Supervisor's Final Report
Regarding Brockville General Hospital

To: Minister of Health and Long-Term Care
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Date: April 26, 2018

Brockville
General Hospital

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1. Highlights

The Minister appointed me as Supervisor by Order-in Council on October 5, 2016.
Brockville General Hospital has made the following achievements in the last 18 months:

a) A $6M budget deficit in 2016/17 has been addressed to a balanced position in 2017/18.
b) A Balanced budget has been submitted for 2018/19.
c) A major capital project to consolidate the two sites has received full approvals and construction started in March 2018.
d) A new senior management team has been recruited, including a new CEO, COS and CNE.
e) A new Board has been recruited. They received orientation last October and have been conducting committee and board meetings since November.
f) New Chiefs have been appointed in Radiology, Medicine, Surgery, Pathology and Molecular Medicine, and Anaesthesia.
g) A focus on clinical risk has been instilled in the team.
h) Certain clinical services have been merged with KHSC/ SEAMO to address risk and improve service. These include laboratory and infection control. ICU, Pediatrics and Pharmacy are in progress.
i) Culture is improving. In a recent engagement survey, staff positive response to the question "Overall, how would you rate your organization as a place to work?" has risen to 66.7% in March 2018 from 54.5% in March 2017.

2. Approach to the Assignment

The approach was fundamentally divided into 4 phases:

a) Assessment

To build a solid foundation for recovery, it was critical to understand what had transpired leading up to my appointment. Interviews were conducted with all board members, the senior leadership team, medical chiefs, the Foundation executive, community leaders, local MPP and the Mayor of Brockville. I also opened the door to staff input and asked medical chiefs and managers to invite me to their department meetings.
I met the SELHIN management team to review what they had observed over the years.

b) Recruit Support Team

Based on the perspective gained from the SELHIN and the lack of leadership, I determined that most likely I would require and interim CEO and advice in IT, Finance and data analytics. I recruited that team, and it was in place in November 2016.

Jeanette Despatie, the current President and CEO of Cornwall Community Hospital assumed the Acting CEO position.
Dan Germain, the current VP/CFO of Runnymede Health Centre assumed acting CIO and acting CFO responsibilities. Dan led the assessment of IT risks and coordinated our budget planning.

c) Engagement

What was not evident externally was that there had been a breakdown in relationships between Physicians and the CEO, the Board and the CEO, Physicians and the Board and staff to management. So, engagement of all these groups was critical in order to start rebuilding a positive culture. I decided to not to continue to engage the Board following one series of committee meetings.

We maintained two functional committees; the Medical Advisory Committee (MAC) and the Community Advisory Council (CAC). The CAC allowed me to receive advice and community reaction as I proceeded. We also worked with the medical staff to re-establish the professional staff association, which was not functioning at the time of my appointment.

I established regular meetings with the MPP, Mayor of Brockville and the CEO of the SELHIN. In addition, I attended all CEO meetings in the SELHIN until our permanent CEO started.

Finally, we re-introduced staff forums, management meetings and Jeanette or I met staff as requested.

d) Recovery

We determined early on that this was not just a financial problem. We needed to address the financial challenge by also addressing management leadership, medical staff engagement, operational quality, staff engagement and culture. The team would need to advance change in these aspects of the Hospital at the same time, some of them urgently. Therefore, I decided to delay work on governance.

We began by assessing critical quality issues and developing action plans in addition to developing a recovery plan. The MAC maintained its focus and was instrumental in advising and supporting me through some interim reductions in clinical services.

3. Elements Contributing to the Problem

Our early assessment identified very fundamental problems as above. There were significant infrastructure issues in both the facility and technology, along with a lack of management tools. Management had stalled on key projects for which the Foundation had recruited donors. We needed to re-scope these projects and re-engage the Foundation and donors. These projects also were important for quality, safety and patient engagement:

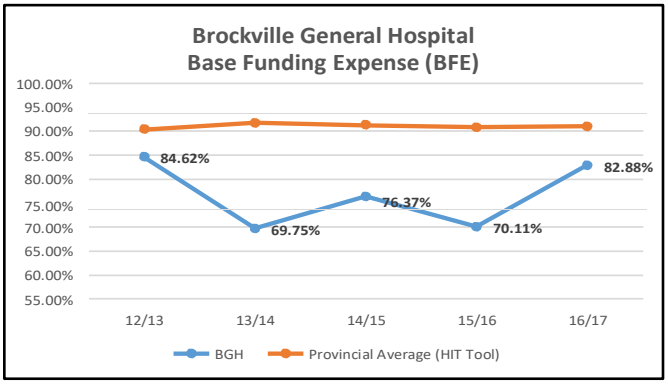
- Renovate the Emergency
- Implement drug dispensing system
- Implement cardiac monitoring in the medical/surgical units.

