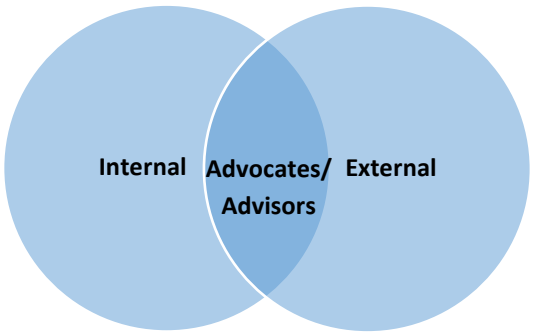
Foundation staff and their Boards of Directors work alongside the hospitals to ensure capital funding priorities are met through community donations.

[10] Shared Communication and Stakeholder Engagement Plan for Scarborough-West Durham Expert Panel. November 12, 2015.

Advocates/Advisors includes those stakeholders who are external audiences but remain very close to the hospitals and who are directly impacted by any changes that the hospitals may undergo. They provide a unique lens as end users of services. Due to their participation in internal hospital meetings and planning discussions, they are positioned here as internal stakeholders. These stakeholders include:

- Community groups aligned with the hospitals (i.e. RVHS' Community Advisory Group and Patient Advisory Committees, and LH Patient and Family Advisory Committee).
- Patient and Family Advisors are patients and family members who work with various hospital departments to provide guidance and advice for potential enhancements to care and services.

Figure 3: Advocates / Advisors



External

Patients and their families (active or past) of the hospitals.

Political stakeholders are considered to be elected officials and staff of municipal, regional, provincial, or federal government (e.g. mayors, regional councils, MPPs).

Heath System Regulatory and/or Funding Stakeholders include the Ministry of Health and Long-Term Care, Central East LHIN, other Ministries and other LHINs.

Health Service Providers include organizations and individuals that are not governed, privileged, or employed by the three hospitals, but provide services along the continuum of care to patients in the community (e.g., community care agencies, unaffiliated primary care physicians and other specialists, paramedics, Public Health, long-term care facilities, Community Care Access Centres, and Health Links). This group also includes other hospitals in the CE LHIN and neighbouring regions (e.g., GTA).

Community Members/Residents/Donors are members of the local community and/or those who donate funds to a hospital Foundation (e.g., residents/members and businesses of the local community; donors; potential hires; community organizations in Ajax or Durham, such as service clubs, religious and multicultural groups, seniors groups, etc., including the Friends of Ajax Pickering Hospital; and disease-/specialty-based groups, such as the Canadian Cancer Society, the Kidney Foundation, mental health associations, etc.).

System partners are considered to be organizations that participate with hospitals in various ways, including providing support (e.g., police, non-urgent transportation) or through contracts (e.g., vendors, tenants, shared

services organizations) and health networks (e.g., Cancer Care Ontario, Ontario Renal Network, Cardiac Care Network).

Media includes traditional media (print, television, radio, etc.) and online and social media (e.g. online news, Twitter, Facebook, etc.)

Please refer to Appendix G for more information.

Engagement Approaches and Tactics

This proposed communication strategy leverages a variety of channels to engage with both internal and external stakeholders throughout the LH RVHS integration process. The three hospitals collaborated and exchanged experiences, insights, and successful approaches and tactics for tailoring communications and engagement activities to specific audiences. Strategies include a combination of digital message delivery and receipt channels, existing meeting structures, in person forums, and print materials. For all stakeholder groups, the approach involves multiple channels. Some channels will be exclusive to internal stakeholders (e.g., Board portals, teleconferences, intranets, huddles/staff and departmental meetings), some exclusive to external stakeholders (e.g., round table discussions, providers forums, media releases), and some shared with both internal and external stakeholder groups (e.g., social media, website, FAQ documents).

Please refer to Appendix H.

Priority Engagement Tactics

A number of initial priorities have been identified by the Community Engagement and Communications Working Group.

- *Priority stakeholders* – During the pre-integration stage, messaging to staff and physicians will be paramount to maintain confidence and stability, and ensure there are no disruptions to care. Additional priority stakeholders include patients and families who are receiving care on November 1, internal panels comprised of staff who have undergone past integrations, the Mayors of Durham Region, and the Friends of Ajax Pickering Hospital.
- *How the three hospitals will work together* – The three hospitals are committed to working in parallel, jointly developing and delivering messaging and engaging with stakeholder groups. As integration progresses towards November 1, 2016, it will be important that neither RVHS nor LH are perceived as leading the messaging. In the short term, it is expected that each of the hospitals will release common messaging. As such, it is recommended that all message branding include both hospital logos. In the medium and long term, separate messaging specific to each corporation (Amalco and LH) may be released. As much as possible, this specific messaging will be between the hospitals to ensure message alignment and continuity**.**
- *Managing stakeholder expectations for November 1, 2016* – This key priority will ensure all stakeholders are aware of what precisely is changing after November 1st, and what they can expect in the months to follow. From an operational perspective, nothing is expected to change at that time. This date marks the beginning of the change in Governance. Further planning (e.g. clinical service design) will follow as integration is operationalized.

