PROVIDENCE
Healthcare

Operating Plan

for the 2015/16 fiscal year

Approved by the Board of Directors

March 30, 2015

Operating Plan for the 2015/16 fiscal year

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Appendices

Introduction

In January 2015, Providence Healthcare approved a new strategic plan: ***BEST Together Strategic Plan, 2015-2020.*** The 2015/16 Operating Plan process began by identifying the Tactical Priorities required to successfully begin addressing the 3 strategic directions from *BEST Together* and to complete the supporting plans to this new multi-year strategic plan in the coming year. Guided by this new strategic plan and a big goal of ensuring that **the people we care for will flourish at Providence and at home**, Providence's Operating Plan for fiscal 2015/16 builds on the legacy of the previous strategic plan and includes Providence's Quality and Safety Promise and an outline of our plans for Academic and Research activity in the coming year. The 2015/16 Operating Plan represents a comprehensive overview of Providence Healthcare's priorities, resource needs, clinical activity and expected quality outcomes for the coming fiscal year.

New Vision and the Development of Providence's New Strategic Plan

Time to Shine Strategic Plan 2010-2015

Over the last decade, the work completed through three successful strategic plans has helped Providence achieve the Vision described in 2004, which was to "*…use best practices, innovative solutions, and leading-edge technology to help patients, residents and clients achieve their highest possible level of independence and dignity*". Most recently, Providence made significant breakthroughs in care through our five-year Strategic Plan *Time to Shine*, 2010-2015. Many of these accomplishments are captured in the summary of achievements presented later in this Plan.

New Vision Statement

In 2011, with our 2004 Vision in reach, Providence initiated a Vision and Mission Project to consider a new course for our future. The result was an update to our Mission and a new Vision.

Mission:

Providence Healthcare, a Catholic healthcare organization, is inspired by the legacy of the Sisters of St. Joseph of Toronto to be a welcoming community of compassion, hope and healing.
We provide rehabilitation, palliative care, long-term care and community programs.

Vision:

Providence Healthcare will extend our community of expert care beyond our walls.
We will give the people we care for the knowledge and confidence
to stay healthy and safe at home, for as long as possible.
(approved by the Catholic Health Corporation of Ontario in January 2014):

Consultations
Through the Vision and Mission project, Providence consulted with approximately 260 stakeholders over a period of more than a year (2013 - 2014). These conversations proved critical to the development of our new Strategic Plan and included numerous meetings with staff, patients, residents and their families and approximately 30 meetings with partners from Local Health Integration Networks, Community Care Access Centres, acute care hospitals and community agencies. The breadth and depth of this consultation informed not only the development of a new Vision and Mission statement, but provided grounding for a new Strategic Plan.

Providence's New Strategic Plan

Ontario's Action Plan (2015) for Health Care provides an inspiring direction: "Make Ontario the healthiest place in North America to grow up and grow old." Building on the best of what we do, Providence is committed to thinking and acting differently to fulfil the promise of our new Vision. Providence has prepared a new Strategic Plan to respond to today's needs with the same courage and capacity as our founders, the Sisters of St. Joseph of Toronto. This new Plan outlines how Providence plans to create value for the people we care for, add value to the healthcare system, and demonstrate the inherent value of our legacy over the next five years.

It is intended that the Big Goal component of the Plan will provide the bridge to guide Providence beyond 2020. We have also embedded in this new Strategic Plan the commitment to develop a robust community engagement plan. If over the next five years we are able to create a deep understanding of our community, the need for episodic consultation in preparation of developing a new strategic plan will be significantly reduced.

Big Goal:

The people we care for will flourish at Providence and at home.

Our Strategic Directions

Three overarching Strategic Directions and their related aims are required to achieve the Big Goal:

1. **BEST Care Experience: The expectations of our patients, residents, clients and their families are always exceeded.**
    - ❖ The people we care for will drive their healthcare journey; what matters to them most is what counts.
    - ❖ The people we care for will always feel safe with us and at home because of our relentless focus on quality.

What will success look like?

- Excellence in person and family centered care
- Highly reliable care
- A therapeutic relationship between clinicians and the people they care for

2. **BEST Community of Experts: Employees, physicians and volunteers are experts and integral to achieving our Vision**
    - ❖ Our staff will feel enriched and empowered to make decisions that create a better Providence.
    - ❖ Our staff will have the confidence and resources to create better care and relationships.

What will success look like?

- Knowledge Centre for learning
- Leadership development for current and emerging leaders

3. **BEST Relationships Beyond Our Walls: Sustainable partnerships support shared accountability for health outcomes and positive experiences for the people we care for.**
    - ❖ We will collaborate to develop and implement integration at the point of care, connecting providers within and across sectors.
    - ❖ Community engagement will bring value to the people Providence cares for through joint planning, decision-making and actions.

What will success look like?

- Integrated care across the continuum of providers
- End-of-Life Care Network
- Coalition of the willing to implement the Ontario Rehabilitative Care Alliance (RCA) recommendations.

The new Vision and Strategic Plan (Appendix 1) outlines how Providence plans to create value for stakeholders over the short-and long-term. In the near future, we must add value for the people we care for and protect the inherent value of our legacy. Over the longer term, we must be adding value to the healthcare system.

The People We Serve

Providence provides leadership within the healthcare system by helping people, often the most vulnerable, to access and receive the care they need in the most effective way possible.

Through **Providence Hospital**, we help adults of all ages rehabilitate after strokes, orthopaedic surgery, lower limb amputations or other complex medical conditions generally associated with aging. With the support of our partners in acute care and the community, we provide excellence in inpatient and outpatient rehab, flow and care to more than 5,000 people each year. Our Ambulatory Services and Clinics promote ongoing recovery, healthy living, and sustained well-being to people in the GTA and beyond.

In our **Palliative Care Program**, we also help people approaching the end of life by providing state-of-the-art care in a supportive environment open to admissions 365 days a year. We also offer short-term respite admissions for palliative patients who require inpatient care before returning home to familiar surroundings to spend their final days.

In our **Adult Day Program** ("ADP") for people with moderate to severe dementia, we have the capacity to care for the most vulnerable clients, around the clock. Families, as well as the general community, have access to the support and education resources in our Scotiabank Learning Centre.

Our long-term care home, the **Cardinal Ambrozic Houses of Providence** ("Houses"), is home for each of our 288 residents. With a focus on quality of life and the implementation of best practices, the Houses provide the highest standards of comfort, care and safety for our residents.

2014/15 Achievements

The past year was the final year for Providence's previous Strategic Plan ***Time to Shine***. The Strategic Directions and Aims of *Time to Shine* will essentially be fully realized by the end of the 2014/15 fiscal year. A visual summary of the completion status of *Time to Shine* appears as Appendix 2 to this Operating Plan**.** Highlights of Providence's major achievements in improving the care we provided to our patient and resident populations over the past fiscal year can be summarized as:

Related to 2014/15 Strategic Priorities

- Completing implementation of the remaining *Transformation by Design* LEAN Process changes across all rehab inpatient units ;
- Completing implementation of the remaining *Transformation by Design* process change for "My Journey Home" and "My Transition from inpatient to outpatient therapy" for Stroke/Neuro and Orthopaedic/Amputee patients;
- Implementing new TCLHIN best practices in the Stroke/Neuro & Orthopaedic/Amputee inpatient programs consistent with the TCLHIN Stroke/Msk Business Case funding;
- Redesigning patient flow in the Stroke/Neuro, Orthopaedic/Amputee and Falls Prevention clinics as part of the Ambulatory Care Flow project;
- Evaluating the implementation of a new model to maximize rehabilitation events and rehab moments on all inpatient rehab units;
- Implementing a standardized discharge process on all rehab units;
- Beginning physical remodeling of the inpatient palliative space on D3;
- Evaluating implementation of Continence Care and Pain Management quality initiatives across all resident care units in the Houses;
- Identifying and implementing targeted initiatives to improve resident outcomes in the Houses related to:
    - harmful falls,
    - unexplained weight loss, and
    - pain management.
- Implementing Phase 2 of the Leadership Development Institute Program;
- Evaluating implementation of the Diversity Plan; and
- Finalizing the Strategic Plan *BEST Together,* 2015-2020

Other Achievements

- Continuing as an active partner in two Health Link Networks in the Toronto Central LHIN ("TCLHIN") and partnering with one Health Link in the Central LHIN;
- With the support of the TCLHIN, reclassifying 47 CCC beds as Rehabilitation beds effective July 1, 2014;
- Providing leadership and content to the Rehabilitative Care Alliance's mandate and interim releases (Definitions and a toolkit for Bed Reclassification);
- Opening a Tim Horton's near the main entrance of the hospital to provide staff, volunteers and visitors with access to fresh food 7 days a week;
- Publishing articles in clinical/trade journals, advertorial supplement in the Toronto Star , various articles and features in mainstream print and broadcast media;
- Significantly higher uptake with our social media presence resulting in 300% growth in online followers and activity;
- Continuing with pension plan merger discussions with St. Michael's Hospital, St. Joseph's Health Centre and the Healthcare of Ontario Pension Plan;
- Recognition as the "gold standard" in discharge planning in the TCLHIN;

- Winning the 2014 Quality Healthcare Workplace Award – Gold Level from the Ontario Hospital Association and the Ministry of Health and Long-Term Care for the second consecutive year; and
- Agreeing to be the subject of a Case Study for the Ivey Business School's MBA, HBA and Executive programs (University of Western Ontario) in relation to our *Transformation by Design* project.

Changes in the External Environment

The slowly recovering global economy, an ageing demographic, and the likelihood of reduced federal transfer payments is continuing to put pressure on Ontario to moderate spending in many areas, including health care. Providence is anticipating that there will be little or no growth in the funding available at the provincial level in fiscal 2015/16 for inpatient based hospital programs. Modest investments in outpatient and community/home based health care will be the principle focus of any increased funding by the provincial government.

Ontario's Action Plan

As noted in Providence's last three Operating Plans, in January 2012, the Ontario Government released *A Policy Blueprint: Ontario's Action Plan for Health Care* which focused on improving access and quality of care in the community. The initial focus was the transition, over a three year period, of hospital funding to increasingly move towards a patient-centered funding model (Appendix 3), where the dollars will follow the patient.

In February 2015, the Minister of Health and Long-Term Care announced "Patients First", the next phase in the transformation of the health care system in Ontario. The principles of "Patients First" are to:

- Support Ontarians to make healthier choices and help prevent disease and illness;
- Engage Ontarians on health care, so we fully understand their needs and concerns;
- Focus on people, not just their illness;
- Provide care that is coordinated and integrated, so patients can get the right care from the right providers;
- Help patients understand how the system works, so they can find the right care they need when and where they need it;
- Make decisions that are informed by patients, so they play a major role in affecting system change; and

- Be more transparent in health care, so Ontarians can make informed choices.

The Government's objective in this next phase of the Action Plan is to put people first by improving their health care experience and their health outcomes. The objectives are to:

- Improve **access** by providing faster access to the right care;
- **Connect** services by delivering better coordinated and integrated care in the community, closer to home;
- **Support** people and patients by providing them with the education, information and transparency they need to make the right decisions about their health; and
- **Protect** universal public health care by making decisions based on value and quality, to sustain the system for generations to come.

In support of the "**Connect**" objective, on February 9, the MOHLTC announced an Expression of Interest process that Health Care Providers are invited to participate in over the next 3 fiscal years to test integrated funding models.

Health System Funding Reform (HSFR) is critical to Providence's ongoing success financially and was a key element of the first phase of the government's action plan launched in March 2012 to accelerate the move to patient-based payments. The two main components of HSFR (Appendix 3) are:

- Quality Based Procedures ("QBPs"), in which specific procedures are identified and a price is set, taking into account an expected outcome; and
- The Health Based Allocation Model ("HBAM"), under development since early 2006, as an allocation model and management tool that uses demographic, clinical and financial information to estimate expected volumes and costs at an organization level; this identifies an organization's expected share of overall hospital sector funding.

HSFR is entering its fourth year with the expectation that, in the coming year or two, 70% of the provincial funding support for hospitals will be tied to the result of an "expected cost" times an "assigned or expected volume" of patients formula. As a corollary of the QBP component of HSFR, clinical handbooks, setting out expected care pathways, have been published for an increasing number of clinical conditions. To date, only the handbooks for primary hip and knee replacements have significantly impacted the rehabilitation sector. It is expected that the funding for strokes and hip fractures will be transferred from the HBAM to QBP component of hospital funding supported by new clinical handbook guidelines for the post-acute care component of these diagnoses, effective on April 1, 2015. HSFR is also a driver for funding changes in the Long-Term Care sector and is expected to eventually extend to community programs such as ADP.

Provincial and TCLHIN Initiatives in support of Ontario's Action Plan continued during the 2014/15 fiscal year with the aim of accelerating the implementation of strategies that will improve geriatric, stroke, orthopaedic and palliative care. These initiatives can be summarized as:

- In the 3rd quarter of the last two fiscal years the Ministry of Health and Long-Term Care ("MOHLTC") through the LHINs, has announced one time funding to support the Assessment and Restoration of the functional independence of seniors ("Assess & Restore").

- In the spring of 2013, the former provincial Rehab/CCC Expert Panel was reconstituted as the Rehabilitative Care Alliance ("Alliance"). The Alliance reports to the 14 LHIN CEOs and is charged with developing a cross-continuum rehabilitative care approach including best practice guidelines for the frail senior and medically complex patient population. In December 2014, the Alliance released new definitions for Rehabilitative Care in designated rehabilitation beds and the Planning Considerations for the Reclassification of Rehab/CCC Beds including Providence's reclassification experience. A two year extension to the Alliance's initial 2 year mandate has just been announced.

- In the spring of 2014, the TCLHIN created the TCLHIN Palliative Care Council and released the TCLHIN Palliative Care strategy. This work will inform and guide our Palliative Care program.

- The TCLHIN continued to support the adoption of best practices related to TJR (total hip and knee joint replacement), Hip Fractures and Strokes by proceeding with the implementation of the TCLHIN Stroke/Msk business case. The premise of the business case to the Toronto acute care hospitals was the transfer of funding to the rehabilitation sector to accelerate the implementation of the TCLHIN Stroke/Msk best practices in support of reduced acute care ALOS and acute ALC days. This funding transfer occurred effective April 1, 2014. There is some concern that the HBAM and QBP funding formulas will accidently reallocate a significant portion of these funds across the province in 2015/16 unless additional funding alignment strategies are adopted by the MOHLTC.

- The **Ontario Seniors' Strategy** was announced in January 2013, and confirmed Ontario's commitment to ensuring that seniors have better access to home care and community supports so they can live independently and in their homes longer.

- In December 2014, provincial Mandate Letters from Premier Wynne to her Ministers outlining their priorities for the year ahead were released for the first time.

Providence's short and long term alignment with these provincial and local initiatives is evident through both the new Strategic Plan and Providence's "Tactical Priorities" for the coming year. Providence's tactical focus and the resulting Tactical Priorities for the coming fiscal year are summarized in the following sections of this Plan.

Tactical Priorities for the 2015/16 Fiscal Year

Providence's Tactical Focus

Providence's 2015/16 Tactical Priorities and Operating Plan preparation are guided by Providence's new strategic plan *BEST Together* and a continued focus on:

- achieving value and cost savings for the system (better outcomes, better cost);
- reducing pressures on General Internal Medicine services, Emergency departments, and ALC beds in acute care by increasing the flow of patients through Providence's in and outpatient programs;
- implementation of TCLHIN 'best practices' for both inpatient and outpatient care of stroke, TJR and hip fractures to achieve 'better value for money';
- closely tracking the processes and outcomes related to the adoption of QBPs. It is expected that Stroke and Hip Fractures will be incorporated in the QBP rollout to Rehab hospitals in the coming fiscal year;
- driving standards for new innovation and change through the Rehabilitation Care Alliance, Health Links and the TCLHIN ;
- ensuring consistent admission/discharge criteria (especially for TJR and stroke);
- enabling earlier onset of rehab assessment and treatment for all patient populations;
- implementing new care delivery models focused on enhancing the intensity of rehabilitation services for complex patients in hospital settings;
- adopting best practice guidelines supported by appropriate accountability mechanisms to ensure their uptake; and
- setting a high standard for the care of people with advanced dementia through a nationally acclaimed Adult Day Program and the more intensive Enhanced Adult Day Program ("eADP"). This makes it possible for the ADP to care for underserved older clients with higher acuity levels.

Providence's Tactical Priorities

Fiscal 2015/16 marks the first year under the new Strategic Plan**.** Immediately following the adoption of *BEST Together* in January 2015, Providence initiated a process to identify its Tactical Priorities for 2015/16. With the development of a new strategic plan for the next 5 years, a major focus of the tactical planning process has been to create the capacity within the management team to focus on the development of the key supporting components of the new strategic plan for 2015 and beyond. These supporting plans are: Quality, People, Information Management, Physical Space, and Financial Health.

Aside from creating these foundational supporting plans to *BEST Together*, the Tactical Priorities (Appendix 4) for the coming year can be summarized under each Strategic Direction as:

1. **BEST Care Experience: The expectations of our patients, residents, clients and their families are always exceeded.**

   - *design, implement and evaluate change ideas to improve the nighttime experience on one hospital unit and develop a plan to spread initiatives across all hospital units and scope the feasibility of spreading across the Cardinal Ambrozic Houses of Providence and Adult Day Program;*
   - *use a recognized tool to establish our current 'patient experience' baseline for our hospital patients and develop a multi-year plan to address any gaps for implementation in the remaining years of this plan;.*
   - *develop a multi-year harm reduction plan based on the principles of a High Reliability Organization;*
   - *implement two palliative best practices as per the Canadian Hospice Palliative Care Association on the hospital's Palliative Care unit and in the Houses of Providence; and*
   - *complete, on time (December 2015) and on a budget of $1,250,000, Phase III of the Palliative Revitalization Project.*

2. **BEST Community of Experts: Employees, physicians and volunteers are experts and integral to achieving our Vision**

   - *begin implementation of Phase III of the Leadership Development Institute program (Business Essentials and Strategic Thinking);*
   - *develop the functional and space plans for a new $2.5 million Knowledge Centre; and*
   - *develop criteria for the allocation of annual scholarship funds totaling $100,000.*

3. **BEST Relationships Beyond Our Walls: Sustainable partnerships support shared accountability for health outcomes and positive experiences for the people we care for.**

   - *identify and initiate an Patient Flow Integration Project together with other health service providers for one patient population using clinical and patient reported outcome measures to assess our success;*

- ❖ *evaluate our current standardized discharge package process, and scope Patient Orientated Discharge Summaries to make the discharge package as user-friendly as possible;*

- ❖ *work with community partners to implement a pathway for admissions from the community to our inpatient rehabilitation programs as well as safe reintegration back to the community post rehabilitation; and*

- ❖ *develop a Community Engagement Plan to guide our conversations with stakeholders and partners, bringing value to individuals and the health care system.*

Providence's Operating Plan Response

Operating Plan Highlights

Providence's clinical activities, Quality Improvement Plans and resource (operating and capital) budgets for fiscal 2015/16 reflect the tactical and provincial health system priorities described above. In particular, in this Operating Plan Providence has:

- prepared for the uncertainty associated with a significant funding transition from HBAM to QBP funding for inpatient stroke and hip fracture patients effective April 1, 2015. Following this transition, approximately 25% of Providence's TCLHIN/MOHLTC funding could be under the QBP formula. At the time (February 2015) of preparation of this Operating Plan, neither the QBP rates nor QBP volumes for stroke/hip fractures had been determined by the MOHLTC. This creates considerable uncertainty concerning the expected TCLHIN/MOHLTC funding for the hospital in the coming year. Providence's mantra has been "earn our funding" since the introduction of HSFR in 2012. This has been achieved in fiscal 2014/15 under the HBAM funding formula, however, in the absence of key QBP funding formula information for fiscal 2015/16, Providence has prepared this Operating Plan based on realistic scenarios of what clinical activity will be required to "earn our funding" in the coming year ;
- provided for the continuation of the physical remodelling and relocation of the 35 bed Palliative Care program to the D Wing of the Hospital with the support of the Providence Healthcare Foundation;
- planned for the completion of the Outpatient Flow Project and installation of a new Outpatient scheduling system and space reorganization to realize significant process efficiencies in the outpatient clinics supporting the Stroke/Neuro, Orthopaedic/Amputee and Geriatric/ Medical Rehab programs at Providence;
- ensured the leadership level of the organization has the capacity to complete the supporting plans to *BEST Together* and to successfully plan for exceeding patient and resident expectations in an era of funding restraint;
- focused on leveraging the funded best practice system improvements to the Stroke and Musculoskeletal (Orthopaedic) programs (6 day a week therapy, 7 day a week

admissions, benchmark ALOS, direct admissions from acute care to outpatient rehab, etc.) in conjunction with Providence's partner organizations to the benefit of the GTA health system;

- continued a $150,000 investment in a community service support budget to facilitate the discharge of patients home to continue their rehabilitation through outpatient rehabilitation programs or to wait for LTC acceptance; and
- added a new dimension to the quality improvement focus for the Houses with the introduction of the Long-Term Care Quality Improvement Plan.