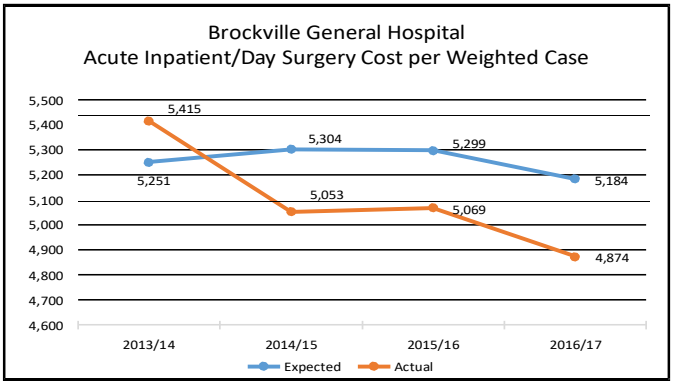
Furthermore, BGH operates several small, fragile medical services, so outreach to KGH/KHSC and QUEEN's/SEAMO was also deemed to be imperative.

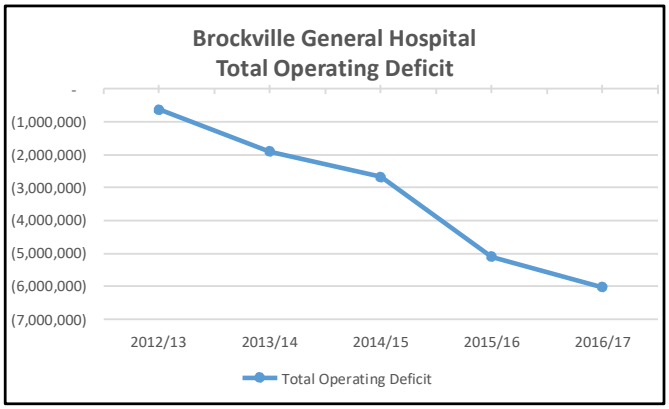
4. Financial Recovery and Assistance

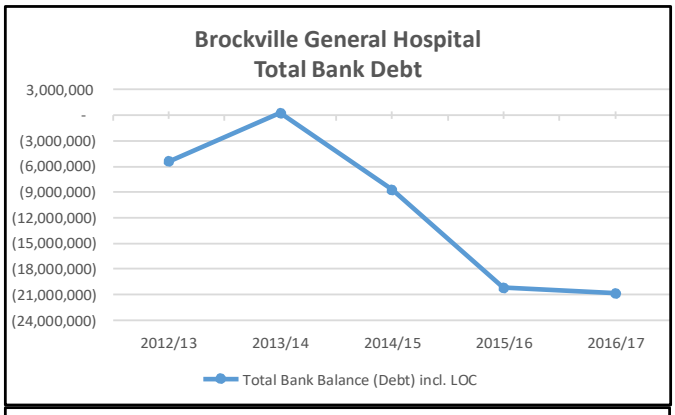
We developed a multi-stage recovery plan, with organization changes in December 2016, February 2017 and June 2017.

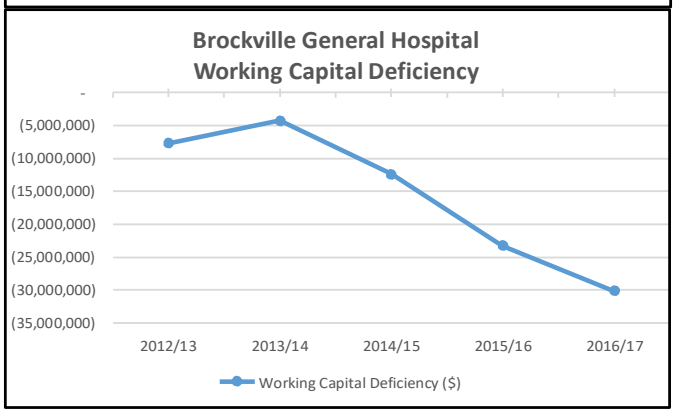
The hospital had been experiencing a significant decrease in funding, and one of the worst BFE ratios in the province. Yet, it was deemed efficient. The following charts outline that revenue was a significant problem, not cost.











These years of deficits have resulted in increasing debt load and a seriously low working capital.