Engagement Process Sequence

In order to effectively engage with all stakeholders, manage expectations, and deliver timely feedback and reporting, a sequenced, parallel approach by stakeholder group will be necessary for the Implementation Planning

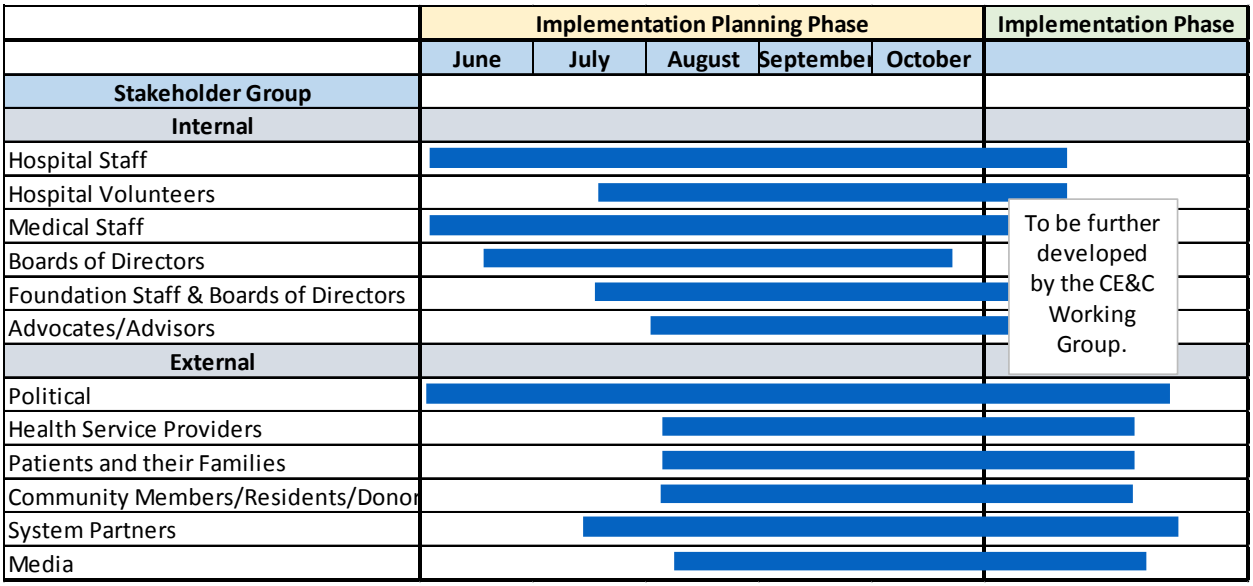
Phase. Subsequent communication efforts will cascade throughout the stakeholder groups continuously or iteratively, according to the phase of implementation and anticipated stakeholder impact. Key messaging will be delivered to internal stakeholders, followed by external stakeholders. For the purpose of this Integration Proposal, initial engagements begin with the hospitals' Boards of Directors, followed by internal stakeholders, advocates/advisors, and external stakeholders. The purpose of engagement and communication with each group will vary according to stakeholder and phase of implementation. A detailed communication and engagement plan and specific communications related to decision points and the ongoing evolution of the integration will be developed by the Working Group for the implementation phase.

It is important to note that community engagement and communications activities are occurring in parallel to the development and submission of this proposal. To date, Mr. Mark Rochon has been acting as external spokesperson. Communications activities before the submission of the proposal include:

- Internal communications from CEOs to staff – aligned between the three hospitals –through the regular release of key messages following each meeting of the RVHS TSH Integration Steering Committee and the LH RVHS Integration Steering Committee;
- Staff sessions at RVHS;
- Meeting of Mr. Mark Rochon and RVHS Medical Staff; and,
- Meetings between Mr. Mark Rochon and four MPPs (either in person or by telephone).

As community engagement and community engagement activities move ahead in the next several months, the organizations will keep the CE LHIN and MOHLTC apprised of emerging themes.

Figure 4: Communications and Engagement Timeline



The figure above illustrates the initiation of engagement and communication with each stakeholder group. Note that frequency (continuous to iterative) and purpose of engagement will vary as the LH RVHS Integration process progresses and different stakeholders are involved.

6. Risks and Mitigation Strategies

Throughout the integration planning process, discussions on the benefits of the LH RVHS Integration were balanced by the consideration of risks. The following section summarizes the key benefits and risks organized by the Guiding Principles – Collaboration and Engagement, Accessibility, Sustainability and Excellence. Included in each section is an overview of the possible risk mitigating strategies.

Collaboration and Engagement

Risks	Mitigation Strategies
Staff and physician engagement and change fatigue – Some staff and physicians at LH may be reluctant to accept the new staff from the RVHS AP while AP staff may also resist the change. For some physician groups, there may be a conflict or lack of cooperation in working together. For many staff groups, job security (related to position and seniority) is a significant concern. RVHS, in particular, has undertaken significant planning and operating changes in recent years with varied outcomes. The lack of stability in the environment will continue to challenge individuals' tolerance for more change.	**One compelling long-term vision for the future** – Continued integration discussions should be framed by one, compelling long-term vision for the future that excites and engages all stakeholders – leaders, staff, physicians, volunteers, patients, partners and community – to achieve.
Stakeholder support – the LH RVHS Integration may create dissatisfaction and confusion for stakeholders. For example, the integration may be seen as a loss to the local communities. Some community members are concerned about loss of services and others that current commitments will not be honoured. For health system partners, there may be potential impacts to their organizations. For example, community providers may need to be ready to handle more referrals in certain areas. **Recruitment and retention** – Given the transition underway and the associated uncertainty, the integration may create recruitment and retention risks.	**Physician engagement** – Physician engagement activities from 2013-14 between RVHS and TSH were extensive and beneficial with conversations moving from a "getting to know you" discussion to insightful and challenging dialogue about the future. It is important that this degree of physician engagement is refreshed and continues in a similar design in support of the LH RVHS Integration. **Physician leadership** – Identify respected leaders and involve them throughout the entire process. **Community engagement** – It is important to keep community members engaged. The trust of the community will be essential to success. Additionally, providing an opportunity for stakeholders to participate in developing the Master Program may further promote engagement. **HR Transition Plan** – As part of the next phase of planning activities, an HR Transition Plan will be developed, which will include retention and recruitment strategies during the period of transition the period leading up to the integration date and the months following.
Organizational culture and trust – Establishing a new corporate-wide culture is a significant undertaking and it may impede success if not achieved. This may be seen as a challenge if there are perceived differences in current practices and behaviours across RVHS AP and LH. Others may see this challenge rooted in the current misconception among clinical leaders at RVHS AP of the nature of the transaction and intentions of LH.	**Clear, timely and transparent communications** – The only way to maintain the trust of members of the hospital communities and to avoid fierce opposition to change is to keep lines of communication open between the hospitals and the communities and for people to see action based on that openness. It is difficult to rush change or to implement it without building a base of support first. Any integration process that tries to do so would be highly unlikely to succeed.