Required Investments

Management believes that the majority of the Tactical Priorities identified for fiscal 2015/16 can be achieved through existing departmental resources and multi-year capital plans. Senior Management has however determined that the following initiatives will require a strategic reallocation of $500,000 in resources in order to be successfully implemented:

- a $90,000 ongoing budget increase to support the recruitment of 1 additional clinical dietician (currently 4.6 FTEs) across the 7 inpatient Hospital units. The increasing clinical complexity on the Orthopaedic/Amputee units and the initiation of weekend admissions in 2014/15 has exceeded the capacity of the current clinical dietician complement to satisfactorily respond to the needs of our patients.
- a $150,000 investment in the Quality/Risk portfolio to provide for an ongoing increase of 1 FTE in the number of quality improvement specialists (currently 2 FTEs) and to insource quality support for the Houses and support the increased demands of the Houses QIP and the Quality Support Plan to *BEST Together*; and
- a $105,000 investment in PT/OT resources to increase the capacity of the Stroke/Neuro outpatient clinic to meet the demand from a planned increase in Stroke/Neuro inpatient discharges in the coming year; and
- A $100,000 ongoing investment in 1 FTE OT/PT in response to the need for increasing weekend assessments/therapy and vacation relief in the Geriatric/Medical Rehab program.
- $55,000 to support an integration initiative in 2015/16 in support of developing sustainable "Best Relationships beyond our Walls".

Quality and Safety Promise

At Providence, our Quality and Safety Promise to our patients, residents, clients and families is to meet their needs and exceed their expectations. There are several aspects of this Promise which incorporate the five dimensions of quality care:

Safe – "Don't hurt me"
Effective – "Heal me"
Accessible – "Be there when I need you"
Patient-Centered – "Be kind and listen to me"
Integrated – "Help me through this complex system"

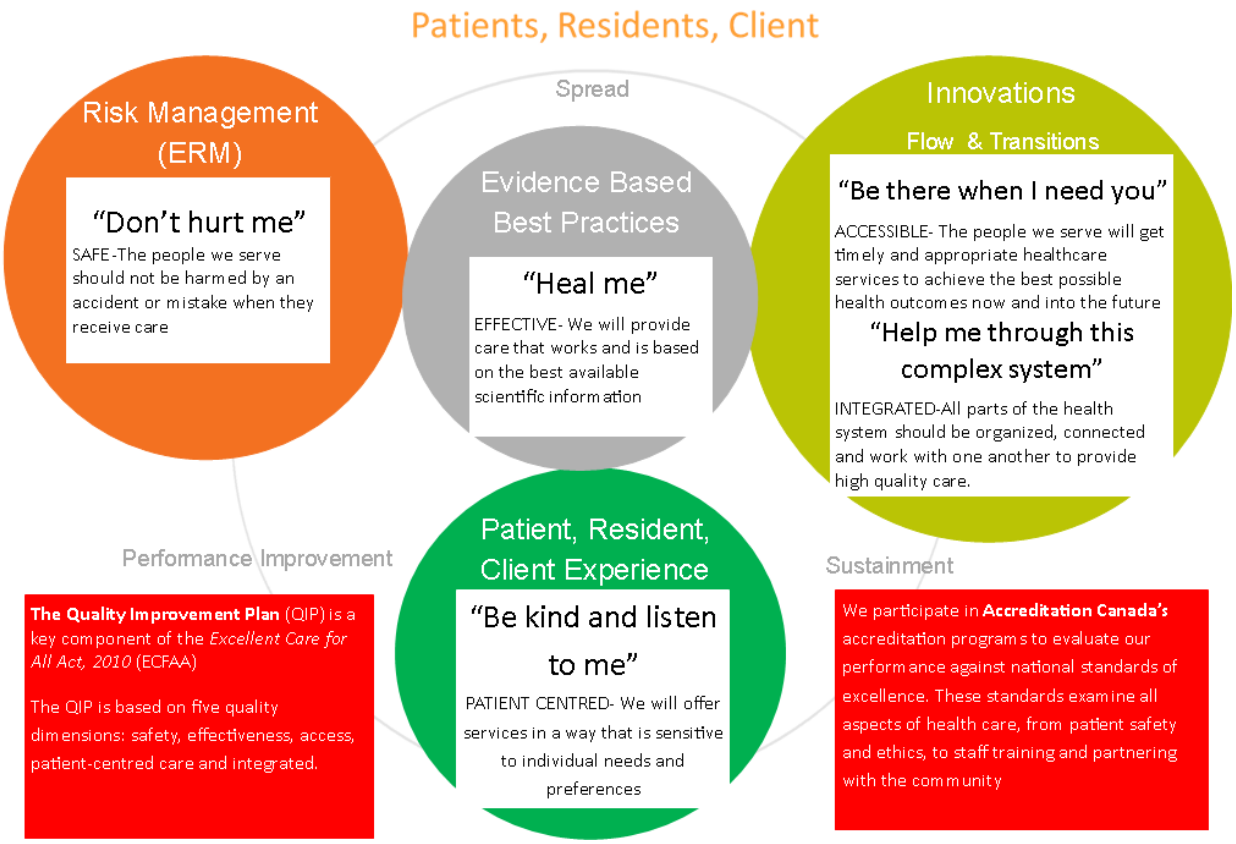
Our Quality and Safety Promise Framework

Our Quality and Safety Promise Framework (depicted on the following page) highlights the various priority areas in each of the dimensions of quality care. We developed this framework to demonstrate how the many quality and safety activities occurring within Providence are connected and supportive of each other. With Board support for this framework, four years ago we completed a core component of the Quality and Safety Promise: our first Quality Improvement Plan (QIP). The requirements of the QIP were defined by legislation and regulations of The Excellent Care For All Act. This Plan has become the focus of our public reporting requirements through to the present. We have continued to refine our processes, evaluate our performance and continually seek out areas of improvement that will improve the care we provide. As of Q3 in fiscal 2014/15, three of the five 2014/15 QIP indicators are solidly "in the green" and we will continue to implement initiatives to meet our targets and sustain our current performance.

The 2015/16 QIP is built on prior years' QIPs and Providence's Balanced Scorecard and identified areas of improvement based on alignment with our strategic plan and areas of self-identified clinical importance. In addition to the areas targeted in the 2015/16 QIP, Providence will continue to improve quality outcomes in many non-QIP areas. These will be brought forward to the Board through Balanced Scorecard reports and through our Enterprise-wide Risk Management program. Each of these reports is first presented to the Board's Safety & Quality Committee.

New Quality Supporting Plan

We will be developing a Quality Supporting Plan to support the new Strategic Plan over the next few months with a report to the Board meeting in October of 2015. We will review and refresh the current Quality and Safety Promise Framework to ensure that it aligns with our new Strategic Plan, provincial priorities and other quality improvement planning processes.



Quality Improvement Plan 2015/2016

The QIP 2015/16 Guidance Document for Ontario's Health Care Organizations outlines a set of priority QIP indicators for each sector. Organizations are expected to review the priority indicators for their sector and determine which are relevant for their organization. Providence has reviewed these indicators and selected several of these as areas for improvement. The remaining indicators either don't apply to us or our Q3 YTD performance already meets or exceeds our target. The remaining priority indicators will be monitored for sustainment.

HOSPITAL

The Quality Improvement Plan 2015/16 format has not changed from last year. It continues to reflect two parts: A narrative with sign-offs (Appendix 5a) and the Improvement Targets and Initiatives spreadsheet (Appendix 5b).

HOUSES OF PROVIDENCE

New for 2015/16 is a requirement for Long Term Care Homes to develop and submit a QIP. The QIP 2015/16 format is identical to the Hospital's QIP except that a section on

Performance Based Compensation and Health System Funding Reform (HSFR) is not required in the narrative (Appendix 6a). The format for the Improvement Targets and Initiatives spreadsheet remains the same (Appendix 6b).

Both QIPs 2015/16 for the Hospital and Houses will be submitted to Health Quality Ontario on April 1, 2015. These measures will be reported on the updated Providence Balanced Scorecard.

Annual Quality and Safety Promise Review

The annual review of the Quality and Safety Promise will include development, review and approval of the organizational Quality Improvement Plan for the fiscal year. Accountability will be to the Board of Directors through the V.P., Chief Medical Officer and Chief of Staff, with program leadership provided by the Director, Quality and Process Improvement.

Research and Academics

As a Community Affiliate of the University of Toronto, Providence provides an attractive community teaching site for medical students, interns, residents, nursing students as well as students in allied professions. In addition, we have increased the number of administrative interns that we supervise from the Institute of Health Policy Management and Evaluation, and in 2014/15, from the School of Health Administration at Dalhousie University. Providence has opened its doors to a total of approximately 700 students from local and international colleges and universities who received training at Providence in 2014/15. Two of our senior managers (Dr. Nord and Maggie Bruneau) sit on academic committees within the Faculty of Medicine, representing Providence and maintaining contact with the educational activities occurring on campus. We also provide a rich learning experience for several Colleges that provide nursing curricula. In the coming year, we will be focusing on developing teaching for Geriatrics and Physiatrists.

Many of our physicians and two of our senior leaders, have academic standing, including Assistant Professorships and Adjunct Lecturer status. Most of our clinical leaders in the organization have advanced academic standing, with multiple degrees in their field. Through these academic leaders, Providence provides thousands of hours of teaching every year.

In 2014/15, Providence continued to make a significant commitment to research. In the past, we attempted to respond to research proposals in an ad hoc manner, without structure or dedicated resources. Providence has now developed and implemented a research database that provides a streamlined way to track studies as they progress. In addition, two part time staff members were hired to provide ongoing support for our Research Committee and our Research Ethics Board. Each committee now has a standardized approach to developing and approving each proposal and this process is

available to all staff through our intranet. Now our process is efficient and transparent, with excellent study design and ethics review. During the past year, the REB approved 3 new study protocols, 4 final reports and 6 annual renewals.

Funding for internally-developed research activities is being provided through a $200,000 restricted grant from the Foundation. In the future we will be seeking further grant support from the Foundation as well as external agencies. Research deliverables provide enhancements to our brand and will further enhance Providence's reputation as a leader in the MOHLTC's strategic priority areas. Research in clinical areas will be focused on improving clinical outcomes and reducing ALOS within our rehab beds, with concomitant positive fiscal benefits under HSFR. All studies are evaluated to the degree that they support our strategic priorities. Furthermore, research activities tend to enhance recruitment and retention.

Activity Levels and Performance Measures

A great deal of thought and planning has gone into establishing the planned service and activity levels for each of Providence's operating divisions (Hospital, Houses and ADP) for the coming fiscal year, with a special focus on the three outpatient rehabilitation clinics and their operation following last year's reorganization of the management of these clinics and the recommendations of the Outpatient Flow Project. Appendix 7a summarizes Providence's planned activity levels by hospital Inpatient program for the 2015/16 fiscal year. Appendix 7b summarizes the planned Outpatient activity levels including the Adult Day Program. Appendix 7c presents the activity levels for the Houses.

Inpatient

Under its previous Strategic Plan, *Time to Shine*, which was completed in the 2014/15 fiscal year, Providence transformed its inpatient focus to one of providing rehabilitative services to all patients (excluding palliative), whether they are admitted to a CCC or an officially rated Rehab bed. The results of this transformation were truly outstanding, with the following results (based on 2014/15 forecasts):

- a 50% reduction in Average Length of Stay ("ALOS") since 2009/10;
- over 80% of CCC and Rehab patients (excluding deaths) being discharged home;
- a 40% increase in admissions over 2009/10 in 20% fewer beds; and
- a 10% reduction in the admission FIM score for Rehab patients.

Providence has been a consistent and strong supporter of the MOHLTC's funding reform agenda since it was introduced in January 2012. The implicit incentives of HSFR are generally consistent with a clinically efficient and high performing health system for the GTA. Under ***Time to Shine***, Providence was an unabashed champion of patient flow, and

when combined with the thrust of HSFR, led Providence to adopt the mantra of "earn its funding". When applied to the planning for this operating plan, Providence has assumed that provincial practice and the resulting HBAM/QBP weights will continue to reflect decreasing ALOS despite the increasing fragility/acuity of rehabilitation patients. Also, the historical trend to establishing QBP funding rates, would suggest that the conversion of stroke/hip fracture funding to QBPs will result in reduced funding per weighted case. In light of these factors, Providence has set a 10% ALOS reduction target for rehab cases in the coming year, with a corresponding increase in FIM efficiency (currently 1.15), such that our goal will be to continue to facilitate the same recovery gains for all our patients, albeit over a shorter period of time. In applying this target to the experience of the past year, it should be noted that the number of designated rehabilitation beds increased by 50% on July 1 (to 134 rehab beds), and that the period from November 1, 2014 to January 31, 2015 saw an increase in ALC cases and ALOS as the Whitby LTC fire and a particularly severe flu season affected system flow. As such, the 10% ALOS reduction factor from 2014/15 actuals is not always apparent when reviewing the Inpatient targets in this Operating Plan. The targets for the coming year are largely based on annualized projections of the most representative period of activity during the past year (August through October 2014).

The result for Providence Healthcare's Inpatient programs is displayed in Appendix 7a and can be summarized as:

- admissions will increase by 7.4% to approximately 2,900 admissions, 7 days a week,
- ALOS will be approximately 29 days, 23.6 days for rehab and 38.2 days for CCC beds,
- the percent occupancy will be 93%, essentially the same as in 2014/15,
- an increase of 55.6 % from last year's rehab weighted cases budget to a target of 2,356 weighted cases, and a decrease in CCC weighted days of approximately 30 %, and,
- 134 rehab beds in operation for the year, 35 palliative beds and 76 non-palliative CCC beds for a total of 245 staffed beds.

Other highlights of the budgeted inpatient clinical activity for 2015/16 include:

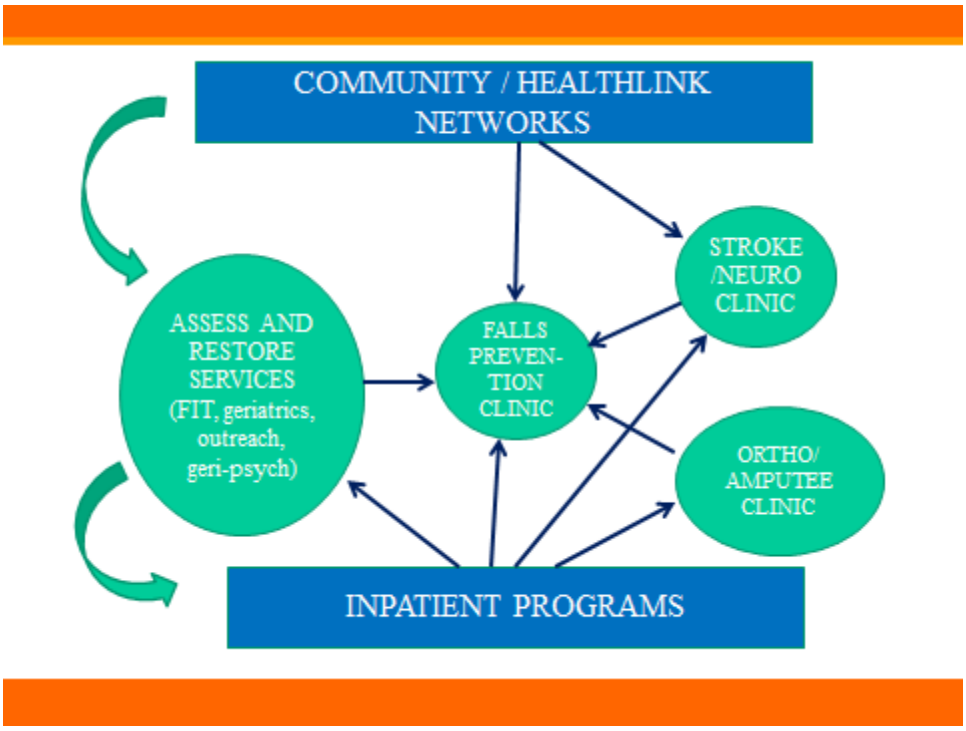
- Providence's budget for 2015/16 is built on maintaining the volume of QBP cases to funded levels for primary hips and knee replacements (55/84 respectively), and to projected volumes for stroke (300) and hip fractures (250) based on the past year,
- maintaining a focus on Providence's 5 formal acute care partner hospitals who account for 85% of annual inpatient admissions,
- managing a majority (55%) of admissions from hospitals outside the TCLHIN; and
- a continued discharge home rate of in excess of 82%.

The operating parameters summarized in Appendix 7d are those that are being proposed by Providence for inclusion in the organization's Hospital Service Accountability Agreement ("HSAA") with the TCLHIN for fiscal 2015/16. The statistics reflect 245 active and staffed beds throughout 2015/16 and a target of 2,500 admissions during the year (slightly below our internal target of almost 2,900 admissions).

Outpatient Activity

The proposed level of Outpatient services for fiscal 2015/16 is shown in Appendix 7b. Since the beginning of the *TbyD* initiative in fiscal 2010/11, Providence has steadily invested in Outpatient services as a cornerstone to realizing the inpatient flow targets of *Time to Shine*.

There is a close relationship between the organization of the Inpatient and Outpatient programs at Providence. There are four overarching program groupings at Providence: stroke/neuro, orthopaedics/amputee, geriatrics/ medical rehab and palliative care. With the exception of palliative patients, each of these areas of focus is reflected in the organization and leadership of Providence's Outpatient services. The goal of the Outpatient programs is to provide care for Providence's discharged inpatient population and increasingly for a community population of patients discharged from other acute care hospitals that have gone home after discharge.



The geriatric/general medicine outpatient services (called the 'Assess and Restore Services', and includes the Falls Prevention Clinic), are partially funded through the Regional Geriatric Program and offer geriatric-psychiatry, geriatric outreach (into clients' homes) and geriatric consulting services to almost 900 patients annually. In 2014/15, Providence invested an additional $210,000 into the Assess and Restore clinic to fulfill our vision for a full continuum of inpatient and outpatient services to support frail seniors. The capstone of the

investment was the creation of a Frailty Intervention Team ("FIT"). This new incremental funding has allowed Providence to better support Family Physicians in our community to treat their most complex seniors by providing a comprehensive geriatric assessment and treatment service as an option to the emergency room.

This is an important aspect of our role within our three partner Health Link networks, and is seen by the TCLHIN/MOHLTC as instrumental in caring for this complex and growing population. This was demonstrated by the recent partial funding of this service by the Ministry and the LHIN. More than simply disease-focused, the focus of care is on the clients' needs, whether they be curative, comfort based, health maintenance or functional improvement/independence based. The program offers health promotion and treatment programs and provides coordinated care planning across the continuum of care for seniors.

The Orthopaedic and Amputee Clinic supports our orthopaedic (most often hip and knee related diagnoses) and amputee populations in regaining maximum mobility following a life-changing illness or injury. Similarly, the Stroke and Neuro Clinic provides post discharge rehabilitation to an estimated 350-400 discharged patients per year. The capacity of these two clinics has increased by over 50% in the past three years as a result of a $350,000 operational funding investment made by the hospital in fiscal 2012/13. This investment has created the capacity to accept more patients directly from our acute care hospital partners in the future.

A number of specialized clinics (Cardiology, Audiology, Chiropody, Ophthalmology, Dermatology) offer services to Providence inpatients, former inpatients, ADP clients and residents of the Houses of Providence. Approximately 1,500 patients/residents/clients per year receive these services. Finally, within the Integrated Healing Arts Clinic there is a suite of fee for service providers that offer such services as Chiropractic, Massage, Chiropody and Acupuncture to 1,960 patients, residents, clients and community members.