5. Quality and Safety

With respect to Quality and Safety, the following were determined to be our priorities:

a) Laboratory – operated with a single pathologist;
b) Pharmacy – physical location, shortage of staff and competence;
c) ICU – poor staffing mix and Insufficient staffing. These resulted in tremendous workload, sick time and departures of many experienced staff;
d) Emergency – very poor physical set up combined with very poor staff attitude leading to the community questioning the quality so driving bye;
e) Medical/Surgical Inpatient units (1East and 2East). These units are not to today's standard, with poor space, circulation and small bathrooms. One floor does not even have suction.
f) Medicine – BGH has an ongoing challenge in maintaining medical coverage. It was an ongoing challenge to staff a full roster of Internists and Hospitalists after the hospital removed community hospitalists.
g) Significant sick time - in diagnostic imaging for example, this was affecting service.
h) Nursing core skills – lack of training and competency testing.
i) Information Technology gaps including poor clinical systems and financial systems.

We determined that these quality problems would be the focus of our recovery. We needed to engage technical, nursing and medical staff in improving quality to contribute to cost reduction.

From a medical staffing perspective, I had several meetings with The Dean of Queen's Faculty of Health Sciences, Dr. Richard Reznick and the President of Hotel Dieu, and then Kingston Health Science Centre, Dr. David Pichora and their teams. Thanks to their interest and partnership we developed the following Integrations and improvements.

a) We integrated BGH laboratory fully into KHSC with merged medical staff and management (July 4, 2017).
b) We are integrating BGH Pharmacy and drug formulary with that of Kingston.
c) We jointly developed a closed ICU with Critical Care Specialists cross-appointed, greatly increasing the quality in the ICU, and attracting staff;
d) We were working on the integration of paediatrics and medicine.

6. Recruitment of New President and CEO

It is often six months before a CEO starts. The question in renewal is whom to recruit first: the CEO or the board. The existing problems of culture, engagement and quality required early intervention. If the recovery team progressed too far down the path of addressing these issues, then a new CEO may set a different path and make further changes. It was important to create stability.

Considering the situation, I made the decision to proceed with recruiting and filing the CEO position. The process was structured to ensure the engagement of both medical staff and community leaders.

7. Governance Renewal

Before bringing in a new board, we wanted to lay a solid governance foundation based on best practice. We revamped the hospital by-laws, committee terms of reference and board policies. We started recruiting a high functioning skill-based board in late summer and made formal appointments in September. Board orientation was held over two days in October. Board and committee meetings were initiated in November, with the understanding that they were working within the authority of the Supervisor. As a result, the Board has had approximately 6 months of functioning and learning as I depart.

8. Recommendations Regarding BGH and Medium Sized Hospitals

I submit the following key learnings as recommendations to medium sized hospital boards, the LHIN's and the MOHLTC

a) BGH Specific

i. BGH must continue to make quality and patient safety improvements. The hospital will continue to be behind on capital spending given their working capital problem. BGH will need SELHIN and MOHLTC support to replace the acute care inpatient units if BGH is to deliver on high quality care ensuring accessibility at today's standards. These units compromise the provision of quality care.

b) Medium- Sized Hospital Boards
   i. All Boards should assess the quality of services, especially small ones.
   ii. Directors need to ask difficult questions about "how" strategy, budget and projects are being advanced. While boards want to stay out of operations, that does not mean they sit back. They need to ask questions and debate with management. They need to ensure they monitor progress. The goal is to help management do the best they can.

c) LHIN's
   i. The LHIN's should monitor revenue, weighted cases and BFE. Indications such as the BFE dropping precipitously at BGH are a clue that something is wrong with financial reporting.
   ii. The LHIN's should regularly review the demands placed on health service provider management teams. The CEO of BGH worked a lot on regional studies to the detriment of his visibility, decision-making and engagement.

d) MOHLTC
   i. Management capability is a challenge in small/medium size hospitals. BGH for example lacked expert leadership in Emergency, Radiology, Finance, ICU, IT, Pharmacy, and Laboratory. The lack of management expertise often results in an inability to ensure quality and risk are managed. The Government and OHA should investigate how smaller management teams can be supported to lead quality services.
   ii. Government policy announcements place additional demands on management. Smaller management teams have a challenge to work on implementation while successfully managing front-line processes at the same time. The government should investigate how smaller teams could be supported in implementing new policy.
   iii. Small services present challenges. The MOHLTC and OHA should embark in academic study of the stability of small services. Is it safe and sustainable for medium and small hospitals to operate services with small numbers of doctors? What are alternatives to manage that fragility in service?