Risks	Mitigation Strategies
Hospital Foundations – Currently, each hospital has a separate, legal charitable Foundation that is responsible for fundraising. The Foundations will have to decide how to organize themselves to support both the RVHS TSH and LH RVHS Integrations. There is a risk that they would not be able to reorganize themselves in a manner that supports the overall interests of the future organizations.	**Planning underway** - Although the Foundations, and the organizations they serve, are currently engaged in concurrent discussions and planning to align on an appropriate model in a post-integration era, the future model is still unclear. The organizations will continue to support these discussions to ensure appropriate risk mitigation strategies are developed as required.

Accessibility

Risks	Mitigation Strategies
Inability to support increased volumes – There is a risk that the existing capacity will not be able meet the demand. Capacity concerns include staffing, beds, equipment and physical space. It should be noted that both hospitals have very high inpatient bed occupancy rates that limit opportunities for additional efficiencies to be achieved. **Access to services** – Although location of services was not in scope for this integration proposal, we know from *Leading for Patients* that many expressed related accessibility concerns. For example, many stakeholders were concerned about the possibility of patients and families having to travel further from home to receive care. For seniors and newcomers, there is concern that changes in services would have an adverse impact due to an inability to easily access services in unfamiliar locations. Serious risks were raised for mental health patients, who could experience reduced access if, for example, mental health services were consolidated at one site.	**Explore possible options to improve access to services** – As stated in the Panel report, with the support of the Ministry and the CE LHIN, planning must begin for the siting and construction of a new comprehensive acute care hospital, taking into account the full spectrum of health care required to meet the needs of residents in the region well into the future. Engaging stakeholders in a meaningful way in this process will mitigate concerns related to access. In addition, accessibility options may include partnerships with transportation providers and community agencies, a comprehensive patient and family navigation model, hospital-based transportation coordination resources and effective marketing and communications. The funding and costs of these strategies would also need to be considered.

Sustainability

Risks	Mitigation Strategies
Financial impact of the integration –There are considerable one-time investments needed to support transition and integration costs including: the need to harmonize wages, benefits and physician stipends where differences currently exist; unavoidable costs of severance for redundant positions; legal, professional fees and other costs to conduct financial and legal due diligence to effect the integration; and capital cost of harmonizing existing clinical and business systems to enable operational integration.	**Secure investments for success** – Investments for one-time transition costs and on-going operating costs would need to be pursued with the Central East LHIN and the MOHLTC to ensure long-term success.

Risks	Mitigation Strategies
Integration is time and resource intensive, and complex – The complexity and scope of an integration cannot be understated. In the first few years, the hospitals would likely not have the capacity to effectively integrate the AP site while concurrently pursuing other transformational changes, particularly operating plans and budgets that may result in significant labour and/or service changes. Experiences in Ontario and other jurisdictions clearly show that hard savings and quality improvements take years to mature and fully realize. Due to limited capacity and resources, it is unrealistic to expect an integrated organization to effectively achieve significant operating budget reductions while attempting to establish foundational pieces for the newly integrated hospital (e.g. updated governance structure, etc.).	**Achievable and transparent plan** – Having an achievable, transparent transition plan that people are involved in developing could increase engagement and reduce anxieties. It will be important to closely monitor transition progress, and analyze trends and outcomes. **Critical path for workforce planning and support** – It will be important to develop and communicate a critical path to guide proper workforce planning and to implement proactive change management processes that support health human resources. This path must include constant messaging to staff, physicians and volunteers, around key information as it becomes available, facilitated through ongoing union/management consultation as appropriate. The communication needs to reinforce that an integrated organization could offer the chance to minimize involuntary separations through increased opportunities for redeployment within a larger workforce group.
Health Human Resource issues – The integration will bring forward a number of health human resource issues including restructuring of positions, increased turnover, increased anxiety, increased strain on clinical teams, engagement of staff and physicians and limitations of collective bargaining agreements.	**Pace the change** – Design and implement a success-based change management program that allows "early adopters" and "winning ideas" to proceed, to achieve gains and build experience. Successful integrations involve planning, engagement and consideration for capacity.