Appendix 7b presents the workload statistics for the Adult Day Program at Providence. This provincially recognized program offers around-the-clock care geared to clients with dementia, allowing them to remain living in their home rather than being institutionalized. It also offers family / caregivers much-needed time to run errands, go to appointments and for their own rest and recovery. Funded directly through the MOHLTC/TCLHIN, the program focus has shifted over the past two years to patients with a higher acuity in terms of their support needs. A $250,000 funding infusion in fiscal 2012/13 resulted in the growth of the *enhanced ADP* aspect of the ADP program (facilitating the care of clients who are more complex) and further community focused funding received through the TCLHIN in fiscal 2013/14 resulted in an expansion of weekend services.

Houses of Providence Activity

Appendix 7c reflects the planned resident activity levels in the Houses of Providence for the coming year. This 288 bed residence will operate at approximately 98% occupancy throughout the year and provide approximately 103,000 days of resident care. 70 new admissions are projected for the coming fiscal year. Approximately 75% of the residents in the Houses reflect the "Catholic Preferred" designation of the facility.

Balanced Scorecard Development

Providence's Balanced Scorecard is used to measure performance against each of the *Time to Shine* Strategic Priorities in addition to monitoring HSAA and QIP targets and indicators. The most visible component of this scorecard is the "stoplight" colour coding that indicates if a performance indicator is better than target (green), is in the monitoring range because it is only slightly better than target (yellow), or worse than target (red). Additionally, a trend arrow (up/down) indicates the direction of indicator movement since the previous scorecard. Before June 2015, Providence will undertake a significant update of the scorecard indicators and their associated targets to reflect the new Strategic Plan. At this point in time, it is anticipated that all QIP indicators and the majority of HSAA indicators will continue to be reflected on the Balanced Scorecard. Because of the importance of this scorecard in monitoring Providence's Strategic and Operating Plan success, the Q3 scorecard for fiscal 2014/15, which was presented to the Board in February 2015, is attached to this Operating Plan for reference (Appendix 8).

Financial Strategy

Providence Healthcare Pension Plan

Providence is one of five hospitals in the province that are not part of HOOPP. Providence is solely responsible for the administration and funding of its single employer pension plan. The financial position of Providence Healthcare's pension plan was severely impacted by the stock market collapse in the fall of 2008. In particular, the market value of the equity investments within the pension plan fell considerably leading to a significant funding deficit that required the organization to initiate annual supplemental payments to reestablish the liquidity of the plan. Concurrent with the development of a recovery plan for the pension plan, the strategic plan *Time to Shine* was approved together with an implementation plan for the redesign of clinical processes and space under the *TbyD* banner. A five-year financial model was also developed to guide the planned implementation of *TbyD* from 2010 to 2015. This financial model demonstrated the organization's ability to re-establish a well-funded pension plan and to fund expected strategic and ongoing operational needs in support of the five-year *Time to Shine* Strategic Plan, 2010-2015.

Going into the first year of *BEST Together*, Providence is financially solid, with a fully funded (on a Going Concern basis) pension plan and over $10 million in working capital. With the recent release of draft pension legislation that removes some of the barriers for merging Providence's pension plan with HOOPP, the organization is optimistic that the funding status of a standalone pension plan will cease to be a financial risk to pursuing the new Vision and Strategic Directions. Based on the last filing (January 1, 2014) with the Pension Commission of Ontario, Providence is still required to make supplementary payments to its pension plan to cover the deficit resulting from the required "Solvency" valuation for single employer pension plans. The required annual contribution by Providence is $4.1 million for calendar years 2014 through 2016 through a combination of current year contributions and supplemental payments.

Achieving a Breakeven Budget

The organization has once again set the objective of budgeting for an overall 'working capital' breakeven position for the 2015/16 fiscal year after providing for these supplemental pension payments and the ongoing capital needs (major maintenance, equipment and Information Technology related) of the organization. Moving from a "breakeven" budget in fiscal 2014/15 to a "breakeven" budget for fiscal 2015/16 would be straightforward if revenue and funding increments matched inflationary expense pressures. Providence is however, anticipating that the inflationary funding increments for the Hospital and ADP from the TCLHIN/MOHLTC will be zero, thus leaving a $1.0 million shortfall from inflationary pressures for Providence in the coming year. Providence has decided to fund this shortfall by budgeting for approximately $1 million in vacancy and other savings/revenue reflective of Providence's actual cost experience over the past 3 fiscal years.

Working Capital Improvement

At the beginning of the 2010/11 fiscal year, Providence had a working capital deficit of $700,000 reflecting a current ratio of .93 (ideally, working capital should be above 1 at all times). Since that time, the organization has budgeted for a "working capital" breakeven budget in each year. Favourable one-time and base funding announcements, primarily associated with the operation of the Houses in fiscal 2011/12 and 2014/15 and the Hospital in fiscal 2012/13 & 2013/14, have contributed significantly to a positive projected year-end working capital position of approximately $ 13 million representing a current ratio of over 2.0. This working capital balance is viewed by management as a necessary and prudent reserve that will be deployed in the future to:

- fund portions of any Board recommended investments flowing from the approval of the new strategic plan *BEST Together* in the coming fiscal year including its supporting plans for Quality, People, Information Management, Physical Space, and Financial Health;
- fund urgent and unexpected capital needs (e.g. a failure of a major cooling system);

- facilitate the planned merger of Providence's pension plan into a jointly sponsored, multi-employer pension plan such as HOOPP; and/or
- provide some resilience against unexpected changes in the funding environment that could occur on short notice or be temporary in nature.

Earn our Funding

Since HSFR was introduced in fiscal 2012/13, Providence has set a goal of "earning its funding" under the new funding formulas. The components of HSFR funding are depicted in Appendix 3. In the Rehab sector, the HBAM funding formula is largely driven by benchmark or "best practice" average lengths of stay. Under-achievement of these ALOS benchmarks will effectively result in a funding reduction in the second year following any given fiscal year's results. This "earn our funding" test was the basis of the 2014/15 Operating Plan, and based on results to December 31, 2014, will be substantially achieved in fiscal 2014/15, boding well for a recovery of over $1.0 m in TCLHIN/MOHLTC funding in fiscal 2016/17.

MOHLTC/TCLHIN hospital funding for 2015/16 will be driven by clinical performance in fiscal 2013/14. Under HBAM funding, Providence should see no significant change from its 2014/15 level of funding (i.e. down $1.2 million from "earning our funding"). During 2014/15, Providence also received $785,000 of funding as a result of the TCLHIN Stroke/Msk Business Case initiative which redistributed base funding from acute care to Rehab/CCC hospitals to facilitate shorter ALOS and a reduction in acute ALC patient days for the stroke and much of the hip/knee patient populations across the TCLHIN. The increase in funded activity resulting from this additional funding would not normally be reflected in HBAM calculations until fiscal 2016/17. It is unclear if the MOHLTC's QBP approach for fiscal 2015/16 will include additional funding reflective of this TCLHIN initiative. The TCLHIN has alerted the MOHLTC to the potential negative funding consequences of the HBAM/QBP formula on this initiative.

Transition to QBP Funding

Additionally and as described previously in the discussion of establishing Inpatient ALOS targets for 2015/16, the funding impact of the transfer of stroke and hip fracture cases from the HBAM to the QBP funding formula expected on April 1, 2015 is difficult to determine in the absence of a funded rate or approved volumes of such cases from the MOHLTC. Providence believes that the QBP funding announcement could range from being funding neutral to a further loss of $1.5 million in fiscal 2015/16 on top of the TCLHIN business case funding issue noted above.

In the absence of definitive information from the MOHLTC regarding the impact of HSFR on Providence next year, the 10% ALOS reduction target that underlies this Operating Plan is management's best estimate of the level of ALOS improvement that will be necessary to "earn our funding" in fiscal 2015/16 (which will be applied to funding in 2017/18) when

approximately 25% of Providence's clinical activity is expected to be funded through QBP funding.

Financial Strategy Summary

In summary, while it remains Providence's plan to achieve a fully funded pension plan within a breakeven operating budget for fiscal 2015/16, the HSFR funding risks described above could result in up to a $2.3 million reduction in MOHLTC/TCLHIN funding for fiscal 2015/16, but should be largely recovered in subsequent years based on the level of clinical activity that has been achieved in fiscal 2014/15. The expected temporary nature of any funding decline suggests a one-time approach to funding remediation by Providence. Management is proposing that working capital of up to $2.5 million be used as a backstop against an unfavourable funding announcement for fiscal 2015/16. Additionally, management is committed to confirming Providence's ability to recover any MOHLTC funding lost in fiscal 2015/16 in future years following the expected June 2015 release by the MOHLTC of the funding calculation for transferring Providence's stroke and hip fracture patient populations to QBP funding. In the event that the clinical activity in this Operating Plan is not sufficient to "earn our funding" under the new QBP rates/volumes, management will develop a recovery plan to identify ongoing savings/revenue enhancements to satisfy any ongoing funding shortfall.

Budget Assumptions

Providence Healthcare's budget can be thought of as the sum of three operating units within the organization:

- Providence Hospital (Hospital)
- Cardinal Ambrozic Houses of Providence (Houses)
- Adult Day Program (ADP)

The major assumptions of the 2015/16 Operating Budget for each operating unit are discussed below. Additional line by line assumptions and analysis are included in Appendix 9.

Ministry of Health and Long-Term Care/TCLHIN Funding

Hospital: Current indications (as of March 1, 2015) are that the final MOHLTC/TCLHIN funding for 2015/16 for the Hospital will not be confirmed until June 2015. This budget has been prepared on the assumption of a 0% increase to the Hospital's base budget and no ongoing negative funding impact due to the application of HSFR.

Houses: Management is estimating a 1.5% global funding increase for the Houses and an additional $230,000 CMI funding increment based on the confirmed MOHLTC adjusted CMI

of 1.02 for fiscal 2015/16. Internally, the calculated and unadjusted CMI for the Houses will decline slightly from 1.08 to 1.05 as MOHLTC guidelines for special rehabilitation continue to be transitioned into day to day operations. Financially, the Houses operates to breakeven in each of its funding envelopes (nursing and personal care, raw food, programs, Other Accommodation and rehabilitation). Any surplus in the "Other Accommodation" envelop from resident payments is applied together with an annual $600,000 grant from the Catholic Charities of the Archdiocese of Toronto (which is committed through calendar 2016) to support enhanced services to the residents.

ADP: Inflation funding of 0% has also been assumed for the ADP and the eADP program that was initiated in 2011/12.

Other Revenue Increases

Other revenue lines have been incremented by between 0-2% representing the anticipated rate increase that will come into effect during the year. In addition, adjustments have been made to reflect forecasted 2014/15 revenues, the most significant of which are a $250,000 recovery in semi-private/private accommodation revenue over the past year and a $200,000 increase in out of province/country revenues.

Salaries & Benefits

Salary increments consistent with existing union contracts (ONA and CUPE), and estimates for non-union staff have been included in the budget estimates.

At the Consolidated level, benefits (excluding Pension costs) have been maintained at approximately 20% of salary costs. Pension costs are based on actuarial estimates and provisions for supplemental pension contributions consistent with those estimates.

Other Non-Salary-related Expenses

Modest (0-5%) inflationary adjustments have been made to each expense category together with adjustments as appropriate reflecting 2014/15 actual expenses.

Operating Budget Overview

Detailed Operating Budgets

Accompanying this plan are detailed operating budgets for the:

- Consolidated operations (Appendix 10a)
- Providence Hospital (Appendix 11a)
- Houses of Providence (Appendix 11b)
- Adult Day Program (Appendix 11c)

Each operating statement in the appendices includes the actual revenues and expenses for the 2013/14 fiscal year, the approved operating budget for the 2014/15 fiscal year, the forecast for the 2014/15 fiscal year, and the operating budget for fiscal 2015/16.

Consolidated Operations

The Consolidated Statement of Operations (Appendix 10a) reflects the sum of the individual operating budgets for Providence's three operating units. The Houses and ADP both operate to breakeven. A $2.1 million operating surplus is achieved in the Hospital to allow for a modest supplemental payment to Providence's pension plan.

Hospital

At the Operating Surplus/deficit line, the Hospital is budgeting for a $2.1 million surplus (Appendix 11a) to fund the majority of the (net) $2.3 million supplemental payment to the pension plan. This surplus is down marginally from the 2014/15 budget and reflects $500,000 in new "required investments" as presented previously in this plan.

Houses of Providence

The Houses are expected to have a slight operating deficit (Appendix 11b) from operations in the coming year based on already announced adjustments to the CMI and other envelopes and an assumption of a 1.5% increase to the various other LTC envelopes during the coming fiscal year. After adding back net building amortization, a **breakeven** position is budgeted. Long Term Care is funded by envelope, the most significant of which are the 'Nursing and Personal Care' ("NPC") and 'Other Accommodation' ("OA") envelopes. The OA envelope includes the impact of all MOHLTC mandated increases in resident revenues for copayment and preferred accommodation. Providence runs a deficit of approximately $2.5 million in the NPC envelope which is funded by the organization's decision to apply the OA envelope surplus against this deficit.

Adult Day Program

The Adult Day Program ("ADP") is budgeted to breakeven at the MOHLTC margin line (Appendix 11c) assuming a 0% economic adjustment in the coming year from the MOHLTC.

Capital Plan

Working capital generated by Providence Healthcare's operations is used to fund the capital needs of the organization after satisfying the organization's pension plan funding needs. Capital planning at Providence includes:

- Equipment for the Hospital (including ADP)
- Major Maintenance and strategic remodeling for the Hospital (including ADP)
- Equipment & Major Maintenance for the Houses
- Information and Communications Technology (ICT) projects

- Major Projects within the $16 million *Hope Starts Here* Capital Campaign of the Providence Foundation

Since fiscal 2011/12, Providence has maintained multi-year plans for all streams of capital. These plans are updated by management annually, however with the approval of *BEST Together* and the pending support plans, only a one year capital projects plan has been developed for Information and Communications Technology ("ICT"). The replacement of Hospital beds and mattresses over the next 5-7 years is the only multi-year priority for Hospital equipment. Details of the approved capital budget for the coming year are included in the updated plans included in this 2015/16 Operating Plan.

Hospital Equipment

$300,000 has been set aside as the annual budget for clinical equipment in the Hospital/ADP, however it is expected that this budget will be further supplemented (by approximately $100,000) by additional grants from Providence Healthcare Foundation ("Foundation") based on donor interest in addressing the clinical needs of the organization during fiscal 2015/16. This additional funding will be used to address equipment pressures that emerge during the fiscal year or to accelerate the replacement of Hospital beds/mattresses. The detailed approved list of clinical equipment requests for the Hospital/ADP is presented in Appendix 12a.

$55,000 has been set aside for non-clinical equipment in the Hospital principally for the Main Kitchen area as presented in Appendix 12a.

Hospital Major Maintenance

The organization's major maintenance needs (generally infrastructure such as plumbing, electricity, life safety, etc.) have been mapped out through to the end of fiscal 2018/19. Since fiscal 2012/13, MOHLTC infrastructure grants ("HIRF" grants) have been inconsequential and are now allocated solely to potential infrastructure projects in the largely unused K wing. The result of this is that Providence is now annually allocating approximately $**750,000**, largely generated by net amortization expense, to major maintenance in the Hospital and ADP. In fiscal 2015/16, management used a special $300,000 allocation of working capital to complete the retrofitting of sprinklers across the facility (excluding the chapel). For 2015/16, the most significant maintenance requirements are an upgrade to the fire alarm panel and upgrades to one of the main Hospital elevators. Details of the fiscal 2015/16 major maintenance plan for the Hospital are presented in Appendix 12b.

Houses: Equipment & Major Maintenance

$250,000 is received annually from the Foundation to support the equipment and Major Maintenance needs of the Houses. The allocation of this funding for fiscal 2015/16 and beyond is detailed in Appendix 12c.

Information and Communication Technology

A multi-year Information and Communication Technology capital project plan has been presented in the Operating Plan in each of the past four years. During fiscal 2013/14, with Board approval, a two year time horizon was set for IM/IT projects pending the development of the new multiyear Strategic Plan for Providence Healthcare in fiscal 2014/15. This timeline has been extended by one year in light of the recent approval of the new Strategic Plan. As a result, a $850,000 budget for the ICT projects needs for the remaining year of the previous IM/IT strategic plan is presented in this Operating Plan (Appendix 12d).

Foundation-Supported Projects

Providence and the Foundation work closely together on an ongoing basis to identify opportunities for fundraising in support of Providence's capital needs. For the past four years, the most significant area receiving Foundation support has been the *TbyD* project, with the Foundation contributing almost $5.5 million to date to transform 6 non palliative inpatient units.

In fiscal year 2012/13, the Foundation approved a $16 million *Fundraising Campaign* that includes $6.0 million (the majority already granted) for *TbyD* projects together with $4.5 million for the Palliative Care unit, $2.5 million in support of a Knowledge Centre and $2.0 million for an Education endowment, in addition to the $1.0 million cost to raise these funds. To date, the Foundation has granted $1.45 million for the planning and remodeling of the Palliative Care unit, with the expectation that a further $1.75 million will be granted in fiscal 2015/16. The expected completion date for the Palliative care remodeling is the summer of 2016. Additionally, the Foundation will be asked to support the Outpatient Flow project of the hospital by granting $300,000 of *TbyD* designated funding that has already been received from donors.

The Foundation has historically also raised funds for the high priority equipment needs of the hospital.

Statement of Working Capital

Attached to this plan is the consolidated statement of Changes in Working Capital (Appendix 10b) reflecting a "working capital" breakeven budget for fiscal 2015/16. In summary, Providence expects to generate $2.0 million from operations to fund the majority of a net supplemental pension payment of $2.3 million. Adding back net amortization generates an additional $2.3 million that funds the shortfall in the pension supplement and the following capital investments:

- $355,000 for hospital equipment
- $750,000 for major maintenance
- $850,000 million for ICT

This will maintain Providence's working capital at approximately $13.3 million throughout the year. Providence views this working capital reserve as a contingency fund, as noted previously to be used to:

- fund portions of any Board recommended investments flowing from the approval of *BEST Together* in the coming fiscal year including its supporting plans for Quality, People, Information Management, Physical Space, and Financial Health;
- fund urgent and unexpected capital needs (e.g. a failure of a major cooling system);
- facilitate the planned merger of Providence's pension plan into a jointly sponsored, multi-employer pension plan; and/or
- provide some resilience against unexpected changes in the funding environment that could occur on short notice or be temporary in nature.

Financial Risks

Providence is working closely with the TCLHIN to bring the issues associated with the alignment of the TCLHIN Business Case initiative and the MOHLTC's planned transfer of stroke and hip fractures in rehabilitation patients to the QBP component of HSFR to the attention of senior officials at the MOHLTC to ensure a fair and equitable treatment for free standing Rehab/CCC hospitals in the GTA such as Providence. In the event of a "worst-case" HSFR induced funding announcement of up to $2.3 million, Providence is prepared to deplete working capital in anticipation of earning its funding for the 2016/17 fiscal year.

CUPE has negotiated a multi-year contract ending in October 2016, and the ONA contract expires on March 31, 2016. The province has stated its expectation that union contract renewals will reflect no net increase to hospitals for the next year. Providence has made provisions for its contractual obligations and reasonable estimates of salary costs for non-union staff in the coming year. Salaries and wages represent almost 60% of Providence's total expenditures; however, management is satisfied that unexpected salary costs represent a minimal threat to this Operating Plan.

Summary

The attached operating plan outlines a comprehensive and ambitious agenda for the coming year that enables the organization to successfully achieve the goals outlined in the *BEST Together* Strategic Plan, 2015-2020 while continuing to invest in evolving best practices in rehabilitation and remaining fiscally responsible. Once approved by the Board of Providence Healthcare, this plan will be shared with the organization at various scheduled gatherings in April including the Leadership Forum and CEO Town Halls.