APPENDIX A—Background

Brockville General Hospital (BGH) had experienced increasing deficits 12 years in a row. The hospital was headed toward another deficit in the year of my appointment (2016/17).

Each year the hospital developed a restructuring and recovery plan. However, these did not achieve the result of a balanced position. Over the later years there were significant decreases in management.
To drive efficient processes, the hospital implemented a management philosophy of LEAN. However, LEAN philosophy was implemented without significant training and with far too many projects, many of which were dropped.
A key factor contributing to the deficit was the decreasing MOHLTC revenues. The hospital was not able to successfully determine why MOHLTC revenue was decreasing.

These ongoing deficits led to a deteriorating debt and working capital situation. As a by-product the cultural situation also continually deteriorated.

The SELHIN had repeatedly worked with BGH to develop Performance Improvement Plans (PIP) and Recovery Plans.

Another element that impeded the ability to advance was the significant turn-over of senior management. Since 2012 the Hospital was had two CEOs and two Acting CEOs, three COS', two CNEs and three CFOs. With the last CEO departure, the Board appointed an Interim CEO and reached out to the SELHIN for assistance, which eventually led to my appointment.

APPENDIX B – Acknowledgements

It is with sincere appreciation that I acknowledge the special efforts of the following individuals who supported me in my work as Supervisor. Each of these contributed to establishing a new core for success at Brockville General Hospital:

External individuals who participated in the recovery team:

- Jeanette Despatie, President and CEO of Cornwall Community Hospital
- Dan Germain, Vice President Finance and CFO, Runnymede Hospital
- Nan Brooks and Lara DeWaal, who performed clinical data analysis and funding/ RIW analysis. They identified significant issues.
- Elaine Pitcher LLP., who worked with me on revising by-laws, policies and the first board retreat.
- The Brockville and District Hospital Foundation, especially Chair, Scott MacCrimmon.

Wayne Blackwell who stepped in as Interim CEO

The members of the Community Advisory Council. I appreciate their devotion to their hospital.

The South East LHIN leadership team, notably Paul Huras and Sherry Kennedy.

I could not have achieved the changes in Brockville, without leaders in Kingston being willing to look at the relationship differently and work to make changes that will greatly enhance BGH over time. I had many discussions about the role of BGH and opportunities to increase linkages with KHSC and Queen's. Key individuals were:

- The Dean of Queen's Faculty of Health Sciences, Dr. Richard Reznick,
- The President and CEO of Kingston Health Sciences, Dr. David Pichora,
- The Vice Dean, Queen's School of Medicine Dr. Chris Simpson.

Key medical leaders at BGH, especially; Dr. Bill Redmond, Dr. Jamie Hynd, Dr. Robert Malone, Dr. Kevin Tyler and Dr. Michael Fuoco.

Jim Cooper and David Beatty, citizens who approached me offering to participate and help recruit a new CEO and Board.

Members of the CEO search committee: Elaine Pitcher, Sarah Jane Dumbrille, Bruce Lounsberry, Jim Cooper, Dr. David Goldstein and Jeanette Despatie.

Members of the Chief of Staff Search Committee: Jim Cooper, Dr. Jamie Hynd, Dr. Bill Redmond, Dr. Michael Fuoco, Nick Vlacholias.

Brockville advisors: Steve Clarke, MPP and his Worship Mayor David Henderson

The former Board of BGH, who graciously stepped aside, yet offered input and advice whenever I reached out.

Various leaders, medical staff and front-line staff at BGH who worked with me and provided ideas and identified issues we needed to address.

Members of the Senior Team at BGH and all of the EAs who worked through changes to the team, helped me and started to run the “new” hospital.

And especially Patty Dimopoulos, EA and Board Coordinator, with out whom I could not have achieved much. Patty helped me tremendously with my orientation, support and helped to establish the new CEO, the new board, by-laws and policies.

Appendix C – Acronyms

Some key acronyms that are used throughout this report are:

BFE	Base Funding Expense
CEO	Chief Executive Officer
CNE	Chief Nursing Executive
COS	Chief of Staff
EA	Executive Assistant
HDH	Hotel Dieu Hospital (former)
ICU	Intensive Care Unit
KGH	Kingston General Hospital (former)
KHSC	Kingston Health Sciences Centre (formerly KGH and HDH)
MAC	Medical Advisory Committee
PIP	Performance Improvement Plan
SEAMO	Southeastern Ontario Academic Medical Organization
SELHIN	South East Local Health Integration Network
LEAN	Methodology-based analysis, project management and performance improvement