Excellence

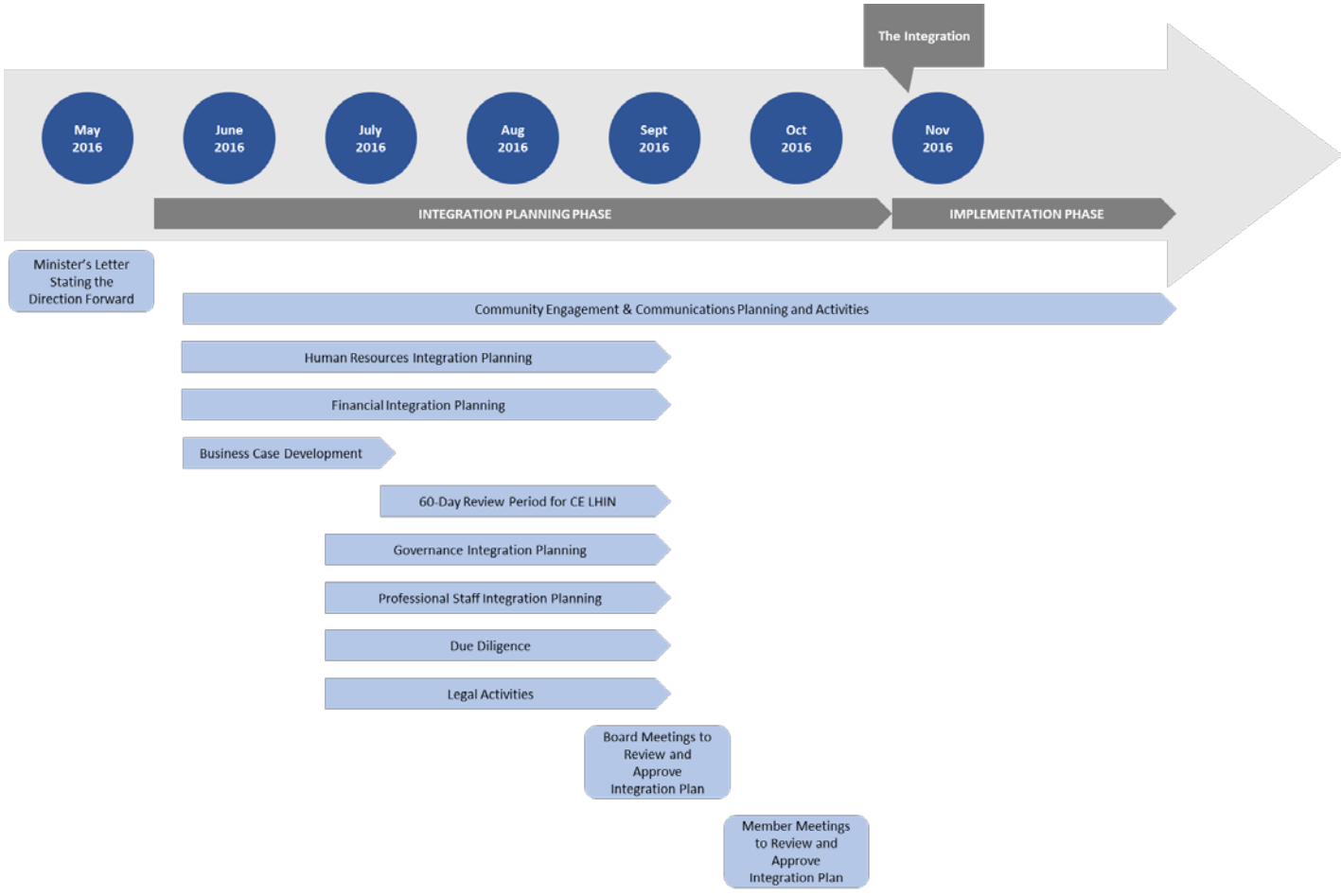
Risks	Mitigation Strategies
Achieving standardization in practice – The lack of standardization in clinical and clinician practice is a risk for the integration. In order to create alignment and integration in programs and advance the quality of patient care, the current variability in practice should be addressed and compared to leading practice standards. Achieving standardization requires significant change effort for people, processes and technology **–** and requires investments in capacity. **Knowledge and skills** – Given the opportunities being explored and the advancements being considered, there is a risk that the current knowledge and skills base will need to be strengthened. Investments would need to be made in education, training and development.	**Standardization in practices** – A comprehensive plan should be developed to implement standardized practices across the corporation. The plan should include a review of current practices, policies and protocols, and an assessment against leading, evidence-based practices. Efforts to standardize work should engage key stakeholders in the design and implementation, including education and training. .

Implementation challenges – There are risks that raising the bar on excellence may be hampered by potential business and clinical continuity issues and variability in implementation of changes across a large, multi-site organization.	**Focus on Lean principles** – Realizing efficiencies requires a focus on Lean principles, which are embedded in the operational fabric of both organizations. The Operational Improvement teams at RVHS AP and LH will be critical in leading the way and supporting the path towards optimal efficiency. **Integration performance management** – The complexity of implementation requires accountability for ongoing integration performance management. Measurement and monitoring of performance-to-plan should be regularly examined and, if required, course-corrections put in place

7. Plan Forward

The successful achievement of the Scarborough Integration by the target date of on or before November 1, 2016 requires thorough planning and preparation in the period leading up the target date as well as after. As can be seen in the diagram below, concurrently to the submittal of this Integration Proposal to the CE LHIN, the work of the Community Engagement and Communications, Human Resources, and Finance Working Groups will continue and several other work streams will be initiated. As new work is completed, the hospital Boards will transmit the results to the CE LHIN.

Figure 5: Integration Timeline



- Community Engagement and Communications Planning and Activities: this Working Group will continue to refine and implement robust Community Engagement and Communications plans which will be reviewed and approved by the ISC.
- Human Resources Integration Planning: this Working Group will continue to develop and refine a Human Resources Transition Plan for review and approval by the ISC.