List of Abbreviations

ADP	Adult Day Program
ALOS	Average Length of Stay
CCC	Complex Continuing Care
CUPE	Canadian Union of Public Employees
eADP	Enhanced ADP Program
EPR	Electronic patient Record
Foundation	Providence Healthcare Foundation
HBAM	The Health based Allocation Procedures
HIRF	Health Infrastructure Renewal Fund
HOOPP	Hospitals of Ontario Pension Plan
Hospital	Providence Hospital
Houses	The Cardinal Ambrozic Houses of Providence
HSAA	Hospital Service Accountability Agreement
HSFR	Health System Funding Reform
ICT	Information and Communication Technology
IM/IT	Information Management/Information Technology
LHIN	Local Health Integration Network
LTC	Long Term Care
MOHLTC	Ministry of Health and Long-Term Care
MSK	Musculoskeletal
NPC	Nursing and Personal Care
OA	Other Accommodation
ONA	Ontario Nurses Association
QBP	Quality Based Procedures
QIP	Quality Improvement Plan
REB	Research Ethics Board
TbyD	*Transformation By Design*
TCLHIN	Toronto Central LHIN
TJR	Total Joint Replacement

Appendix 1

BEST Together Strategic Plan 2015-2020

PROVIDENCE Healthcare

Our Vision Providence Healthcare will extend our community of expert care beyond our walls. We will give the people we care for the knowledge and confidence to stay healthy and safe at home for as long as possible.

Our Goal The people we care for will flourish at Providence and at home.





BEST CARE EXPERIENCE:

The expectations of our patients, residents, clients and their families are always exceeded.

BEST COMMUNITY OF EXPERTS:

Employees, physicians and volunteers are experts and integral to achieving our Vision.

BEST RELATIONSHIPS BEYOND OUR WALLS:

Sustainable partnerships support shared accountability for health outcomes and positive experiences for the people we care for.

AIM

- The people we care for will drive their healthcare journey; what matters to them most is what counts.
- The people we care for will be safe with us and at home because of our relentless focus on quality.

AIM

- Our staff will feel enriched and empowered to make decisions that create a better Providence.
- Our staff will have the confidence and resources to create better care and relationships.

AIM

- We will collaborate to develop and implement integration at the point of care, connecting providers within and across sectors.
- Community engagement will bring value to the people Providence cares for through joint planning, decision-making and actions.

Our Mission Providence Healthcare, a Catholic healthcare organization, is inspired by the legacy of the Sisters of St. Joseph of Toronto to be a welcoming community of compassion, hope and healing. We provide rehabilitation, palliative care, long-term care and community programs.

Our Values

Sanctity of Life
Every life is a sacred gift that has meaning and value.

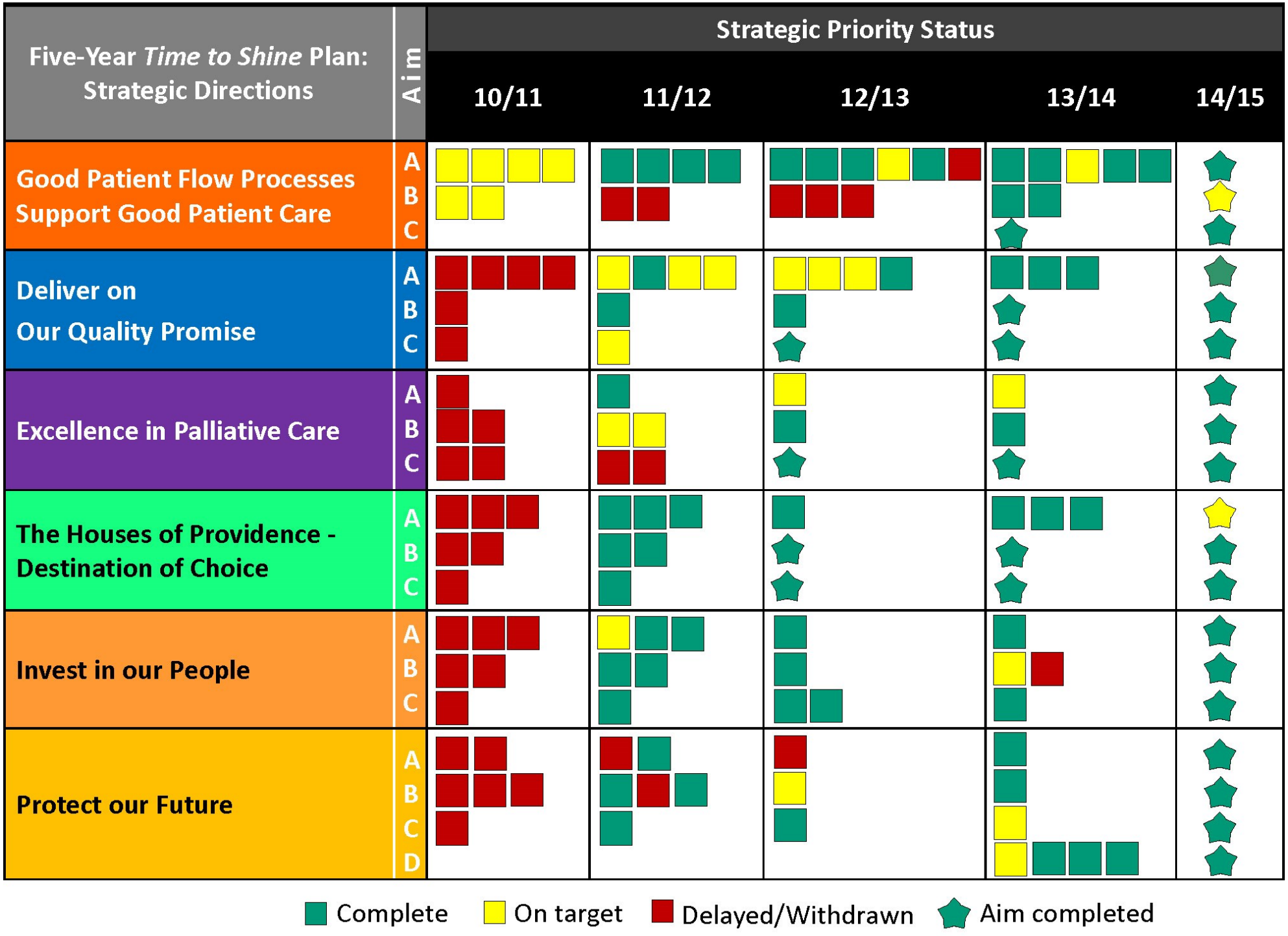
Human Dignity
Everyone has intrinsic value and is worthy of respect.

Compassionate Service
The needs of every person are attended to with thoughtfulness, understanding and sensitivity.

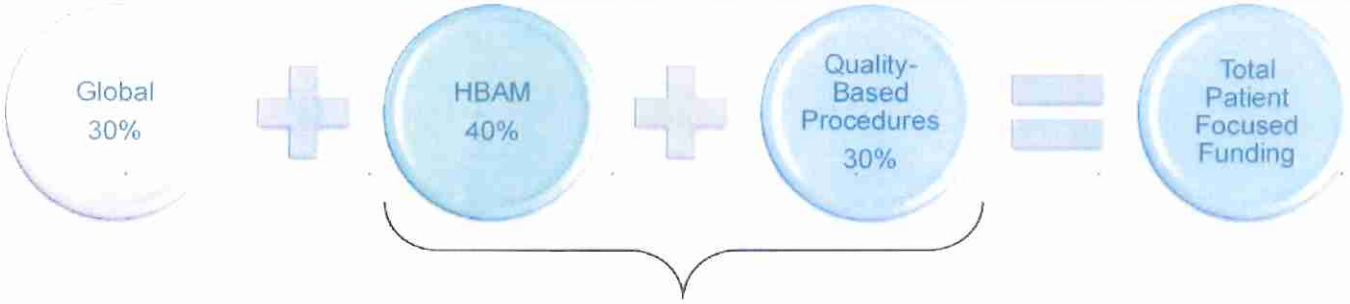
Community
People of diverse backgrounds gather together with a shared purpose and support each other in hope and celebration.

Social Justice
Each person is treated in a fair and equitable manner, according to one's needs.

Social Responsibility
Accountability is demonstrated by the prudent use of resources given to us in trust.


Five-Year *Time to Shine* Plan: Strategic Directions
Aim
Strategic Priority Status
10/11
11/12
12/13
13/14
14/15
Good Patient Flow Processes Support Good Patient Care
A
B
C
Deliver on Our Quality Promise
A
B
C
Excellence in Palliative Care
A
B
C
The Houses of Providence - Destination of Choice
A
B
C
Invest in our People
A
B
C
Protect our Future
A
B
C
D
Complete
On target
Delayed/Withdrawn
Aim completed

Patient Focused Funding will be phased-in to comprise 70% of a hospital's funding within a three year period



Health Based Allocation Model (HBAM):

HBAM is an allocation model and management tool that uses demographic, clinical and financial information to estimate expected volumes and costs at a facility level; this identifies an organization's expected share of overall sector funding.

The model provides an evidence-based distribution of funding by shifting resources informed by the aggregate cost, volume and type of patients.

Other activities which can not be modelled or face unique circumstances will be funded on a global basis (e.g. small hospitals and forensic mental health).

Quality-Based Procedures:

Quality-Based Procedures (QBP) are targeted activities that are funded on a 'price x volume' basis.

They are funded based on evidence (e.g. utilization patterns, best practices) to encourage improvement in value for money, including improved outcomes and reduced variation across Health Service Providers.

Year 1 proposed QBPs are: Primary Unilateral Hip Replacement, Primary Unilateral Knee Replacement, Chronic Kidney Disease and Cataract Surgery.

Source: MOHLTC, Health System Funding Reform Webinar with Health Service Providers: Part 2, March 16, 2012

Ontario

PROVIDENCE Healthcare

BEST Together Strategic Plan
Tactical Priorities 2015/16

1. BEST Care Experience: The expectations of our patients, residents, clients and their families are always exceeded.

The people we care for will drive their healthcare journey; what matters to them most is what counts.

The people we care for will be safe with us and at home because of our relentless focus on quality.

TACTICS	EXECUTIVE LEAD	Final Rpt to Sr. Management
1.1 For our patients to flourish at Providence, they need a good night's sleep. In annual patient satisfaction surveys, the 'nighttime experience' has been identified as an opportunity for improvement. *We will design, implement and evaluate change ideas to improve the nighttime experience on one Hospital unit. We will develop a plan to spread initiatives across all Hospital units and scope the feasibility for the Cardinal Ambrozic Houses of Providence and Adult Day Program.*	James Fox	Q4
1.2 To better understand the experience of the people we care for, we will need to undertake a multi-year 'patient experience' project involving patients, residents, clients, and families. *We will use a recognized tool to establish our current 'patient experience' baseline for our Hospital patients. A multi-year plan will be developed to address gaps for implementation in the remaining years of this plan.*	James Fox	Q2
1.3 To ensure reliable, quality care we will continue to build on our Safety and Quality Promise. *We will develop a multi-year harm reduction plan based on the principles of a High Reliability Organization: 0% harm for all preventable injuries and 100% compliance for all key processes.*	Peter Nord	Q3

1.4 A patient-centred model of end-of life care will support our pursuit of excellence in palliative care. *We will implement two palliative best practices as per the Canadian Hospice Palliative Care Association on the Hospital's Palliative Care program and in the Houses of Providence.*	James Fox	Q4
1.5 The relocated and modern new Palliative Care program will be in a patient- and family-centred environment. *To advance the project, we will complete, on time and on budget, Phase III of the Palliative Revitalization Project - $1,250,000.*	Marc Beaudry	Q3

2. BEST Community of Experts: Employees, physicians and volunteers are experts and integral to achieving our Vision.

Our staff will feel enriched and empowered to make decisions that create a better Providence.		
Our staff will have the confidence and resources to create better care and relationships.		
TACTICS	**EXECUTIVE LEAD**	**Final Rpt to Sr. Management**
2.1 Providence is empowering its leaders of today and tomorrow with the tools and resources required to be successful. W*e will begin to implement Phase III of the Leadership Development Institute program (Business Essentials and Strategic Thinking).*	Marc Beaudry	Q3
2.2 The Knowledge Centre, for staff and students, will create a dynamic environment to fully engage the hearts and minds of our current and future staff in learning. *To move this project forward, we will develop a functional and space plan, based on the $2.5 million budget, for the new Knowledge Centre.*	Marc Beaudry	Q2

2.3 Staff access to the education and financial resources is required to help us achieve our Vision. *We will develop criteria for the allocation of annual scholarship funds of $100,000.*	Marc Beaudry	Q3

3. BEST Relationships Beyond Our Walls: Sustainable partnerships support shared accountability for health outcomes and positive experiences for the people we care for.

We will collaborate to develop and implement integration at the point of care, connecting provider within and across sectors.		
Community engagement will bring value to the people Providence cares for through joint planning, decision-making and actions.		
TACTICS	**EXECUTIVE LEAD**	**Final Rpt to Sr. Management**
3.1 People must receive the care they need in the right place, at the right time, and by the right provider. *We will identify and initiate an Patient Flow Integration Project together with other health service providers for one patient population using clinical and patient reported outcome measures to assess our success.*	Maggie Bruneau	Q4
3.2 Building on the standardized patient discharge package implemented in 2014/5 we will continue to implement new processes to support our patients, after discharge, in following up with their family physicians, to ensure a smoother transition home. *We will evaluate our current standardized discharge package process, and scope Patient Orientated Discharge Summaries to make the discharge package as user-friendly as possible.*	Peter Nord	Q3
3.3 People living in the community who require rehabilitation need direct access to our inpatient programs. *We will work with our community partners to prevent potential emergency department use by offering rapid access now to our inpatient rehabilitation programs as well as safe reintegration back to the community post rehabilitation.*	Maggie Bruneau	Q4

3.4 The people we care for and our community need to understand us, and we need to understand them. *We will develop a Community Engagement Plan to guide our conversations with stakeholders and partners, bringing value to individuals and the health care system.*	Maggie Bruneau	Q4

SUPPORTING PLANS

Five unique plans are required to support the new Strategic Plan. The nature of the plans is such that there will be significant connections and coordination required between the plans, e.g. the cost of achieving high Quality needs to be factored into the Financial Health Plan, and the Information Technology component of the Information Management Plan needs to follow the development of a vision for Information Management. Significant components of these supporting plans will be presented to the Board in the fall of 2015.

1. The Quality Plan

TACTICS	EXECUTIVE LEAD	Final Rpt to Sr. Management
The **Quality Plan** will…. • Champion continuous improvement • Strengthen organization-wide performance management • Actively manage the change process	Peter Nord	Q3

2. The People Plan

TACTICS	EXECUTIVE LEAD	Final Rpt to Sr. Management
The **People Plan** will… • Ensure we retain and recruit the best staff • Recognize and reward innovation and excellence • Facilitate skill growth and leadership development	Marc Beaudry	Q3

3.The Information Management Plan

TACTICS	EXECUTIVE LEAD	Final Rpt to Sr. Management
The **Information Management Plan** will… • Develop a comprehensive coordinated e-health strategy • Ensure that health information is available to all stakeholders when it is needed • Ensure that we have an information technology (IT) plan to support our information management needs	Jim Elliott/Marc Beaudry	IM – Q2 IT progress report -Q4

4.The Physical Space Plan

TACTICS	EXECUTIVE LEAD	Final Rpt to Sr. Management
The **Physical Space Plan** will… • Optimize the current physical infrastructure • Promote a socially responsible environment • Develop a Master Plan for future redevelopment	Marc Beaudry	Q3

5.The Financial Health Plan

TACTICS	EXECUTIVE LEAD	Final Rpt to Sr. Management
The **Financial Health Plan** will… • Sustain and continue to achieve operational effectiveness • Earn our funding • Coordinate with Providence Healthcare Foundation to align fundraising with Providence Healthcare's strategy	Jim Elliott	Q2

Let's Make Healthy Change Happen.

Appendix 5a

2015/16 Providence Healthcare Quality Improvement Plan (QIP) Narrative - Providence Hospital

Providence Healthcare

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Overview

2015 marks the beginning of a new five-year strategic plan for Providence Healthcare. Our 2015-2020 Strategic Plan called '*BEST Together*' is our first step towards achieving our new Vision, established in early 2014: *"Providence Healthcare will extend our community of expert care beyond our walls. We will give the people we care for the knowledge and confidence to stay healthy and safe at home for as long as possible"*. Our Quality Improvement Plan (QIP) for the Houses of Providence is directly aligned with the Plan's three strategic directions:

1. **Best Care Experience**: The expectations of our patients, residents, clients and their families are always exceeded.
2. **Best Community of Experts**: Employees, physicians and volunteers are experts and integral to achieving our Vision.
3. **Best Relationships Beyond Our Walls**: Sustainable partnerships support shared accountability for health outcomes and positive experiences for the people we care for.

In addition to our *BEST Together* Strategic Plan, our QIP aligns with provincial priorities and other planning processes such as:

- Provincial and LHIN priorities including obligations contained within the Hospital Service Accountability Agreement (HSAA)
- Auditor General of Ontario Report on Rehabilitation Services at Hospitals
- Auditor General of Ontario Report on Discharge of Hospital Patients
- Accreditation Canada Standards and Required Organization Practices (ROPs)
- Accreditation Canada Stroke Distinction Standards
- Providence's Operating Plan
- Providence's "Quality and Safety Promise" Plan
- Patient Relations Process
- Professional Practice – best practices across nursing and allied health professionals
- Organization-wide Incident Management System
- Excellent Care for All Act (ECFAA)

For 2015/16 the priority measures in our QIP are:

Measure	Baseline	Target	Target Justification
Clostridium difficile Infection rates/1000 patient days for all hospital inpatient beds	0.22	0.21	Improve by 5%
% patients where actual average length of stay (LOS) in A3/B3 stroke rehabilitation is equal to or less than expected LOS (based on TCLHIN Stroke Best Practice)	57%	63%	Improve by 10%
% discharge summaries dictated and delivered to B4 *before* patient discharged home	73%	80%	Improve by 10%

% positive patient response to night time noise levels on B5 Ortho/Amp Unit	50%	55%	Improve by 10%
Geriatric Medicine Clinic wait time	98 days	78 days	Improve by 20%

Reduce *Clostridium difficile* Infection (CDI) Rates *(Safety)*

CDI causes significant inflammation in the large intestine resulting in abdominal pain and mild to severe diarrhea, sometimes resulting in death. It is commonly associated with use of antibiotics and longer hospitalization stays. Although we meet our Hospital System Accountability Agreement (HSAA) floor and our current performance is below the provincial average, we believe we can further improve the CDI rate when compared to CCC/Rehab benchmarks. We would also like to improve this infection rate for CDI acquired at Providence in order to improve our patient safety and experience.

1. **Improve length of stay in stroke rehabilitation (*Effectiveness*)**
   Patients who have suffered a stroke now have a care trajectory/timeline and funding based on a "Quality Based Procedure" (QBP) framework supported by the Ministry of Health and Long-Term Care. A number of inpatient stroke rehab patients exceed their expected length of stay (based on TCLHIN Stroke Best Practice) and requires improvement in order to secure funding for this population.

2. **Improve patient transition from Providence to home (*Integrated*)**
   We would like to further improve the patient transition from Providence to home by increasing the percentage of completed discharge summaries provided to the patient prior to discharge. These discharge summaries have pertinent information that the patient and their family physician require in order to make the transition home safe and smooth. Improving the discharge process will prevent or minimize risks of post discharge adverse events that can result in harm, sometimes leading to readmission.

4. **Improve the patient's night time experience *(Patient-Centred)***
   Improving the night time experience at Providence was highly cited in our 14/15 patient satisfaction surveys as an area for improvement. Specifically, patients often reported not being able to sleep due to excess noise throughout the night. A good night sleep is paramount in order to achieve maximal recovery during their rehabilitation stay. We would like to improve the noise levels during the night time in order to ensure a better night sleep for our patients and therefore optimal recovery.

5. **Reduce wait times for our Geriatric Medicine Clinic (*Access*)**
   The current wait time to see a Geriatrician in our Geriatric Medicine Clinic is approximately three months. This prolonged wait could increase the likelihood of admission to the Emergency Department and could negatively impact patients' ability to stay at home safely. As reported by our patient caregivers, it can also increase anxiety regarding their loved one's safety and treatment plan. We would like to reduce the wait time to gain access to our Geriatric Medicine Clinic to improve patient safety and experience.