- Financial Integration Planning: this Working Group will continue to refine a Financial Integration Plan, specifically in support of the Due Diligence process (see below).
- Health Systems Governance Integration Planning: a Governance Working Group will develop recommendations, related to appropriate amendments to the LH governance structure, so it appropriately recognizes the addition of the Ajax Pickering site to LH, which will include guidance on the matters below and will be submitted to the ISC for review and approval.
    - Determination of LH board size and composition
    - Process to select additional LH directors
    - Recruitment of additional LH directors
    - Recommendations on appointment of additional directors to appropriate LH committees
    - Review and adaptation of existing LH corporate by-laws.
- Professional Staff Integration Planning: Professional Staff Working Group will develop recommendations and a report on professional staff integration that will be submitted to the ISC for review and approval.
- Due Diligence: a Due Diligence Working Group will ensure the required due diligence is completed, including the financial analysis associated with the allocation of assets and liabilities. The two Boards of Directors will review for approval.
- Legal Activities: the necessary legal documents, including organizational resolutions, will be prepared and submitted to the ISC and, subsequently, to the two Boards of Directors, for review and approval.

It is important to note that the Foundations, and the organizations they serve, are currently engaged in concurrent discussions and planning to align on an appropriate model in a post-integration era. Areas of consideration include organizational structure, governance, the number of foundations as well as the allocation of assets and liabilities. As a consequence of the LH RVHS Integration, there may be costs associated with restructuring the Foundations. As planning continues, the organizations will keep the CE LHIN and MOHLTC informed as the discussion and analysis of cost implications progress.

In September, both hospital Boards will meet to review the Integration Plan for approval. Next, in October, member meetings will be held to review the Integration Plan for approval. If approved, this will signal the end of the Integration Planning Phase and the beginning of the Implementation Phase, on or before November 1, 2016.

In summary, the LH RVHS Integration outlined in this Integration Proposal signals the eagerness of both Boards of Directors in working collaboratively to ensure the Durham community has access to a stronger health care system tailored to their needs. Both hospitals are optimistic that through the integration planning outlined above, they will contribute to creating a hospital system that is positioned to succeed in improving quality and safety, enhancing access to services, and delivering patient-centered care to the residents of Durham.

8. Recommendation

RESOLVED that:

1. the Integration Proposal in the form presented to the directors is hereby approved;
2. the board chair and chief executive officer, together (the "Authorized Signatories"), are authorized and directed to sign the Integration Proposal and cause it, together with any related correspondence or documents (collectively, the "Documents") acceptable to the Authorized Signatories, to be submitted to the Central East Local Health Integration Network (the "LHIN") pursuant to s. 27 of the Local Health System Integration Act, 2006, and to the Ministry of Health and Long-Term Care (the "Ministry") pursuant to s. 4 of the Public Hospitals Act;
3. the Authorized Signatories may approve non-material amendments or variations to the Documents, as jointly agreed upon with the Authorized Signatories of the other hospital corporation, without further approval of the Board or the Integration Steering Committee, said approval to be conclusively evidenced by the signature of the Authorized Signatories on the final form of Documents; and
4. the Authorized Signatories are authorized to work with the CE LHIN and/or the Ministry to finalize appropriate financial support to cover the costs of integration, as it is the Board's expectation that the integration costs are covered.

Appendix A: HR Working Group Guiding Principles

In order to facilitate an effective and optimal workforce integration process, it is essential to articulate a set of key workforce integration principles. It is also important to focus significant efforts on organizational culture alignment and proactive change management strategies. Lakeridge Health Corporation, Rouge Valley Health System and The Scarborough Hospital believe that and have agreed to the following guiding principles to assist all Parties as the integration progresses, recognizing that this is a merger of an existing corporation with part of a dissolved corporation:

- Honour the history and embrace the future;
- Foster an open and transparent environment;
- Create and follow a clearly defined and ethical decision making framework;
- Treat employees, volunteers, and medical staff with respect and provide them with timely support through the change;
- Be guided by principles of fairness and equity and where possible provide choice to staff;
- Seek the valuable contribution of employees, volunteers and medical staff based on their experience and knowledge to benefit the integration process;
- Respect and work with labour representatives;
- Create opportunities to minimize labour disruption;
- Minimize overall staffing impacts through attrition and redeployment;
- Support staff in retraining;
- Create opportunities for existing staff where possible; and,
- Provide Leadership the support they need to lead the change.

Appendix B: HBAM Overall Variance Simulation for LH RVHS Integration

Analysis of the LH RVHS Integration indicates that expenses would go from being $6.3M lower than HBAM predicts before the integration, to $4.3M lower than HBAM predicts post-integration. The inefficiency of the RVA site impacts the LH RVHS Integration, resulting in a $0.7M reduction in HBAM incremental funding (36% of $2M).

	Acute	ER	CCC	Rehab	MH	Non Modeled	Total Hospital
LH pre-Integration							
Actual Ontario Expenses	$190.3M	$32.6M	$17.1M	$16.1M	$10.6M	$112.0M	$378.7M
HBAM Cost Variance	-0.44%	-1.93%	9.86%	-8.67%			-0.4%
Dollar Value of HBAM Efficiency/Inefficiency	-$0.84M	-$0.63M	$1.52M	-$1.53M			-$1.5M
HBAM Overall Variance	-1.5%	-4.2%	8.5%	-9.9%	0.3%	-1.1%	-1.6%
Dollar Value of HBAM Variance*	-$3.02M	-$1.46M	$1.41M	-$1.88M	$0.03M	-$1.30M	-$6.3M
LH post-Integration							
Actual Ontario Expenses	$249.4M	$47.2M	$24.4M	$21.7M	$10.6M	$126.3M	$479.7M
HBAM Cost Variance	0.13%	-1.63%	17.86%	-2.96%			0.6%
Dollar Value of HBAM Efficiency/Inefficiency*	$0.31M	-$0.77M	$3.68M	-$0.66M			$2.7M
HBAM Overall Variance	-1.1%	-4.2%	15.6%	-4.9%	0.3%	-1.3%	-0.9%
Dollar Value of HBAM Variance	-$2.88M	-$2.08M	$3.49M	-$1.17M	$0.03M	-$1.67M	-$4.3M
Net Change in HBAM Efficiency							$2.0M
Effect on HBAM Incremental Funding (Net Change in HBAM efficiency x 36%)							-$0.7M