Integration & Continuity of Care

Providence Healthcare continually works with system partners in developing and executing quality improvement initiatives to improve integration and continuity of care. In collaboration with partners, we have several initiatives underway to better link care across the continuum that promote integration and facilitates continuity of care for the patient via our 2015/16 QIP:

- Tight connections through formalized acute care partners – via our Patient Flow Coordinators we are notified in real time re. outbreaks (including *Clostridium difficile*) at our partner sites and can therefore be proactive re *Clostridium difficile* precautions with recent/future admissions
- Close links with patients' family physicians re. discharge summaries and planning
- A new Outpatient Flow Coordinator role to support quicker access to outpatient services including Outpatient Geriatric Medicine and Stroke and Neuro Clinics
- As part of our health link commitments, Providence offers Telemedicine Impact Plus (TIP) for current complex discharges. This could expand to provide consultation for our frail elderly population, thereby assisting with the Geriatric Medicine Clinic wait time
- Collaborating with Variety Village and the Scarborough Prevention Program to provide wellness and exercise services for patients recovering from a stroke post discharge from Providence inpatient and outpatient stroke rehab programs
- Providence is a founding member of two health links - North East Toronto Health Link and East Toronto Health Link – a stand-alone metric within both health links is to improve the patient transition (including such things as standard discharge packages to patients)

Challenges, Risks & Mitigation Strategies

There are a number of identified areas of challenges and risks in the execution of our QIP. Many of them centre on the availability of resources to implement and sustain the large number of change ideas, and unforeseen events such as outbreaks. To mitigate these risks, we will monitor our progress through regular tracking of data, monthly meetings, and a quarterly Balanced Scorecard. Each objective under the QIP is linked to an Executive Lead and Implementation Lead with clear accountability and responsibility for each initiative. The QIP deployment is also centrally directed by the Quality Improvement Department. The Senior Leadership team and the Quality and Safety Committee of the Board will review each priority indicator every quarter. This regular review will help our leaders and staff to identify any early potential risks to the execution of the QIP and implement countermeasures to ensure targets will be met. Also, since many of the planned improvement initiatives are not fully implemented at the beginning of the fiscal year, target achievement timelines may vary. To help with resources, we have ensured that our plan takes into consideration a staggered implementation for each of our quality projects.

Information Management Systems

Providence Healthcare currently uses several information management systems to understand our patient population needs, set targets and identify areas for quality improvement. Some of our clinical information management systems include Clinical Assessments, Incident Management, Workload, Patient Satisfaction, Pharmacy, and Laboratory systems. By accessing the data and monitoring performance, various working groups, clinicians, committees and leaders use this information to choose indicators, set targets, monitor performance and later course correct if necessary. Quality initiatives are planned and implemented when information shows the need for improvement or when current performance falls short of reaching targets. In addition, Providence Healthcare will be developing a comprehensive Information Management/Information Technology (IM/IT) Supporting Plan to support our new Vision and Strategic Plan. We will continue to adopt other systems and technology to give clinicians and leadership access to the best available information to understand patient needs and inform future quality improvement initiatives.

Engagement of Clinical Staff & Broader Leadership

"From the Board to the Ward", our quality improvement initiatives cascade down to every level in our organization. Our Senior Management team drives many of the quality initiatives to ensure that they align with the strategic goals of the organization and that they are adequately resourced. Once a need for an improvement is identified, an Executive Lead and an Implementation Lead is assigned to ensure that the initiatives are implemented, monitored and sustained. The Implementation Lead brings together a clinical team to develop the change ideas, performance metrics and a project plan. The Senior Management team, the Quality, Safety and Risk Management Committee and the Quality and Safety Committee of the Board regularly review the performance of key quality initiatives through the quarterly Balanced Scorecard and reports.

Our QIP is developed by the Quality Improvement team and the QIP Task Force that is comprised of Professional Practice Leaders, Managers, Directors and members from the Senior Management Team. The QIP Task Force reviewed our Balanced Scorecard, critical incidents, complaints, satisfaction surveys, program priorities, strategic priorities, provincial and LHIN commitments, potential future trends and our current year's QIP. Based on the data analysis, several working groups were tasked with developing priority indicators as a focus for next year's quality improvement activities. A Criteria Tool was developed to "weigh" each proposed indicator as a way to determine which were the most important to the organization. Once a potential priority indicator was selected, there was consultation from the larger leadership teams, Information and Performance team, Physicians, Practice Consultants, and front-line staff to set targets and develop change ideas. The QIP is recommended to the Board for approval by the Quality and Safety Committee of the Board.

Patient/Client Engagement

Providence engages its patients/families in different forums. One way is through a patient satisfaction survey that is completed with the Patient/Family member by a volunteer 48 hours prior to discharge. The survey information is coded and themed on a monthly basis and reviewed/responded to by our Patient Care Managers. The themes are reviewed by our Patient Experience Committee on a quarterly basis and action items/projects determined as required to respond to the feedback. Patients/caregivers are often engaged at the bedside via informal interviews/surveys for specific improvement initiatives in order to obtain more valuable information and insights.

As required by ECFAA and recommended by the Auditor General of Ontario Report on Rehabilitation Services at Hospitals, Providence is also initiating its first Caregiver Survey in early 2015. The goal of this survey is to solicit feedback re. the caregiver experience and to determine if improvements are required. Providence is developing its first Patient/Family Advisory Council in 2015/16 that will formally advise the annual QIP initiatives among other improvement initiatives at Providence.

The 2015/16 QIP developed was informed by a group of Providence patient and caregivers through semi-structured interviews. One patient/caregiver was interviewed from each of our four inpatient programs and four outpatient programs. These eight patients/caregivers supported the five key initiatives on the 2015/16 and offered some suggestions for consideration for following year QIP that were documented by the Quality Improvement Department.

Accountability Management

Providence Healthcare's Management Incentive Compensation Plan (MICP) will be directly linked to the 2015/16 QIP in adherence with Ontario Regulation 444/10. As part of the organization's executive compensation plan, a specific percentage of compensation is at risk based on achieving the goals within the QIP. Executive compensation will be linked to our five "improve" measures: Improve CDI rate, reduce LOS in our inpatient Stroke and Neuro Rehab program, improve patient transition from Providence to home, improve the night time experience and reduce wait times for our Geriatric Medicine Clinic.

Performance Based Compensation

The following percentages will be linked:

Position	% Amount at risk pay FY 2015/16
President and Chief Executive Officer	4%
VP, Chief Medical Officer and Chief of Staff	2.4%
VP, Programs	2.0%
VP, Finance and Chief Financial Officer	2.0%
VP, Corporate Services and Chief Human Resources Officer	2.0%
Vice President, Partnerships and Chief Nurse Executive	2.0%
Director, Mission and Values	2.0%
Chief Communications Officer	2.0%

Health System Funding Reform (HSFR)

A series of initiatives are in place to help us earn our funding. Some examples of the ongoing initiatives include:

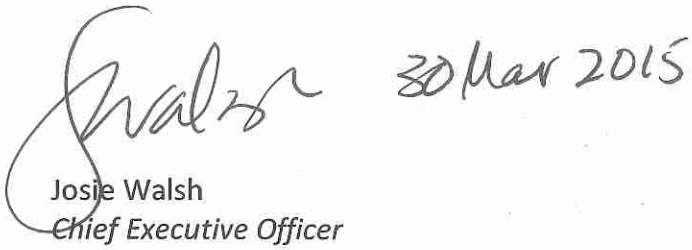
- Rapid assessment of new admissions to determine Rehabilitation Patient Groups' (RPG) anticipated length of stay and then managing to that estimated discharge date (discharge planning starts on admission). This process ensures a safe discharge.
- Continuing to partner with acute care hospitals and community agencies/CCAC to create safe handoffs.
- Anticipating QBPs in the post-acute sector and into the community that apply to Providence.
- Building on the work of *Transformation by Design* (31 process changes to ensure that flow has improved while maintaining quality outcomes).
- Include HBAM/QBP indicators on the Balance Scorecard to track performance on a monthly/quarterly basis.
- Access and Flow Committee to track performance on a bi-weekly basis.
- Improving our Stroke and Neuro Rehab program's length of stay that is now a QBP via HSFR

Other

The QIP Guidance Document for Ontario's Health Care Organizations outlines a set of priority QIP indicators for each sector. Organizations are expected to review the priority indicators for their sector and determine which are relevant for their organization. Providence has reviewed these indicators and determined that one of the sixteen priority indicators was an area for improvement – improving C. *difficile* infection rates. The remaining indicators either don't apply to us or our Q3 YTD current performance already meets or exceeds our target.

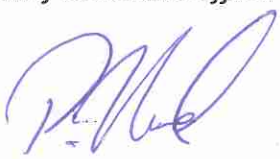
Sign-off

I have reviewed and approved our organization's Quality Improvement Plans



30 Mar 2015

Josie Walsh
Chief Executive Officer



Dr. Peter Nord
Chief of Staff

Virginia West
Board Chair

Mark Murphy
Safety and Quality Committee Chair

2015/16 Quality Improvement Plan for Ontario Hospitals - Providence Hospital
"Improvement Targets and Initiatives"

Providence Healthcare 3276 St.Clair Avenue East, Toronto, ON

Appendix 5b

AIM		MEASURE						CHANGE				
Quality dimension	**Objective**	**Measure/ Indicator**	**Unit/ Population**	**Source/ Period**	**Current performance**	**Target for 2015/16**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas (2015/16)**	**Comments**
Safety	Reduce hospital acquired infection rates	C. *difficile* Infection (CDI) rate per 1000 patient days	Hospital inpatient beds	MOHLTC/ January 2014-December 2014	0.22	0.21	Aiming for better than the 90th percentile among our CCC/Rehab peers (HQO ranking analysis table from 2012: QIP Benchmark and Target Setting). The target represents a 5% improvement for fiscal year 2015/16 and ramp up to achieve an additional 5% improvement in 2016/17. The target is 0.21 for fiscal year 2015/16 and 0.20 for fiscal year 2016/2017.	•Antibiotic stewardship – prudent antibiotic and PPI prescribing	Antimicrobial Stewardship Program (ASP) is promoting optimal utilization of antibiotics by creating standardized Urinary Tract Infection preprinted order and monitoring the utilization of all antibiotics . Pharmacy and Therapeutics Committee is charged with responsibility to develop evidence base guidelines for usage of PPI and will audit adherence to the established guidelines.	Defined Daily Dose/1000 patient days (DDD) for each antibiotic.	Reduce DDD for quinolones by 5%.	
								Develop a CDI risk assessment tool	Under the guidance of our ASP Medical consultant, a risk assessment tool will be designed to include the risk factors for CDI. This tool will be used to assess all admissions. Patients identified as high risk will be monitored closely and processes will be in place to minimize the risk of CDI during their hospital stay.	Completion of the CDI Risk Assessment tool on targeted population	100% completion	
								Environmental cleaning audits	Rooms on Contact precautions for CDI will be audited for terminal cleaning.	% environmental cleaning audits completed when C. *difficile* precautions are discontinued or patient is discharged (terminal clean)	90% completion per month	
								Staff and patient education (C diff awareness, hand hygiene) – *Perfect Practice Makes Perfect ("Perfect Practice")* campaign	IPAC will provide annual mandatory education to clinical staff with a focus on proper technique of hand hygiene and donning and doffing of Personal Protective Equipment (PPE)	% of clinical staff educated and trained on *Perfect Practice Makes Perfect*	80% annually	
Effectiveness	Improve length of stay in rehabilitation	% of patients where the actual length of stay matches or is less than the expected length of stay for Stroke Rehab patients as per Toronto Central LHIN Best Practice (excluding ALC)	Stroke Rehab A3 & B3/ Stroke Patients in Rehab beds	Hospital Collected Data/ August to October 2014	57%	63%	QBP 10% improvement for fiscal year 2015/16	Completion of admission FIM: Process review and education refresh to determine LOS targets earlier	Information and Performance collects and generates a report. Director, Interprofessional Practice will analyze and review data monthly. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly.	% of patients with FIM completed within 72 hours	85% per month	
								Analysis and evaluation of patient cases who exceed LOS by 10% to determine reasons.	Social Work will evaluate and analyze patient cases. Recommendations for improvement will go to the Director, Interprofessional Practice and Stroke and Neuro Patient Care Managers for scoping	% reviewed	50% cases reviewed by end of Q1	
								Implement process changes to decrease Stroke/Neuro Clinic wait times for internal inpatients	Change champion will implement and evaluate tactics. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly.	wait times in weeks for internal inpatients to the Stroke/Neuro Clinic	3 weeks by end of Q4	
								Welcome letter with Expected Date of Discharge (EDD) given to patients within 2 business days (Redesigned processes)	HIM will do monthly audits. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly.	Monthly audit: % welcome letter given	80% per month	
Integrated	Improve patient transition from Providence to home	Percent discharge summaries dictated and delivered to unit before patient discharged home	B4 Geriatric Rehab Unit	Hospital Collected Data/ 2014/15 Q3 YTD	73%	80%	10% improvement for fiscal year 2015/16	Redesign process to ensure physician dictates discharge summaries before patient discharged home	HIM will do monthly audits. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly.	% discharge summaries dictated by physician prior to discharge	90% per month	
								Decrease number of steps to deliver the discharge summaries to the unit (e.g. email instead of hand delivery)	HIM will do monthly audits. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly.	% decrease in number of steps	10% reduction in steps	
								Education on new process	Change champion will track attendance. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly.	% targeted staff educated and trained on new process	80% attended	
								Provide regular reports to MAC	HIM will provide monthly reports to MAC monthly	# times reports provided	once a month	

Quality dimension	Objective	Measure/ Indicator	Unit/ Population	Source/ Period	Current performance	Target for 2015/16	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas (2015/16)	Comments
Patient Centred	Improve night time experience	% positive response to noise level	B5 Ortho/Amp Unit	Hospital collected data/ Q3 2014/15	50%	55%	10% improvement for fiscal year 2015/16	Staff education session on promoting restful sleep	Change champion will track attendance. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly.	% evening and night-time staff participate in education session	80% by Q4	
								Environmental modifications- e.g. white noise machines	Change champion will track modifications. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly.	% patient rooms have been modified	50% by Q4	
								Patient surveys	Quality Improvement Manager will conduct surveys and analyze data monthly	% patients surveyed monthly	20% per month	
								Environmental sound levels	Change champion will check sound levels monthly	% reduction in sound levels	10% by end of Q4	
Access	Reduce wait times	Average wait time in days from referral to first visit	Assess and Restore/ Geriatric Medicine	Hospital collected data/ 2014/15 June to November	98	78	The target represents a 20% improvement. This target will be a snapshot at Q4	Reduce assessment and follow up time	Change champions will do monthly audits. Patient Care Manager will analyze and review data monthly. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly	% time team achieving assessment and follow-up time slots	Average of 80%	
								Streamline assessment forms from three to one	Change champions will do monthly audits. Patient Care Manager will analyze and review data monthly. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly	# of initial assessment forms	1 form	
								Expand clinic hours	Change champions will do monthly audits. Patient Care Manager will analyze and review data monthly. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly	% times clinic runs with new expanded hours	Average of 70%	
								Better align scope of practice	Change champions will do monthly audits. Patient Care Manager will analyze and review data monthly. Director, Quality and Process Improvement will review and report progress to Senior Management and Safety Quality Committee quarterly	% times duplication of information occurs between RN and MD	10%	

Let's Make Healthy Change Happen.

Appendix 6a

2015/16 Providence Healthcare Quality Improvement Plan (QIP) Narrative - Cardinal Ambrozic Houses of Providence

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2. **Best Community of Experts**: Employees, physicians and volunteers are experts and integral to achieving our Vision.
3. **Best Relationships Beyond Our Walls**: Sustainable partnerships support shared accountability for health outcomes and positive experiences for the people we care for.

In addition to our Strategic Plan, our QIP aligns with provincial priorities and other planning processes such as:

- Provincial and LHIN priorities including obligations contained within the Long-Term Care Accountability Service Agreement (L-SAA)
- Accreditation Canada Standards and Required Organization Practices (ROPs)
- Providence's "Quality and Safety Promise Plan"
- Providence's Operating Plan
- Toronto Central LHIN long term care indicator project
- Areas arising from the annual Resident and Family Satisfaction surveys
- Surge which is an on-line training program focusing on learning needs for long-term care staff
- Professional Practice- best practices across nursing and allied health professionals
- Organization-wide Incident Management System

For 2015-2016 the priorities in our QIP are to:

Measure	Baseline	Target	Target Justification
% of residents whose pressure ulcer that recently got worse	4.2%	3.9%	Improve by 7%
% of residents who were physically restrained (daily)	8.6%	8.0%	Improve by 7%
% of residents on antipsychotics without a diagnosis of psychosis	21.7%	20.6%	Improve by 5%
% of residents with worsening bladder control during a 90 day period	29.5%	26.5%	Improve by 10%
% of residents responding "always/usually" to the question "meal time is pleasurable"	76%	84%	Improve by 10%

1. **Reduce Worsening Pressure Ulcers (Safety)**
   Worsening pressure ulcers aligns with our philosophy of "do no harm". Promoting quality of life and preventing suffering are essential aspects of resident-centred care. While the causes of pressure ulcers can vary, early assessment, prevention and treatment are all essential if pressure ulcers incidence is to be reduced In the Houses. Our goal is to reduce pressure ulcers that recently got worse in order to improve our resident safety and experience.

2. **Reduce Restraint Utilization (Safety)**
   The Houses of Providence has a minimal restraint policy whereby restraints are only used as a last resort and for the shortest period of time when a resident is a risk of injury to themselves or others. The risk of restraints is clearly outlined in literature and alternative measures are tried prior to a restraint being used. Our goal is to further reduce the incidence of restraints while balancing the incidence of falls.

3. **Reduce antipsychotic utilization (Effectiveness)**
   Recent reports have highlighted the high rates of anti-psychotic use in long-term care homes in Ontario based on CIHI data. While the rate with the Houses of Providence is below the provincial average, we would like to further reduce utilization in order to implement medical best practices and improve resident and staff safety.

4. **Reduce worsening bladder control (Effectiveness)**
   Urinary incontinence can increase the risk of urinary tract infections and is a risk factor associated with the incidence of pressure ulcers. Regular toileting schedules and prompted voiding initiatives are part of the Continence and Bowel Management Program at the Houses of Providence. Improving continence enhances the self-esteem of residents and at the same time reduces the development of other negative outcomes; therefore a reduction in worsening bladder control remains an improvement focus.

5. **Improve receiving and utilizing feedback regarding resident experience and quality of life (Resident-Centred)**
   The Houses of Providence utilizes a Resident and Family Satisfaction Survey tool that is also used by a group of not-for-profit long-term care homes called the Alliance Group to elicit feedback on care and services provided by the home. Overall satisfaction responses were very positive however we strive to continuously improve. Based on the 2014 results, the goal is to improve the positive responses to the question "meal time is pleasurable".

Integration & Continuity of Care

The Houses of Providence continually works with system partners in developing and executing quality improvement initiatives to improve integration and continuity of care. Some examples of these quality initiatives include:

- Participation with a group of non-profit organizations representing approximately 5,000 beds in the Greater Toronto Area. This group focuses on sharing information, implementing best practices and benchmarking with each other to identify best performers.
- In keeping with the provincial focus of palliative/end of life programs, the Houses of Providence has collaborated with Hospice Ontario and Toronto East General Hospital (TEGH) on an Integrated Long-Term Care Project (I-LTC) to implement a Palliative/End of Life Program. The partnership with the (I-LTC) and the Nursing Led Outreach Team (NLOT) has assisted the Houses in reducing unnecessary Emergency Department visits.
- The Houses works collaboratively with a number of different partners to manage responsive behaviours. Partners include the Psychogeriatric Outreach Program (POP), the Behaviour Support Outreach Team (BSOT) at Baycrest Centre, the Alzheimers Society of Toronto and the Psychogeriatric Resource Consultant.
- Anti-microbial initiative – the Houses of Providence is working collaboratively with the hospital and TEGH to establish an anti-microbial stewardship sub-committee in keeping with Accreditation Canada's Required Organizational Practices.
- The Houses of Providence is fortunate to be a program within Providence Healthcare and therefore has access to diagnostic services such as X-ray and ultra-sound which contribute to the home's efforts to reduce unnecessary ED visits.
- The Enterostomal Therapist (ET) provides consulting services on pressure ulcer treatment for Stage 3 and greater pressure ulcers and has assisted in the development of the Pressure Ulcer Prevention Program.