** The dollar value is derived by multiplying the care type specific percent variance by the respective actual expenses*

Appendix C: QBP Distribution

			Based on 13/14 data	Based on 14/15 Data	Baseline Transfer to		Funding Transfer to	
	2016/17 Baseline	**2016/17 Funding**	**% Baseline to RVC**	**% Funding to RVA**	**Amalco**	**LH**	**Amalco**	**LH**
Total MOH QBPs	**$24.1M**	**$23.6M**	**59%**	**60%**	**$14.1M**	**$10.0M**	**$14.1M**	**$9.5M**
Chemotherapy	$1.4M	$1.4M	100%	100%	$1.4M	$0.0M	$1.4M	$0.0M
GI Endoscopy	$2.9M	$2.9M	60%	60%	$1.8M	$1.2M	$1.8M	$1.2M
Colorectal/Prostate Cancer Surgery	$3.2M	$2.9M	69%	69%	$2.2M	$1.0M	$2.0M	$0.9M
Breast/Thyroid Cancer Surgery	$2.4M	$2.5M	38%	46%	$0.9M	$1.5M	$1.2M	$1.4M
Total CCO QBPs	**$9.9M**	**$9.8M**	**63%**	**65%**	**$6.2M**	**$3.7M**	**$6.3M**	**$3.4M**
MOHLTC and CCO QBPs	**$34.0M**	**$33.4M**	**60%**	**61%**	**$20.4M**	**$13.6M**	**$20.4M**	**$13.0M**

Appendix D: Investment Required to in IM/IT to Support Integration

1. Consolidate Enterprise Clinical Information Systems (CIS) ($4.4M)

LH, RVHS and TSH use Meditech as their enterprise HIS, however there are three completely separate installations of this system with distinct databases and configurations. In addition, the breadth and depth of functionality deployed at the three hospitals is not the same.

The main objective for merging the Meditech systems and support operations would be to enable universal reporting and common clinical processes within the LH RVHS and RVHS TSH Integrations.

There will be costs to implement uniform Meditech functionality (modules) and clinical workflows at the hospitals. This work will involve Meditech consulting, as well as internal and external resources to configure extend modules to both sites (RVHS TSH and LH RVHS Integration). Additional financial resources will be needed for project management, mapping workflows and standardizing processes, delivering training and providing backfill to enable training attendance.

The two organizations will be required to invest in privacy auditing technology to assure compliance with the Information and Privacy Commissioner (IPC) order HO-13.

2. Consolidate Departmental Clinical Systems ($5.5M)

There are a number of other departmental clinical systems (e.g. operating room, emergency department, labor and delivery, cardiac diagnostics information systems) which will need to be integrated to enable standardized cross-site flow of key clinical information, physician and staff mobility, and operational efficiency in the delivery of care at the sites of the two hospitals. While the best way to support seamless care delivery would be to deploy common systems across all sites, the financial investment in technology and change management required to achieve this would be prohibitive. Therefore, the approach for the integrated organizations would be to deploy common systems where possible that are financially feasible, and to connect and make accessible key information from disparate departmental systems from any site. Connecting systems and data will require an investment in system interoperability and interface development.

The costs in this section do not include biomedical engineering equipment (e.g. ECG machines) that must be harmonized or introduced to capture digital images. There is a need to also do a comprehensive review of biomedical equipment as part of the integration exercise.

- Integrate specialty clinical documentation systems: $750K x 2 sites x 3 modalities (cardiology, ED, labour and delivery) = $4.5M
- Harmonize interoperability platforms and develop interfaces: RVHS - Orion Rhapsody; LH - Microsoft Biz Talk; TSH - Summit = $800K
- Merge OR Systems: $350K
- Merge PACS Systems: $450K
- Consolidate remaining clinical systems = $2.0 million
- Training = $2.0 million (conservative)

3. Consolidate Back Office Systems ($3.1M)

There is opportunity to consider consolidating back office systems. RVHS currently uses Meditech financials and SAP supply chain hosted by Plexxus. TSH uses SAP, hosted by Plexxus, for both financials and supply chain. LH uses SAP for supply chain only. Realization of operational efficiencies and cost savings in the back office areas is largely

dependent on using a common, integrated finance and supply chain system. Therefore, the Scarborough Integration could consolidate the Plexxus SAP financials platform and LH could migrate to this platform.

LH, TSH and RVHS have distinct systems with specific HRIS functionality. A comprehensive centralized HRIS could help manage the present challenge for the existing organizations by assisting with management of the human resources function to realize operating efficiencies. The cost to acquire a new HRIS is approximately $20M. While the cost to consolidate and optimize existing systems is less, the existing systems lack full functionality and reduce efficiency.

- Consolidating: LH and RHVS AP site to consolidate on SAP financials - $1.3M; RVHS Centenary to join the TSH instance as the Scarborough Integration - $600K = $1.9M
- Optimizing existing system: including attendance management, scheduling, onboarding, payroll (Meditech), eRecruiting = $5.0M
- New HRIS = $20.0M. HRIS costs have not been included in the financial projections and will be considered in the implementation phase.

4. Merge Networks and eMail Systems ($1.0M)

A minimum requirement to support seamless communication in an integrated organization is a common computer network and email system. A core network infrastructure and application components enable all physicians and staff to efficiently access any computer system from any site. The scope of work required includes: Network (core, LAN, firewalls, wireless); WAN connectivity; Active Directory; and Exchange Mail Servers.

5. Merge Telecommunication Systems ($1.6M)

Merging telecommunication systems and integrating functions across all sites will be required to enable seamless communication, voice messaging, and alarm monitoring (where possible) across all sites of the organizations resulting in potential cost efficiencies.

Consolidating telephone communications is a two stage process. The first stage to integrating functions would be to consolidate telephone communications, along with a consolidated dialing plan for the LH RVHS and RVHS TSH Integrations. This will ensure that every person with a phone extension can be accessed at any site of the LH RVHS and RVHS TSH Integrations without dialing any extra digits.

The second stage would involve consolidating the telecommunication functions from TSH/Centenary and LH/AP to two consolidated sites. Paging system upgrades to enable seamless paging across all sites and implementing common policies and procedures will also be done as part of this stage. The estimated cost of this work is $1.6M.

The financial impact to harmonize incremental licenses, switches and voicemail services to consolidate technology across all campuses and the associated internal project costs are estimated to impact operating budget by $1.0M for each organization. Harmonization is defined as introducing new functionality to the sites that currently do not have automated processes. This introduction will result in additional operating costs for application licenses at the sites that do not currently have this functionality.

Appendix E: Cost Allocation Method

RVHS Departments	*Allocation Measure Selected*	*Exceptions*
Nursing		
Inpatient Nursing excluding OR and PARR	Reported Expenses	
Operating Room & Recovery Room	Reported Expenses	
Inpatient nursing administration	Proportional to Nursing Direct activity	-Clinical Resources allocations updated as per RVHS -Medical Resources allocated based on reported expenses
Emergency Department	Reported Expenses	
Endoscopy	Reported Expenses	
Ambulatory clinics	Reported Expenses	Obstetrics, Pediatrics and Acute Psychiatry expense allocations updated as per RVHS
Day surgery pre and post	Reported Expenses	
Ambulatory care nursing administration	Reported Expenses	
Diagnostics and Therapeutics		
Laboratory	Reported Expenses	
Laboratory Admin	Reported Expenses	
Diagnostics	Reported Expenses	
Respiratory services	Reported Expenses	
Pharmacy	Reported Expenses	
Allied Health	Reported Expenses	
Pharmacy admin and drug procurement	Proportional to Clinical Pharmacy activity	
Diagnostic and Therapeutic Administration	Proportional to D&T Direct activity	-D&T Program Management allocated based on reported expenses
Administration and Support		
General Administration; Finance; Systems Support;Materiel Management; Communication; Education; Research	Proportional to Total Direct activity	
Human Resources	Proportional to Total Direct FTEs	
Reprocessing	Reported Expenses	
Laundry and Linen	Reported Expenses	
Housekeeping; Plant Administration, Plant Operation; Plant Maintenance	Reported Expenses	
Health Records; Patient Transport; Registration	Proportional to Admissions and Clinic Visits	-Registration alloated based on reported expenses -Patient Transport alloated based on reported expenses
Marketed Services	Reported Expenses	
Patient Food Services	Proportional to Patient Days	

Appendix F: Summary of Expenses and Revenues by Site 2015/16

2015/16 Summary of Expenses and Revenues by Site					
	RVHS	**RVC**	**RVA**	**Excluded**	**% RVA**
OCDM Net Expenses					
Nursing	$159.1M	$101.7M	$57.3M		36.0%
Diagnostic and Therapeutic Services	$68.2M	$46.9M	$21.3M		31.2%
Administration Services	$78.4M	$51.5M	$26.9M		34.3%
OCDM Adjustments	$1.4M	$0.9M	$0.5M		34.4%
OCDM Net Expenses Total*	**$307.1M**	**$201.2M**	**$106.0M**		**34.5%**
Expenses Not Included in OCDM					
Bad Debts	$1.4M	$0.9M	$0.5M		33.3%
Undistributed Amortization	$8.3M	$4.3M	$4.0M		48.3%
Interest on long term liabilities	$1.0M	$0.1M	$0.0M	$0.96M	10.0%
Other	$0.1M	$0.0M	$0.0M		34.5%
Total Undistributed Expenses	**$10.7M**	**$5.3M**	**$4.5M**	**$1.0M**	**45.8%**
Fund Type II (72)**	$5.1M	$3.4M	$1.7M		33.1%
Fund Type III (73)**	$2.2M	$2.2M	$0.0M		0.0%
Marketed Services**	$3.4M	$2.5M	$0.9M		25.8%
OCDM Exclusions	$16.5M	$9.9M	$6.6M		39.8%
Expenses Not Included in OCDM Total	**$38.0M**	**$23.4M**	**$13.6M**	**$1.0M**	**36.8%**
Total Expenses	**$345.1M**	**$224.5M**	**$119.6M**	**$1.0M**	**34.8%**
Revenues					
LHIN	$131.9M	$82.9M	$49.0M		37.1%
LHIN HBAM	$89.4M	$59.2M	$30.2M		33.8%
LHIN QBPs	$24.1M	$14.5M	$9.6M		40.0%
MOHLTC Base (Cardiac)	$21.4M	$21.4M	$0.0M		0.0%
MOHLTC One Time	$7.3M	$3.5M	$1.9M	$1.9M	35.1%
MOHLTC Other Enveloppe	$0.1M	$0.0M	$0.0M		28.5%
CCO	$11.7M	$9.0M	$2.5M	$0.2M	21.7%
Other MOHLTC (HOCC)	$4.8M	$2.8M	$2.0M		41.6%
Federal	$0.2M	$0.1M	$0.0M		19.4%
Paymaster	$0.5M	$1.2M	$0.1M	-$0.8M	4.1%
OHIP Professional	$12.1M	$6.4M	$5.8M		47.6%
OHIP Technical	$6.1M	$3.5M	$2.6M		42.9%
MOHLTC Revenue Total	**$309.6M**	**$204.5M**	**$103.7M**	**$1.4M**	**33.7%**
Patient Revenues	$10.5M	$5.5M	$4.9M		47.2%
Amortized Donations Equpt & Bldg	$9.5M	$3.0M	$5.2M	$1.4M	63.6%
Marketed Services	$6.3M	$3.9M	$2.5M		38.7%
Other	$2.0M	$0.1M	$0.0M	$1.8M	3.0%
Non MOHLTC Revenue Total	**$28.3M**	**$12.5M**	**$12.6M**	**$3.2M**	**50.1%**
Fund Type II	$5.1M	$3.4M	$1.7M		33.1%
Fund Type III	$3.2M	$3.2M	$0.0M		0.0%
Fund Type II and Fund Type III Total	**$8.4M**	**$6.7M**	**$1.7M**	**$0.0M**	**20.3%**
Total Revenues	**$346.2M**	**$223.7M**	**$118.0M**	**$4.6M**	**34.5%**
Surplus/Deficit net of exclusions	**$1.1M**	**-$0.9M**	**-$1.6M**	**$3.6M**	