Challenges, Risks & Mitigation Strategies

There are numerous challenges associated with implementing the QIP and sustaining the targets. Many of the challenges arise from the availability of resources, unpredictable funding, increasing acuity levels, including responsive behaviours, staffing ratios and access to timely data. Another challenge is unexpected/unplanned events such as outbreaks and pressures from other Ministries (i.e. The Ministry of Labour). Efforts are made to integrate improvements into existing routine practices, educate staff and increase staff accountability through the

development of staff champions for each improvement initiative. The Houses of Providence will try to further mitigate the risk by setting realistic targets given the changing resident population, staggering the achievement of targets and monitoring performance monthly through the Best Practice committee at the front-line staff level and through the Balanced Scorecard quarterly at the Quality, Risk and Safety Committee and at the Board.

Information Management Systems

The Houses of Providence uses a variety of information systems to understand resident needs, set targets and identify areas for improvement. Some of our clinical information management systems include clinical documentation (assessments, care planning and general charting), Incident Management, Medication Administration, Family and Resident satisfaction, Social Engagement, Pharmacy and Laboratory systems. By accessing data and monitoring performance, various working groups, clinicians, committees and leaders use this information to select indicators, set targets, monitor performance and change course if needed. Quality initiatives are planned and implemented when information shows the need for improvement or when current performance falls short of reaching target. In addition, Providence Healthcare will be developing a comprehensive Information Management/Information Technology (IM/IT) Supporting Plan to support our new Vision and Strategic Plan. We will continue to adopt other systems and technology to give clinicians and leadership access to the best available information to understand resident needs and inform future quality improvement initiatives.

Engagement of Clinical Staff & Broader Leadership

The Senior Management team drives many of the quality initiatives to ensure they align with the strategic goals of the organization and that they are adequately resourced. Once a need for an improvement is identified, an Executive Lead and an Implementation Lead is identified. A team is brought together to develop change ideas, performance metrics and a project plan. The Resident Experience Committee, Pharmacy and Therapeutics and Best Practices Committee report to the Quality and Safety Committee of the Houses. The chair then reports to the Quality, Safety and Risk Management Committee and the Safety and Quality Committee of the Board. These committees regularly review the performance of key quality initiatives through internal reports and the Balanced Scorecard. The QIP is recommended to the Board for approval by the Quality and Safety Committee of the Board.

Resident/Client Engagement

The Houses of Providence engages with residents and their caregivers in a number of ways which has assisted in the development of the Quality Improvement Plan. Family and Resident Council meetings are held on a regular basis and quality improvement is a standing item on the agenda. The draft QIP was discussed and feedback on change ideas was obtained at Council meetings. Resident and Family Satisfaction Surveys are conducted annually and results are compared with a group of homes called the Alliance Group. Results of the survey are discussed at Council meetings and at the Resident Experience Committee. Areas for improvement are identified and change ideas are brought forward for discussion. Three to four initiatives are chosen and they become part of the goals and objectives for the upcoming year.

Accountability Management

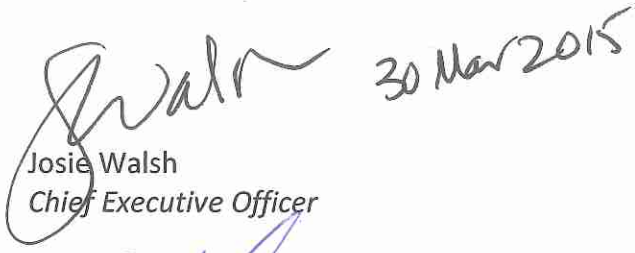
The Houses of Providence is part of the broader Providence Healthcare and organizationally there are a number of integrated reporting systems in place for which leadership is held accountable. For example there is one Balanced Scorecard representing Providence Hospital, Providence's Adult Day Program and the Houses of Providence. A robust reporting system is in place throughout the organization to address QIP indicator performance and achievement of targets. The Balanced Scorecard is reviewed quarterly at Senior Management and the Quality, Safety and Risk Committee, and presented to the Board's Safety and Quality Committee, as well as the full Board, along with a report outlining improvement strategies for indicators not meeting targets.

Other

The QIP Guidance Document for Ontario's Health Care Organizations outlines a set of priority QIP indicators for each sector. Organizations are expected to review the priority indicators for their sector and determine which are relevant for their organization. The Houses of Providence has reviewed the indicators and has chosen five indicators as areas for improvement.

Sign-off

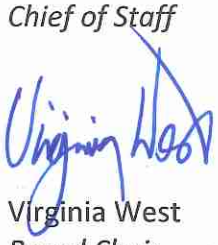
I have reviewed and approved our organization's Quality Improvement Plans



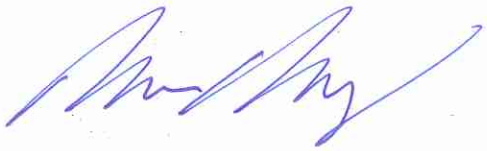
30 Mar 2015

Josie Walsh
Chief Executive Officer

Dr. Peter Nord
Chief of Staff



Virginia West
Board Chair



Mark Murphy
Quality Committee Chair

2015/16 Quality Improvement Plan for Long Term Care Homes - Cardinal Ambrozic Houses of Providence
"Improvement Targets and Initiatives"

Providence Healthcare 3276 St. Clair Avenue East, Toronto, ON

Appendix 6b

AIM		MEASURE						CHANGE				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit/ Population**	**Source/ Period**	**Current performance**	**Target for 2015/16**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas (2015-016)**	**Comments**
Safety	Reduce worsening of pressure ulcers	**Pressure ulcers:** Percentage of residents who had a pressure ulcer that recently got worse	Residents with existing Stage 2, or 3 pressure ulcers	Q2 FY 2014/2015, CCRS eReports (unadjusted)	4.2%	3.9%	The target represents a 7% improvement for fiscal year 2015/16 and ramp up to achieve an additional 10% improvement in 2016/17. The target is 3.9 % for fiscal year 2015/16 and 3.5% for fiscal year 2016/2017	1)Initiate a Program champion model for the Pressure Ulcer Prevention Program (PUP).	The DRC will create a checklist of responsibilities that align with the MOHLTC Inspection Protocols and the Long Term Care Homes Act. Responsibility for each requirement will be assigned to either the Management or Staff Champion as appropriate. The Management Champion will analyze and review the data quarterly. The Management Champion will present the data, analysis and trends quarterly at the Best Practice Meeting where areas of strength and additional areas for improvement will be discussed. The Management Champion will provide a progress update at the Quality and Safety meeting quarterly. The DRC will incorporate identified areas for improvement into the annual PUP Program Evaluation.	% of PUP "checklist tasks" completed as indicated on the annual PUP program evaluation.	80% checklist tasks" completed as indicated on the annual PUP program evaluation by Q3 2015/2016	
								2) Redesign high risk rounds.	The PUP management champion will set up a weekly schedule for high risk rounds. Registered staff will conduct high risk rounds using a specific template. Following rounds the registered staff on each unit will circulate the revised list of high risk residents to the all registered staff including the program champions. The Staff Champion will audit the care plans of high risk residents to ensure that interventions align with identifies interventions for the high risk residents.	% of houses conducting weekly high risk rounds.	80% of units conducting weekly high risk rounds by Q1 2015/2016	
								3) Equipment (electronic measuring and documentation tool-ZOOM) purchased and utilized to ensure accurate wound measurement.	The DRC will purchase the ZOOM electronic wound measurement and tracking tool from Cardinal Health. The company will provide a webinar for registered staff on the functionality of the tool. The program champions will implement the tool on a unit by unit basis until all staff are familiar with the operation of the tool. The Informatics Specialist will assist is setting up the report (generated by the tool) in Point Click Care. The Management Program Champion will report on worsening wounds monthly at the Best Practice Meeting.	% of residents with pressure ulcers (Stage 2 to 4) will have a wound assessment completed using the ZOOM tool.	60% of residents with pressure ulcers will have a wound assessment completed using the Zoom tool by Q4 2015/2016	
								4) Education refresh.	The Program champions will create a power point presentation on skin and wound care including the specific Houses protocols. The Quality coordinator will upload the presentation into Surge and assign to all direct care staff.	% of FT and PT staff will have completed the Pressure Ulcer Prevention inservice module in SURGE.	100% by Q4 2015/2016	

Quality dimension	Objective	Measure/Indicator	Unit/ Population	Source/ Period	Current performance	Target for 2015/16	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas (2015-016)	Comments
	Reduce use of restraints	**Restraints:** Percentage of residents who were physically restrained (daily)	All residents	Q2 FY 2014/2015, CCRS eReports (unadjusted)	8.6%	8.0%	Target represents a 7% improvement at fiscal year 2015/2016	1) Initiate a Program champion model for the Restraint Minimization and Personal Assistive Service Devices.	The Director of Resident Care will create a checklist of responsibilities that align with the MOHLTC Inspection Protocols and the Long Term Care Homes Act. Responsibility for each requirement will be assigned to either the Management or Staff Champion as appropriate. The Management Champion will analyze and review the data quarterly. The Management Champion will present the data, analysis and trends quarterly at the Best Practice Meeting where areas of strength and additional areas for improvement will be discussed. The Management Champion will provide a progress update at the Quality and Safety meeting quarterly. The DRC will incorporate identified areas for improvement into the annual Restraint and PASD Management Program Evaluation.	% of Restraint and PASD checklist tasks completed as indicated on the annual Restraint and PASD Management program evaluation.	80% of checklist tasks will be completed by Q4 2015/2016	We endeavour to balance restraint utilization and falls management
								2) Education refresh and roll-out.	The Director of Resident Care will arrange for Shopper's Drug Mart to provide education for Resident Assistants on proper application of seat belts for residents currently using restraints (e.g. seatbelts) . Managers will take attendance at inservices and the Quality Coordinator will enter the data in SURGE.	% of Full and Part time staff participating in either SURGE Minimizing Restraints or Shoppers demonstration.	100% of Full and Part time staff completed inservices by Q3 2015/2016	
								3) Ensure RAI-MDS coding reflects CIHI definitions which are different than the MOHLTC definitions.	The Informatics Specialist will check each resident in collaboration with nursing to determine if they would have been physically/cognitively unable to rise from any chair and if so they will be coded zero. (CIHI definition considers a tilted chair as a restraint regardless of intent which is different than the MOHLTC regulations).	% of residents using PASD are coded correctly in RAI-MDS.	100% of residents using PASD are coded correctly in RAI-MDS	
Effectiveness	Reduce antipsychotic utilization	**Antipsychotics:** Percentage of residents on antipsychotics without a diagnosis of psychosis	Residents on antipsychotics without a dx of hallucinations, Schizophrenia or Huntington's Disease	(Q2 FY 2014/2015, CCRS eReports (unadjusted)	21.7%	20.6%	Target represents a 5% improvement at fiscal year 2015/2016	1) Develop a sub-committee of the Pharmacy and Therapeutics committee to review best practices and resource materials specific to antipsychotic utilization by resident	Pharmacy and nursing will review two proposed forms, one that would be used when an resident is ordered an antipsychotic and a second one that would be used for monitoring the effects	The interprofessional team will review the forms and make an decision to implement or not.	Forms will be reviewed and a decision made to implement/or not by Q3 2015/2016	
	Reduce worsening bladder control	**Incontinence:** Percentage of residents with worsening bladder control during a 90-day period -	Residents who are not totally incontinent	Q2 FY 2014/2015, CCRS eReports (unadjusted)	29.5%	26.6%	Target represents a 10% improvement for fiscal year 2015/16 and ramp up to achieve an additional 5% improvement in 2016/17. The target is 26.6% for fiscal year 2015/16 and 25.1% for fiscal year 2016/17	1) Initiate a Program champion model for the Continence and Bowel Management Program	The Director of Resident Care will create a checklist of responsibilities that align with the MOHLTC Inspection Protocols and the Long Term Care Homes Act. Responsibility for each requirement will be assigned to either the Management or Staff Champion as appropriate. The Management Champion will analyze and review the data quarterly. The Management Champion will present the data, analysis and trends quarterly at the Best Practice Meeting where areas of strength and additional areas for improvement will be discussed. The Management Champion will provide a progress update at the Quality and Safety meeting quarterly. The DRC will incorporate identified areas for improvement into the annual Continence and Bowel Management Program Evaluation.	% residents with the right incontinent product as per assessment	80% of residents will have the right incontinent product as per the assessment by Q2 2015/2016	
								2) Institute electronic version of the Continence Assessment Record in Point Click Care.	Informatics Manager will load the electronic version of tool into Point Click Care. The Management Program champion will audit to ensure that the tool is completed for 5 days for new admissions. The Management Champion will collect and present the data, analysis and trends quarterly at the Best Practice Meeting where areas of strength and additional areas for improvement will be discussed. The Management Champion will provide a progress update at the Quality and Safety meeting quarterly.	% of new admissions with a completed voiding assessment completed for 5 days in point click care.	75% of new admissions will have a completed 5 day voiding record	

Quality dimension	Objective	Measure/Indicator	Unit/ Population	Source/ Period	Current performance	Target for 2015/16	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas (2015-016)	Comments
Resident- centred	Receiving and utilizing feedback regarding resident experience and quality of life	% of residents responding "Always/usually" to the question " meal time is pleasurable"	Residents with Cognitive Performance Scores of ≤3	2014 satisfaction survey results	76%	84%	Target represents a 10% improvement by fiscal year 2015/2016.	1)Partner with an academic partner	The Registered Dietitian will collaborate with Ryerson University to obtain two student placements to work on a pleasurable dining project.	# of dietitian student placements	2 dietitian student placements	
								2) Refresh the Breakfast Dining Program	Conduct spot baseline audits of the breakfast dining program project implemented in 2012. Each manager will conduct an audit of a pre-determined unit to determine the sustainability of the project, determine gaps and identify areas for improvement. The information will be shared with the pleasurable dining task force consisting of managers, dietitian and front line staff to establish a plan to sustain the gains achieved in 2012.	% of eligible residents at breakfast in the dining room	80% of eligible residents at breakfast in the dining room by Q1 2015/2016	
								3) Conduct focus groups - what elements contribute to pleasurable dining	The Quality Coordinator will conduct a minimum of 4 focus groups of front line staff, the Resident Experience Committee and other stakeholders to determine what elements of pleasurable dining are important and to elicit suggestions for improvement initiatives. The pleasurable dining task force will take the suggestions and test change ideas using a quality improvement methodology.	% of focus groups conducted	100% of focus groups conducted	

Hospital In-Patient Activity
Operating Plan 2015/16

Unit	Beds Staffed			# of cases Admitted			Average Length of Stay (ALOS)			% Occupancy		
	2013/14 Actual	2014/15 Forecast	2015/16 Budget	2013/14 Actual	2014/15 Forecast	2015/16 Budget	2013/14 Actual	2014/15 Forecast	2015/16 Budget	2013/14 Actual	2014/15 Forecast	2015/16 Budget
Stroke/Neuro	70	70	70	733	731	722	36.2	33.5	32.9	92.5%	93.5%	93.0%
Orthopaedics/ Amputee	74	70	70	789	842	946	34.4	27.9	25.1	94.1%	93.6%	93.0%
Geriatrics	70	70	70	840	861	929	29.7	27.4	25.6	91.9%	93.3%	93.0%
Pallative	35	35	35	283	235	260	43.0	50.6	45.7	89.8%	91.7%	93.0%
Providence Totals	**249**	**245**	**245**	**2,645**	**2,669**	**2,857**	**34.8**	**31.4**	**29.1**	**92.4%**	**93.2%**	**93.0%**

*2014/15 Rehab Admission forecast = 1,693
*2014/15 CCC Admission forecast =976

Unit	Weighted cases/days					
	2013/14 Weighted Cases Actual	2013/14 Weighted Days Actual	2014/15 Weighted Cases Forecast	2014/15 Weighted Days Forecast	2015/16 Weighted Cases Budget	2015/16 Weighted Days Budget
Stroke/Neuro	652	13,423	999	6,934	1,056	5,300
Orthopaedics/ Amputee	541	14,991	548	12,667	706	10,877
Geriatrics	387	15,899	492	12,997	594	12,359
Pallative		10,776		11,045		11,168
Providence Totals	**1,580**	**55,089**	**2,040**	**43,643**	**2,356**	**39,704**
Type of Beds	**Rehab**	**CCC**	**Rehab**	**CCC**	**Rehab**	**CCC**
Numbers of Beds	87	162	122	123	134	111

Quality Based Procedures (QBPs)	Cases				
	2012/13 Actual	2013/14 Actual	2014/15 Budget	2014/15 Forecast	2015/16 Budget
Hip	54	61	55	51	55
Knee	78	84	84	86	84
Bilateral			1	3	1
Hip Fracture					250
Stroke					300

Number of Admissions by Referring Hospital

	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Forecast	2015/16 Budget
ST MICHAEL'S	405	370	322	346	320	343
SUNNYBROOK	291	336	347	341	300	322
TORONTO EAST GENERAL HOSPITAL	350	339	366	367	294	314
THE SCARBOROUGH HOSPITAL	579	733	788	980	1,107	1,185
NORTH YORK	92	61	82	184	247	264
TCLHIN	357	329	326	427	195	209
NON-TCLHIN					111	119
Others (Home, Unknown)					95	101
Total	**2,074**	**2,168**	**2,231**	**2,645**	**2,669**	**2,857**

Number of Discharges by Destination

	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Forecast	2015/16 Budget
Home & Retirement Home	1,457	1,534	1,657	1,906	1,989	2,154
Houses of Providence & LTC	114	120	87	78	97	105
Acute Hospital	290	293	299	349	311	336
Rehab/CCC Hospital	5	10	15	10	8	9
Death	16	16	9	18	19	20
Other	1	2	3	1	-	-
Death on Palliative Care	207	211	185	265	215	232
Total	**2,090**	**2,186**	**2,255**	**2,627**	**2,639**	**2,857**

Percent Discharged home (excluding deaths)

	78.0%	**78.3%**	**80.4%**	**81.3%**	**82.7%**	**82.7%**

Average Length of Stay (ALOS)

	55.3	**47.7**	**43.9**	**34.8**	**31.4**	**29.1**

Providence Healthcare Out Patient Activity
Operating Plan 2015/16

Hospital OutPatient Clinics		Actual - Fiscal 2013/14		Forecast - Fiscal 2014/15		Budget - Fiscal 2015/16	
		# of Visits	# of Individuals Served	Total # of Visits	# of Individuals Served	Total # of Visits	# of Individuals Served
Assess & Restore Clinic	Clinic Medicine & Psychiatry	673	348	748	420	760	425
	Outreach	322	184	500	267	600	280
	Internal Consult-Medicine/Psychiatry	478	264	349	197	400	215
Geriatric Program Total		**1,473**	**796**	**1,597**	**884**	**1,760**	**920**
OutPatient Clinics	**Mobility**	5,032	521	4,740	539	4,659	532
	Stroke/Neuro	7,622	356	8,299	377	9,641	422
	Falls Prevention	195	30	2,402	212	2,575	210
Treatment Clinics Total		**12,849**	**907**	**15,442**	**1,128**	**16,875**	**1,164**
Specialized Clinics	Eye	398	295	348	265	350	270
	ENT	-	-	180	144	200	160
	Dermatology	184	104	196	119	100	60
	OTN e-consults	-	-	-	-	96	60
	Cardiology	78	47	98	58	100	60
	Pain	700	155	528	131	500	130
	Physical Medicine/Rehab	611	386	904	540	1,000	600
	Audiology	12	9	104	100	125	120
	Dental	331	124	380	127	380	130
Specialized Clinics Total		**2,314**	**1,120**	**2,738**	**1,484**	**2,851**	**1,590**
Integrated Healing Arts	Chiropractic	1,607	135	1,464	155	1,500	160
	Massage Therapy	272	90	301	103	300	100
	Chiropody	4,740	1,583	4,656	1,688	4,700	1,700
Integrated Healing Arts Total		**6,619**	**1,808**	**6,421**	**1,946**	**6,500**	**1,960**

Adult Day Program	Actual - Fiscal 2013/14		Forecast - Fiscal 2014/15		Budget - Fiscal 2015/16	
	# of Visits	# of Individuals Served	Total # of Visits	# of Individuals Served	Total # of Visits	# of Individuals Served
Day/Evening	8,850	292	9,120	278	9,000	320
Overnight	887	43	792	45	910	34
Enhance Adult Day Program (eADP)	2,537	65	2,650	66	2,500	50
Scotiabank Learning Centre - Caregivers	17,662	1,309	16,800	1,300	17,000	1,400
Adult Day Program Total	**29,936**	**1,709**	**29,362**	**1,689**	**29,410**	**1,804**

Houses of Providence
Residents Activity Stats for 2015/16

	Beds Staffed			# of Admissions			ALOS in years			% Occupancy			Patient Days			CMI		
	2013/14 Actual	2014/15 Forecast	2015/16 Budget	2013/14 Actual	2014/15 Forecast	2015/16 Budget	2013/14 Actual	2014/15 Forecast	2015/16 Budget	2013/14 Actual	2014/15 Forecast	2015/16 Budget	2013/14 Actual	2014/15 Forecast	2015/16 Budget	2013/14 Actual	2014/15 Forecast	2014/15 Budget
LTC	**288**	**288**	**288**	**66**	**64**	**70**	**3.7**	**3.8**	**3.7**	**97.6%**	**98.1%**	**98.0%**	**102,642**	**103,149**	**103,300**	**1.09**	**1.08**	**1.05**

Providence Healthcare
HSAA Indicators
Year Ending 31 March 2016

	FY14 Annual Performance Target	FY14 Annual Operating Plan Target	FY14 Annual Performance Standard	FY14 Annual Forecast	FY15 Annual Target
Global Volumes					
CCC - Weighted Patient Days	56,559	56,559	>52,034	43,643	39,704
Inpatient Rehabilitation - Weighted cases	1,514	1,514	>1,362	2,040	2,356
Ambulatory Care Visits - MD/RN	1,300	1,300	> 975	5,148	1,300
Quality Based Procedure indicators					
Inpatient rehab for primary hip	55	60	N/A	51	55
Inpatient rehab for primary knee	84	90	N/A	86	84
Inpatient rehab for bilateral knee	1	-	N/A	3	1
Outpatient rehab for primary hip	90	N/A	N/A	98	90
Outpatient rehab for primary knee	164	N/A	N/A	189	164
Patient Experience					
Rate of C-Diff	< .23	0.00	<.23	0.22	<.23
System Perspective Indicators					
ALC rate - CCC	15.2%		18.2%	22.0%	15.2%
ALC rate - Rehab	4.1%		8.4%	2.0%	4.1%
Performance Indicators					
Current Ratio	1.80	1.80	0.8 - 2.00	2.36	2.50
Total Hospital Margin	0%	0%	0.65	8.40%	0.00%
For Information purposes only					
Avg CCC staffed beds incl palliative		158		123	111
CCC patient days		53,057		41,407	37,782
CCC admissions		1,270		976	850
Avg Rehab staffed beds		87		122	134
Inpatient Rehabiliation - Patient days		29,215		41,947	45,611
Rehab admissions		1,120		1,693	1,650

Balanced Scorecard Summary

Providence Healthcare
Helping people. Healing lives.

Period Ended 2014/15 Q3 (Dec 31, 2014)

	Performance Indicator	Flag	Q3 Actual		Plan (Target)	Variance	YTD Actual	YTD Plan (Target)	YTD Variance	Annual Target for 2014/15	Annual Tolerance Limit 2014/15
Flow (Hospital)	Rehabilitation - Weighted Cases	H-SAA	579	↑	588	-9	1,488	1,504	-17	>=2,080	Red < 2,080 Yellow {2,080 - 2,184} Green >=2,184 HSAA Target: 1,200
	Complex Continuing Care - Weighted Days	H-SAA	10,141	↑	9,859	282	34,376	33,819	557	>=43,463	Red <43,463 Yellow {43,463 - 45,637} Green >=45,637
	Primary Hip Replacement - Rehab Cases	HSAA/ QBP	2	↓	14	-12	51	42	9	55	Red <50 or >60 Yellow {53 - 50} or {57 - 60} Green {54 - 56}
	Primary Knee Replacement - Rehab Cases	HSAA/ QBP	10	↓	21	-11	87	64	23	85	Red <80 or >90 Yellow {80 - 82} or {88-90} Green {83-87}
	% Patients Discharged Home		81%	↓	80%	0.8%	83%	80%	2.7%	>=80%	Red <80% Yellow {80% - 84%} Green >=84%
	ALC Patients (Snapshot)	HSAA	37	↑	34	3	Not Applicable			<=34	Red>34 Yellow in {32 - 34} Green <= 32
	Number of New Outpatients Per Week	QIP	18	↑	18	0	17	18	-1	>=18	Red <18 Yellow in {18-19} Green >=19
Quality (Hospital)	Providence acquired C.diff infection rate per 1,000 Patient Days	HSAA	0.19	↑	0	0.2	0.22	0	0.2	0	Red >0.23 Yellow {0 - 0.23} Green 0
	Number of Harmful Falls as Reported by Providence Incident forms	QIP	17	↓	18	-1	69	53	16	<=71	Red >71 Yellow {67-71} Green <=67
	Stage II or Greater Pressure Ulcer - Providence acquired - Harm		5	↓	0	5	14	0	14	0	Red >24 Yellow {0 - 24} Green 0
	FIM Efficiency on all beds (Except Palliative)	QIP	1.18	↓	1.15	0.03	1.17	1.15	0.02	>=1.15	Red <1.15 Yellow {1.15-1.2} Green >=1.2
	Average FIM score on Admission - all beds (Except Palliative)		67.8	↔	60±10	17.8	68.2	60±10	18.2	60±10	Red <40 or >80 Yellow{40-50} or {70-80} Green{50-70}
	% of patients who prior to leaving the hospital have an appointment booked with their Family Physician within 7 days of discharge (Start from Aug 2014)	QIP	90.6%	↑	76%	15%	86.9%	76%	11%	>76%	Red <76% Yellow{76%-81%} Green>81%
	% Positive Results on Question "I would recommend this hospital to my friends and family" -Inpatients and Outpatients		94%	↓	85%	9%	95%	85%	10%	>=85%	Red <85% Yellow {85%- 90%} Green >=90%
PALLIATIVE CARE (Hospital)	% of Patients Family contacted 3 weeks post death (Q2)		96%	↑	92%	4%	93%	92%	1%	92%	Red <92% Yellow {92% - 97%} Green >=97%
	% of patients days without pain or pain <4 using ESAS tool	QIP	87%	↑	76%	11%	81%	76%	5%	76%	Red <76% Yellow {76%-80%} Green >=80%

Balanced Scorecard Summary

Period Ended 2014/15 Q3 (Dec 31, 2014)

Providence Healthcare
Helping people. Healing lives.

	Performance Indicator		Flag	Q3 Actual		Plan (Target)	Variance	YTD Actual	YTD Plan (Target)	YTD Variance	Annual Target for 2014/15	Annual Tolerance Limit 2014/15
Houses of Providence	Providence acquired C.diff infection rate per 1,000 resident days			0.00	↓	0	0	0.05	0	0	0	Red >0.3 Yellow {0 - 0.3} Green 0
	Number of Harmful Falls as Reported by Providence Incident forms			39	↑	25	14	101	75	26	<=100	Red >100 Yellow {95 - 100} Green <= 95
	Percentage of residents who had a newly occurring stage 2 to 4 pressure ulcer (rolling 4 quarters as of Q2)				↔	See YTD		2.5%	2.6%	-0.1%	<=2.6%	Red > 2.6 % Yellow {2.5% - 2.6%} Green <= 2.5%
	Percentage of residents who had unexplained weight loss (rolling 4 quarters as of Q2)				↓	See YTD		4.9%	6.8%	-1.9%	<=6.8%	Red > 6.8 % Yellow {6.5% - 6.8%} Green <= 6.5%
	Percentage of residents whose pain worsened (rolling 4 quarters as of Q2)				↓	See YTD		8.6%	11.3%	-2.7%	<=11.3%	Red > 11.3 % Yellow {10.7% - 11.3%} Green <= 10.7%
	% Positive Results on Question "would you recommend the Houses of Providence to a family member or friend looking for LTC"			Annual Indicator - 2014 year end value shown				98%	85%	13%	>=85%	Red <85% Yellow in {85% - 90%} Green >= 90%
People	Annualized Paid Sick Days per Full Time Employee	Hospital		7.7	↑	7.0	0.7	6.4	7.0	-0.6	<=7	Red > 10.5 days (2011 Provincial Avg.) Yellow in {8 - 10.5} Green <= 8
		Houses		13.6	↑	10.0	3.6	10.2	10.0	0.2	<=10	
		Total		8.9	↑	8.0	0.9	7.2	8.0	-0.8	PHC Total: <=8	
	Annualized Education per Full Time Equivalent			3.5	↓	3.0	0.5	3.7	3.0	0.7	>=3 days	Red <3 Yellow {3 - 4} Green >=4
Future	Total Margin		H-SAA		↑	See YTD		8.40%	4.61%	3.79%	4.61%	Red<4.61% Yellow{4.61%-4.84%} Green >= 4.84%
	Pension Plan Solvency Position (Solvency Ratio)				↓	See YTD		98.2%	110%	-11.8%	>=110%	Red <100% Yellow {100% - 110%} Green >=110%
	Current Ratio		H-SAA		↑	See YTD		2.36	1.80	0.56	>=1.80	Red <1.80 Yellow (1.80-1.89) Green >=1.89
	% of Strategic Initiatives "On Target"				↓	See YTD		92%	90%	2%	>=90%	Red <90% Yellow {90% - 95%} Green >=95%

No Action Required
Watch
Action Required

Balanced Scorecard Summary

Providence Healthcare
Helping people. Healing lives.

Period Ended 2014/15 Q3 (Dec 31, 2014)

	Performance Indicator		Bd	Bd - Q	Bd - F	Definition	Target Source
Flow (Hospital)	Rehabilitation - Weighted Cases		✓	✓	✓	Number of Rehab weighted cases = # of discharged cases x Rehab Case Weight	OP Plan (higher standard than HSAA)
	Complex Continuing Care - Weighted Days		✓	✓	✓	Number of RUG weighted patient days = # of patient days x Average CMI (Average CMI based on most recent CIHI report)	HSAA & OP Plan
	Primary Hip Replacement - Rehab Cases		✓	✓	✓	Number of Primary Hip Replacement Cases in Rehab Beds	HSAA
	Primary Knee Replacement - Rehab Cases		✓	✓	✓	Number of Knee Replacement Cases in Rehab Beds	HSAA
	% Patients Discharged Home		✓	✓		Number of patients discharged home (Home + Retirement Home + Convalescent Care) divided by all discharges to external excluding deaths	Internal Target (higher standard than Provincial Average)
	ALC Patients (Snapshot)		✓	✓	✓	Snapshot of the # of ALC patients at the end of the quarter	HSAA
	Number of New Outpatients Per Week		✓	✓		Average Number of New Patients attending Stroke, Mobility and Falls Prevention Clinics per week Numerator = Sum of New Patients in the time frame Denominator = Number of Weeks in the time frame (Each Qrt has 13 weeks)	Internal Target
Quality	Providence acquired C.diff infection rate per 1,000 Patient Days		✓	✓		Numerator : # of Providence-acquired C.diff cases Denominator: Total # of patient days/1000	HSAA
	Number of Harmful Falls as Reported by Providence Incident forms		✓	✓		Number of falls with severity of Mild, Moderate, Severe or Death	QIP
	Stage II or Greater Pressure Ulcer - Providence acquired - Harm		✓	✓		Stage II or greater pressure ulcer discovered after admission or stage II or greater pressure ulcer that has worsened	Target is 0
	FIM Efficiency on all beds (Except Palliative)		✓	✓		The change in Total Function Score per day of client participation in the Rehab and CCC except Palliative. Calculated as change in Total FIM from Adm to Discharge divided by length of stay, where length of stay does not include ALC Days.	QIP
	Average FIM score on Admission - all beds (Except Palliative)		✓	✓		The average of the Total Function Score on admission for all patients except Palliative admitted in the reporting period.	TCLHIN peer average
	% of patients who prior to leaving the hospital have an appointment booked with their Family Physician within 7 days of discharge (Start from Aug 2014)		✓	✓		Process has not started yet.	QIP
	% Positive Results on Question "I would recommend this hospital to my friends and family" -Inpatients and Outpatients		✓	✓		Results for survey question: "I would recommend this hospital to my friends and family" number of positive responses divided by the total number of responses for inpatients and outpatients except palliative.	HQO
Palliative Care	% of Patients Family contacted 3 weeks post death (Q2)		✓	✓		Numerator : Family whom were contacted 3 weeks post death of patient (Including Voicemail) Denominator: Total # of patients passed away on A2-PAL	Internal Target
	% of patients days without pain or pain <4 using ESAS tool		✓	✓		Numerator: The # of patient days without pain or pain score below 4 Denominator: The total # of patient days on the Palliative unit	QIP
Houses of Providence	Providence acquired C.diff infection rate per 1,000 resident days		✓	✓		Numerator : # of Providence-acquired C.diff cases Denominator: Total # of patient days/1000	Target is 0
	Number of Harmful Falls as Reported by Providence Incident forms		✓	✓		Number of falls with severity of Mild, Moderate, Severe or Death	Target is 100
	Percentage of residents who had a newly occurring stage 2 to 4 pressure ulcer (rolling 4 quarters as of Q2)		✓	✓		Numerator: Residents who had a pressure ulcer at stage 2 to 4 on their target assessment and no pressure ulcer at stage 2 to 4 on their prior assessment Denominator: Residents with valid assessments, excluding those with stage 2 to 4 ulcers on their prior assessment	Provincial Average
	Percentage of residents who had unexplained weight loss		✓	✓		Accurate weights are critical to determining actual weight loss. Numerator: Residents with weight loss documented on their target assessment; Denominator: Residents with valid assessments, excluding end-of-life residents and those on a planned weight-loss program	Provincial Average
	Percentage of residents whose pain worsened		✓	✓		Numerator: Residents with greater pain (higher Pain Scale score) on their target assessment than on their prior assessment; Denominator: Residents with valid assessments whose pain symptoms could increase (did not have maximum Pain Scale score on prior assessment)	Provincial Average
	% Positive Results on Question "would you recommend the Houses of Providence to a family member or friend looking for LTC"		✓	✓		Numerator: Number of people responding "Definitely Yes" and "Possibly Yes" for the question "would you recommend the Houses of Providence to a family member or friend looking for LTC" Denominator: Number of survey respondents	Internal Target
People	Annualized Paid Sick Days per Full Time Employee	Hospital	✓		✓	Paid sick days per Full Time Employee for hospital, houses and PHC total.	Provincial Average
		Houses	✓		✓		Provincial Average
		Total	✓		✓		Provincial Average
	Annualized Education per Full Time Equivalent		✓		✓	Education per Full Time Equivalent (FTE)	Internal Target
Future	Total Margin		✓		✓	Operating surplus excluding net building amortization / total revenue	OP Plan (higher standard than HSAA)
	Pension Plan Solvency Position (Solvency Ratio)		✓		✓	Solvency Assets / Actuarial liability	Internal Target
	Current Ratio		✓		✓	Current Asset / Current Liability	OP Plan & HSAA
	% of Strategic Initiatives "On Target"		✓		✓	Number of strategic initiatives on target divided by the total number of strategic initiatives in Board approved operating plan	Internal Target

Providence Healthcare
Financial Budget - Analysis & Assumptions
Year Ending 31 March 2016

Hospital

MOHLTC revenues represent funding for the Hospital and for the Regional Geriatric and Psychogeriatric Programs within the Community Centre. These have been budgeted based on the assumption that there will be no inflationary increase in funding and no net change in HBAM/QBP funding.

Providence has anticipated a continuation in $145k in one-time MOHLTC funding for the Outpatient Geriatric Assess & Restore program and TCLHIN support for the Stroke/Msk Business Case Iniative at the same level as in 2014/15 ($932k).

Hospital Co-Payment revenue budgets have been increased by 1.4% based on a mid year increase from the MOHLTC and ALC copayment days similar to 2014/15. Preferred Revenues include proposed April 1 rate increases of 2% for Rehab services and reflect expected gains associated with our new Differential Coordinator role.

Other Inpatient & Outpatient revenues reflect income associated with Out of Country, Out of Province, WSIB & Refugee patients. Rates are driven by MOHLTC and are largely dependant on the mix of patients in any given year.

Recoveries Sales & Other revenues include Outpatient Pharmacy Recoveries, Rental & Parking income, Gift Shop sales and Community Centre recoveries. In general a 2-5% rate increase has been applied to these areas.
Outpatient Pharmacy revenues have been budgeted to achieve a breakeven position for this retail operation. Parking revenues are expected to benefit from the installation of a new payment and gate control system by early summer. Gift Shop sales have been reduced to reflect the closure of the Hospital Gift Shop.

Shared Service Recoveries reflect a revised shared service allocation developed by management and consistent with recommendations from our Auditors Ernst & Young.

Salaries & Benefits include expected Union & Non-Union pay increases. Additional costs beyond a cost of living increase include Employee Step Increases and $1m for specially funded positions (FIT, Stroke, etc).

Purchased Service budgets include an estimate of COLA increases for Security services.

Medical & Surgical Supplies, **Drugs & Medicine** and **Food & Dietary** budgets all reflect expected cost increases, which range from 2% to 4%, as identified by HealthPRO with offsets for a continued realisation of savings associated with annualization of prior years' bed reductions.

Housekeeping includes expected cost increases in Janitorial contract costs (currently in yr 3 of a 4-yr contract) & Waste Removal costs. Providence is currently negotiating a 1 Year extension of Laundry contracts with no expected increase in costs.

Repairs & Maintenance budgets remain in line with 14/15 budget and primarily reflect costs incurred by the IT and Major Maintenance departments. The it budget was adjusted downwards following a zero-based budget review. Forecasted expenditures for 14/15 include one time unbudgeted costs for roof repairs, installation of a new Tim Horton's kiosk, Storm & Roadside repairs which are not included in the budget for 15/16

Utilities budgets reflect increases in Water and Hydro rates with an offseting savings from Gas costs

Insurance budget reflects our expectation that there will be no increase in costs for 2015/16

Professional Fee budgets remain in line with the 2014/15 budget.

Other Supplies & Expenses represents Software License fees, General Department Supplies, Minor Equipment, Drug Costs for our Retail Pharmacy, Course Registration Costs & Membership Fees. This expense category also reflects savings from the review of the IT budget referred to above.

Houses of Providence

MOHLTC revenues are estimated to increase by 1.5% increase in per diem funding, a continuation of Physiotherapy funding and an increase in the funded CMI.

Houses of Providence Resident Payments include estimated mid year rate increases of 1.4%.

Other Inpatient & Outpatient revenues reflect recoveries for Footcare Services which are expected to remain in line with Forecast.

Grants from Providence Healthcare Foundation include approved funding of $600,000 from the Catholic Charities for calendar 2015 and 2016.

Recoveries Sales & Other represent Gift Shop sales and claims for High Intensity Need recoveries.

Salaries & Benefits include expected Union & Non-Union pay increases and the addition of 2.0 Resident Assistants positions against the special PSW funding envelope.

Purchased Service budgets include Physiotherapy costs which are now cashflowed by the TCLHIN.

Housekeeping includes expected 2- 3% increases in Janitorial costs.

The majority of non-salary costs for the Houses of Providence are typically allocated via a Shared Service or Corporate Service allocation from the Hospital. **Corporate Service Charges** are calculated at a rate of 6.5% of MOHLTC & Resident Revenues. **Shared Service Costs** previously based on the results of a Shared Service Review by Specialty Care in 2007, have been revised for the first year based on a recommendation by our auditors.