** Expenses are net of recoveries*
***Excludes all recoveries*

Appendix G: Stakeholders

All stakeholder groups have been categorized into the table below and reflect each organization's relationship with these groups.

Stakeholder Group	Members
Internal Stakeholders	
Hospital Staff	• All Staff
Hospital Volunteers	• Ajax Auxiliary Group • LH Volunteer Association
Medical Staff	• Physicians • Privileged Staff (e.g. midwives, dentists) • RVHS Medical Staff Society, Medical Advisory Committee • LH Medical Advisory Committee, Medical Staff Association
Boards of Directors	• RVHS, TSH, LH
Corporate Members	• RVHS, LH
Foundation staff and Boards of Directors	• RVHS, LH
Unions	• RVHS: ONA, CUPE, OPSEU, SEIU and CEP • LH: ONA, ONA-Allied, CUPE Clerical, and CUPE Service, OPSEU, OPSEU Pinewood and PIPSC.
Advocates/Advisors	• RVHS Patient Advisory Committees • RVHS Community Advisory Group • LH Patient and Family Advisory Committee
External Stakeholders	
Patients and their Families	• Active or past patients of the hospitals and their families
Political	• Elected officials (including mayors, regional councils, MPPs, and associated staff)
Heath System Regulatory and/or Funding	• Ministry of Health and Long-Term Care • Central East LHIN • Other Ministries (e.g., Ministry of Labour) and other LHINs
Health Service Providers	• Community Care Agencies • Primary Care (unaffiliated) physicians and other specialists • Other hospitals (including Central East LHIN hospitals and GTA hospitals) • Paramedics • Public Health • Long-Term Care facilities • Community Care Access Centres (CCACs) • Health Links
Community Members/Residents/Donors	• Residents/members and businesses of the local communities • Donors • Potential hires

Stakeholder Group	Members
	• Community organizations in Ajax or Durham (e.g., service clubs, religious and multicultural groups, seniors groups, and disease-/specialty-based groups, such as the Canadian Cancer Society, mental health associations, etc.) • Friends of Ajax-Pickering Hospital
System Partners	• Police • Non-urgent transportation providers • Vendors (e.g., security, food, and retail) within the hospitals • Tenants within the hospitals • Shared services organizations (e.g., Booth Centennial, HIROC, Plexxus) • Academic Partners • Cancer Care Ontario, Ontario Renal Network, Cardiac Care Network
Media	• Traditional media (print, television, radio, etc.) • Online and social media (e.g. online news, Twitter, Facebook, etc.)

Appendix H: Stakeholder Engagement Tactics Table

Internal Stakeholder Channels	**Audience**
Board portals	Boards of Directors
Board meetings	Boards of Directors
Teleconferences	Boards of Directors
Verbal communications	Boards of Directors, Staff, Medical Staff, Volunteers, Foundation staff and Boards of Directors
Integration Steering Committee members	Boards of Directors
Intranet (including interactive Q&A)	Staff, Medical Staff, Volunteers, Foundation staff
Internal e-newsletters	Staff, Medical Staff, Volunteers, Foundation staff
Leadership Forum	Staff, Medical Staff
Town halls	Staff, Medical Staff, Volunteers, Foundation staff
Director's Council	Directors, Senior Medical Staff (i.e., Chiefs)
Huddles/Staff and Departmental Meetings	Staff, Medical Staff
Road shows	Staff, Medical Staff, Volunteers
External Stakeholders	**Audience**
Round table discussions	All external stakeholders, including advocate/advisor stakeholders
Central East Executive Committee	GTA Hospital and CCAC Executives
Providers Forum	Health Service Provider partners and Service providers
Existing forums/meeting structures	Health Service Providers, Community organizations (i.e. service clubs, multicultural/religious organizations)
Media releases	Media
Shared Channels (both internal and external stakeholders)	**Audience**
Social media (Facebook, Twitter, etc.)	All stakeholders
E-Newsletter	All stakeholders
Website	All stakeholders
FAQ documents	All stakeholders
Meetings	All stakeholders