Adult Day Program

As is the norm, our Adult Day Program is required to operate at breakeven and our proposed budget reflects this.
No increase in funding is expected at this stage

Providence Healthcare
Consolidated Operating Statement
Year Ending 31 March 2016

	2013/14 Actuals	2014/15 Budget	2014/15 Forecast	2015/16 Budget
Toronto Central Local Health Integration Network/				
Ministry of Health & Long-Term Care				
Hospital	60,463,588	59,665,868	60,454,235	60,232,655
Houses Of Providence	12,663,024	13,013,577	13,852,631	13,410,561
Community Programs	1,705,548	1,852,741	1,836,120	1,836,120
Houses of Providence Resident Payments	6,481,338	6,668,372	6,546,789	6,737,844
Hospital Co-Payment & Preferred Accomodation	703,416	663,720	923,153	1,043,701
Other Inpatient & Outpatient	223,972	165,308	371,491	371,491
Grants From Providence Healthcare Foundation	679,556	640,000	680,000	640,000
Amort Of Deferred Capital Contributions	2,675,618	2,634,548	2,634,540	2,356,050
Recoveries Sales and Other	2,906,225	3,227,790	3,419,594	3,230,879
Total Revenues	**88,502,285**	**88,531,924**	**90,718,553**	**89,859,301**
Salaries and Wages	48,902,201	51,093,526	50,490,047	52,971,292
Employee Benefits	10,370,201	10,780,715	10,195,389	11,096,662
Pension Benefits	2,065,000	1,912,000	1,885,964	1,885,965
Purchased Services	1,022,602	1,007,906	1,092,608	1,081,067
Medical and Surgical Supplies	683,917	714,324	645,947	673,853
Drugs and Medicines	881,964	920,966	858,052	888,629
Food and Dietary Supplies	2,130,407	2,176,876	2,109,883	2,151,055
Housekeeping	2,648,487	2,618,624	2,703,412	2,800,960
Repairs and Maintenance	1,563,502	1,487,922	1,714,451	1,679,746
Utilities	1,948,737	2,001,663	1,909,317	1,978,565
Insurance	315,540	312,867	361,851	348,912
Community Support Service Fees	65,711	150,000	137,077	150,000
Professional and Other Fees	1,525,536	1,682,382	1,787,167	1,490,064
Other Supplies and Expenses	4,183,027	4,213,346	4,335,420	4,012,222
Amortization Of Capital Assets	4,787,002	5,197,839	4,854,325	4,675,757
Total Expenses	**83,093,834**	**86,270,956**	**85,080,909**	**87,884,750**
Operating Surplus/(Deficit)	**5,408,451**	**2,260,969**	**5,637,644**	**1,974,551**
Addback Depreciation	3,474,155	3,602,046	3,547,062	3,368,400
Deduct Amortisation	(2,329,434)	(2,337,748)	(2,337,744)	(2,087,642)
Total Margin $ - MOHLTC	**6,553,172**	**3,525,266**	**6,846,962**	**3,255,309**
Total Margin % - MOHLTC	7.60%	4.09%	7.75%	3.71%

Providence Healthcare
Consolidated Statement of Working Capital
Year Ending 31 March 2016

	2013/14 Actuals	2014/15 Budget	2014/15 Forecast	2015/16 Budget
MOHLTC Margin	6,553,172	3,525,266	6,846,962	3,255,309
Addback Restricted Cash offsetting Operating Expenses	27,847		169,785	
Addback Equipment Depreciation	1,312,847	1,595,793	1,307,263	1,307,357
Deduct Amortization of deferred grants	(346,184)	(296,800)	(296,796)	(268,408)
Cashflow from Operations	**7,547,682**	**4,824,259**	**8,027,214**	**4,294,258**
Internally Restricted Cash at Year End	(520,991)			
Prior Year Internally Restricted Cash Not Utilized	52,153			
Supplementary Pension payment	(2,935,000)	(2,596,259)	(2,596,259)	(2,591,259)
Post Employment Benefit adjustment	219,975	252,000	252,000	252,000
Capital Expenditures				
Information Technology	(463,234)	(1,380,000)	(821,730)	(850,000)
Amounts included in Operating Expenses	284,180	-	409,524	-
Capital Rollover			(60,000)	
Information Technology Rollover	(27,847)	(220,000)	(46,919)	(60,000)
Funded from Restricted Net Assets	27,847	220,000	46,919	60,000
Outpatient Project Rollover		(250,000)	(95,865)	(150,000)
Funded from Restricted Net Assets		250,000	95,865	150,000
Major Maintenance - Hospital	(635,235)	(813,000)	(724,042)	(810,000)
Amounts included in Operating Expenses	10,879	-	5,445	-
HIRF funding	41,563	63,000	30,000	60,000
Foundation funding	24,361	-	-	-
Capital Rollover			(90,000)	-
Palliative Unit Renovations	(203,780)	-		(2,375,000)
Foundation grant	200,000	-		2,375,000
Transformation by Design	(1,410,880)	-	(625,000)	(300,000)
Foundation grant	1,654,341	-	625,000	300,000
Non clinical	(52,928)	(50,000)	(39,680)	(55,000)
Foundation grant	-	-	-	-
MOH Funding	-	-	-	-
Clinical Equipment	(379,870)	(300,000)	(239,204)	(300,000)
Foundation grant	141,780	-		-
Amounts included in Operating Expenses	6,833		69,170	
Capital Rollover			(61,000)	
Clinical Equipment Rollover		(14,216)	(9,570)	(61,000)
Funded from Restricted Net Assets		14,216	9,570	61,000
Houses of Providence Equipment & Major Maintenanc	(231,043)	(250,000)	(165,987)	(250,000)
Amounts included in Operating Expenses	40,420		34,953	
Foundation grant	190,622	250,000	108,168	250,000
Net change in working capital	**3,581,827**	**0**	**4,138,572**	**0**
Opening Working Capital	5,542,943	9,124,770	9,124,770	13,263,342
Closing Working Capital	**9,124,770**	**9,124,770**	**13,263,342**	**13,263,342**

Providence Healthcare
Hospital Operating Statement
Year Ending 31 March 2016

	2013/14 Actuals	2014/15 Budget	2014/15 Forecast	2015/16 Budget
Toronto Central Local Health Integration Network/ Ministry of Health & Long-Term Care				
Hospital	60,463,588	59,665,868	60,454,235	60,232,655
Hospital Co-Payment & Preferred Accomodation	703,416	663,720	923,153	1,043,701
Other Inpatient & Outpatient	208,352	150,308	357,704	357,704
Grants From Providence Healthcare Foundation	36,043	40,000	40,000	40,000
Amort of Deferred Capital Contributions	883,514	835,154	835,152	856,547
Recoveries Sales and Other	2,481,811	2,712,547	2,625,177	2,743,599
Corporate Service Charge	1,372,703	1,399,023	1,400,895	1,428,551
Recoveries Shared Services	3,624,569	3,995,182	4,564,335	4,150,081
Total Revenues	**69,773,996**	**69,461,801**	**71,200,651**	**70,852,838**
Salaries and Wages	37,380,694	39,121,133	38,280,503	40,772,371
Employee Benefits	7,526,748	7,723,260	7,169,875	8,108,305
Pension Benefits	1,463,547	1,506,147	1,480,119	1,480,119
Purchased Services	814,912	754,472	793,993	809,166
Medical and Surgical Supplies	517,747	537,189	485,175	498,859
Drugs and Medicines	877,888	914,365	855,273	885,795
Food and Dietary Supplies	1,999,266	2,037,293	1,970,371	2,011,162
Housekeeping	1,693,769	1,667,463	1,696,663	1,782,112
Repairs and Maintenance	1,563,169	1,486,615	1,714,451	1,679,746
Utilities	1,948,737	2,001,663	1,909,317	1,978,565
Insurance	315,540	312,867	361,851	348,912
Professional and Other Fees	1,459,989	1,642,382	1,719,943	1,450,064
Community Support Service Fees	65,711	150,000	137,077	150,000
Other Supplies and Expenses	3,825,650	3,999,333	4,037,840	3,790,457
Amortization Of Capital Assets	2,876,065	3,285,209	2,937,748	3,026,069
Total Expenses	**64,329,432**	**67,139,393**	**65,550,198**	**68,771,702**
Operating Surplus/(Deficit)	**5,444,564**	**2,322,408**	**5,650,453**	**2,081,136**
Addback Depreciation	1,738,262	1,861,876	1,805,064	1,862,334
Deduct Amortisation	(671,425)	(659,018)	(659,016)	(688,161)
Gross Margin $ - MOHLTC	**6,511,401**	**3,525,266**	**6,796,501**	**3,255,309**
Total Margin % - MOHLTC	9.42%	5.12%	9.63%	4.64%

Providence Healthcare
Houses of Providence Operating Statement
Year Ending 31 March 2016

	2013/14 Actuals	2014/15 Budget	2014/15 Forecast	2015/16 Budget
Toronto Central Local Health Integration Network/ Ministry of Health & Long-Term Care				
Houses Of Providence	12,663,024	13,013,577	13,852,631	13,410,561
Houses Of Providence Resident Payments	6,481,338	6,668,372	6,546,789	6,737,844
Other Inpatient & Outpatient	15,620	15,000	13,787	13,787
Grants From Providence Healthcare Foundation	643,513	600,000	640,000	600,000
Amort of Deferred Capital Contributions	1,680,487	1,688,975	1,688,964	1,395,314
Recoveries Sales and Other	181,360	166,721	501,252	137,522
Total Revenues	**21,665,342**	**22,152,645**	**23,243,423**	**22,295,028**
Salaries and Wages	10,237,886	10,522,190	10,753,631	10,718,071
Employee Benefits	2,586,796	2,764,498	2,720,365	2,672,492
Pension Benefits	542,364	371,707	371,703	371,703
Purchased Services	177,356	225,097	286,361	259,920
Medical and Surgical Supplies	160,512	169,843	158,056	173,242
Drugs and Medicines	3,828	3,687	2,779	2,834
Food and Dietary Supplies	41,083	40,672	48,455	47,518
Housekeeping	939,814	934,502	996,091	1,005,609
Laundry and Linen				
Repairs and Maintenance	333	1,307	-	-
Professional and Other Fees	65,547	40,000	67,224	40,000
Other Supplies and Expenses	251,264	111,837	205,321	122,614
Amortization Of Capital Assets	1,790,778	1,802,123	1,804,727	1,543,573
Shared Service Costs	3,606,420	3,945,520	4,545,824	4,131,569
Corporate Service Charge	1,266,208	1,281,014	1,282,887	1,310,542
Total Expenses	**21,670,189**	**22,213,998**	**23,243,423**	**22,399,687**
Operating Surplus/(Deficit)	**(4,847)**	**(61,353)**	**0**	**(104,659)**
Addback Depreciation	1,615,734	1,629,664	1,630,148	1,399,951
Deduct Amortisation	(1,546,392)	(1,568,311)	(1,568,304)	(1,295,292)
Total Margin $ - MOHLTC	**64,495**	**0**	**61,844**	**-**
Total Margin % - MOHLTC	0.32%	0.00%	0.29%	0.00%

Providence Healthcare
Adult Day Program Operating Statement
Year Ending 31 March 2016

	2013/14 Actuals	2014/15 Budget	2014/15 Forecast	2015/16 Budget
Toronto Central Local Health Integration Network/ Ministry of Health & Long-Term Care				
Community Programs	1,705,548	1,852,741	1,836,120	1,836,120
Amort Of Deferred Capital Contributions	111,617	110,419	110,424	104,189
Recoveries Sales and Other	243,054	348,523	293,165	349,758
Total Revenues	**2,060,219**	**2,311,683**	**2,239,709**	**2,290,067**
Salaries and Wages	1,283,621	1,450,203	1,455,913	1,480,850
Employee Benefits	256,657	292,957	305,149	315,865
Pension Benefits	59,089	34,146	34,143	34,143
Purchased Services	30,334	28,337	12,253	11,981
Medical and Surgical Supplies	5,658	7,291	2,716	1,752
Drugs and Medicines	248	2,914	-	-
Food and Dietary Supplies	90,058	98,910	91,057	92,375
Housekeeping	14,904	16,660	10,659	13,239
Repairs and Maintenance	-	-	-	-
Other Supplies and Expenses	106,113	102,175	92,259	99,151
Amortization Of Capital Assets	120,159	110,506	111,850	106,115
Shared Service Costs	18,149	49,662	18,511	18,512
Corporate Service Charge	106,495	118,009	118,008	118,009
Total Expenses	**2,091,485**	**2,311,770**	**2,252,518**	**2,291,993**
Operating Surplus/(Deficit)	**(31,266)**	**(87)**	**(12,809)**	**(1,926)**
Addback Depreciation	120,159	110,506	111,850	106,115
Deduct Amortisation	(111,617)	(110,419)	(110,424)	(104,189)
Total Margin $ - MOHLTC	**(22,724)**	**0**	**(11,383)**	**0**
Total Margin % - MOHLTC	-1.17%	0.00%	-6.23%	0.00%

Providence Healthcare
Clinical & Non-Clinical Equipment Capital Plan
Year Ending 31 March 2016

Clinical Equipment	2014/15 Budget
Bladder Scanner With Stand	12,995
Whole Body Range Of Motion Exercise Device	3,995
30 In. Bariatric Wheelchair	5,342
Raz Ap Bariatric Wheeled Commode (Attendant Propelled)	1,922
Chg Spirit One Bariatric Bed	17,837
Bariatric Mattress System	13,180
Bariatric Hi-Lo Table	20,195
Haag Streit Observer Tube With Eyepiece Opthalmology Clinic	3,764
Haag Streit Beam Splitter Opthalmology Clinic	2,635
Four Bay Cassette Transfer Cart	14,584
Electric Low Beds For Patient Use/ With Specialty Surface Mattress (11)	99,000
Mechanical Lift With (1) Sit Stand Lift (1 Per Level)	45,000
Portacount- Mask Fitting Machine	15,104
Contingency	44,448
	300,000

Non - Clinical Equipment		Budget
Pot Washer	Kitchens	55,000
		55,000

Providence Healthcare
Hospital Major Maintenance Multi Year Capital Plan
Year Ending 31 March 2016

	2014/15 Budget	2014/15 Forecast	2015/16 Budget	2016/17 Plan	2017/18 Plan	2018/19 Plan
Strategic Remodelling						
Transformation by Design	-		300,000	350,000	-	-
Palliative Unit Renovations D1/D3	1,250,000	625,000	2,375,000	1,300,000	-	-
Knowledge Centre			-	-	2,300,000	200,000
Total Costs	**1,250,000**	**625,000**	**2,675,000**	**1,650,000**	**2,300,000**	**200,000**
Foundation Funding	**(1,250,000)**	**(625,000)**	**(2,675,000)**	**(1,650,000)**	**(2,300,000)**	**(200,000)**
	-	-	-	-	-	-
Hospital Major Maintenance						
Sprinkler Project **	300,000	300,000				
Seasons Café Upgrade - Lounge Upgrade & Furniture			80,000			
Seasons Café Upgrade - Servery			50,000			
Asphalt Walkway - Whimsical/St George Garden Path			25,000			
Chaplain Bathroom Renovation			5,000			
Rest Benches/Way Finding						
Chapel - Assess & Repair			20,000			
Addressable Fire Alarm System			155,000	500,000		
Chiller Replacement					500,000	500,000
Door Replacement, Hospital	10,000	10,000				
Roof Replacement					150,000	150,000
Exterior Signage (Hospital, Houses, Clinics)	10,000	-				
Underground Storage Tanks	75,000	65,969				
Elevator Controls Upgrade	150,000	-				
Elevator Controls Upgrade # 3			30,000			
Elevator Controls Upgrade # 4			180,000			
Auditorium Lighting	30,000	20,755				
Auditorium Tech Upgrade	23,000	22,000				
Door Access Documed	7,000	7,000				
Admitting Redesign	50,000	50,000				
Air Curtain Clinics Outpatient Entrance	10,000	15,285				
High Pressure Steam Upgrades			75,000			
Maintenance Master Plan			50,000			
Hospital Lounge Furniture 2nd & 3rd Floor			40,000	150,000	150,000	150,000
Stairwell Fixtures			10,000			
Contingency	85,000	203,033	30,000	100,000	100,000	100,000
K Wing Projects	63,000	30,000	60,000	40,000	40,000	40,000
Total Expenditure	**813,000**	**724,042**	**810,000**	**790,000**	**940,000**	**940,000**
Less Amounts Included in Operating Expenses		(5,445)				
Less Funding	(63,000)	(40,873)	(60,000)	(40,000)	(40,000)	(40,000)
	750,000	**683,169**	**750,000**	**750,000**	**900,000**	**900,000**

** PLUS an additional Special Working Capital Appropriation Request of $300,000 for Remaining Sprinkler system (chapel excluded)

Providence Healthcare
Houses of Providence Equipment & Major Maintenance Multi Year Capital Plan
Year Ending 31 March 2016

	2014/15 Budget	2014/15 Forecast	2015/16 Budget	2016/17 Plan	2017/18 Plan	2018/19 Plan
Equipment						
Minigens Retherm Oven	13,875	13,197				
Spa - easy access tub and shower lift chair	29,125					
Hi Low beds + mattress (3)	7,000					
Food Service Equipment					20,000	
Bariatric Equipment			20,000			
Bed Replacement+ Mattresses (43)			75,000			
Contingency		22,867	5,000	50,000	50,000	50,000
Total Equipment	**50,000**	**36,064**	**100,000**	**50,000**	**70,000**	**50,000**
Houses Major Maintenance						
Furniture & Fittings						
Carpet replacement, corridors	60,000	67,539	60,000			
Resident Furniture	20,000	20,008	20,000	20,000	20,000	
Houses living room furniture	20,000	18,244	20,000	20,000		
Spa Floors/Spa room refurbishing	20,000			20,000	-	
Wood refurbishing	10,000			10,000	-	10,000
Exterior Furnishings					25,000	
Building						
Controls Upgrades	47,000	40,098				50,000
Washroom Millwork	7,000			40,000	45,000	40,000
Servery Millwork	10,000			10,000	10,000	
Toilet Replacement	6,000					
Parking Repairs			20,000	10,000	40,000	
VFD & Actuator Replacements				10,000	10,000	
Tree Replacement			10,000			
Boiler Gas Exhaust Redesign			20,000			
Painting				30,000		
Major Mechanical						50,000
Exterior Works				30,000		50,000
Lighting Exterior					30,000	
Total Maintenance	**200,000**	**145,889**	**150,000**	**200,000**	**180,000**	**200,000**
Total Equipment & Maintenance	**250,000**	**181,953**	**250,000**	**250,000**	**250,000**	**250,000**
Included in Operating Expenses		**(34,953)**				
Funding	**(250,000)**	**(124,133)**	**(250,000)**	**(250,000)**	**(250,000)**	**(250,000)**
	-	**22,867**	**-**	**-**	**-**	**-**

Providence Healthcare
ICT Capital Plan
Year Ending 31 March 2016

	2014/15 Budget	2014/15 Forecast	2015/16 Budget
Electronic Health Record Reserve	**500,000**	**-**	**-**
Provincial & LHIN Initiatives	**50,000**	**10,000**	**50,000**
Organisation Strategy, Infrastructure & Other			
IM Supporting Plan Development			100,000
Service Desk Upgrades			12,000
Infrastructure Upgrades			75,000
Server Upgrade - File			20,000
Server Upgrade - Exchange			50,000
Switch Upgrades - A wing			25,000
MDM and Mobile Device Upgrade			45,000
Two Factor Authentication			10,000
Test environment for Decision Support			15,000
iPads for Clinical Areas			10,000
Pharmacy Accessory Label Printing			5,000
Merging inventory dictionary project			10,500
UPS for Xray Machine			2,000
TEGH diagnostics software upgrade			15,000
OTN hardware			25,000
Learning Management System			80,000
Community Information Management System – ADP/SBLC			35,000
Intranet Optimization			35,000
PAF Dev and Process Improvement			1,000
Employee Incident Form			1,000
Tim Horton's Signage			2,500
Patient Kiosk			70,000
Automated mass calling solution			10,000
Device refresh & Infrastructure Upgrades	100,000	100,000	
SAN Replacement	276,500	257,595	
Learning & Development Software	5,000	6,165	
Meditech Optimization - CWS	60,000	522	
Firewall Upgrade	40,000	60,000	
Smartprint - Printing/Reporting Solution	12,000	12,227	
PHA Meddispense Interface (Palliative)	22,000	21,593	
ATP Meddispense Interface (Pm Cupboard)	4,500	3,955	
Alaris Pumps Wi-Fi	35,000	39,544	
Just In Time - Materials Management	35,000	36,160	
Internet Refresh	30,000	37,121	
Vocera - Porters And Ward Aides	5,000	5,000	
Communications For Maintenance/Security	30,000	26,697	
Houses - Down Time Process/Printer Refresh	10,000	10,151	
Houses - Vocera	80,000	110,000	
Board Portal	10,000	10,000	
Contingency	75,000	75,000	146,000
Less Amounts Included in Operating		(409,524)	
	1,380,000	412,207	850,000