Report of NHS Review of HIP Implementation Issues

Meetings April 19-21, 2010

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Executive Summary

After the review by Dr. Kitts of the original HIP there were a few concerns expressed by the team as to the proposed primary location of some clinical services particularly Urology.

There were also decisions to be made as to the location of some clinical service's out patient surgical activity.

Meetings were held with key physician leaders and administrative leaders and support personnel.

It was not the intent to open the full HIP to a review nor should it be done. However, the following are recommendations directly related to clinical services that still needed some conclusions as to where all or part of their clinical services would be located.

Recommendations

1. Urology in-patient services at St. Catherines and out-patient at Welland.
2. Gynecology surgery in-patient at St. Catherines and out-patient at Welland.
3. All obstetrics at St. Catherines .
4. Welland orthopedics, as in the original HIP, to move to GNG.
5. General surgery and medicine in-patient beds to remain at Welland.

Purpose of Review:

The purpose of the engagement was to review and make recommendations for potential modifications to configuration of surgical services at NHS as identified in the Hospital Improvement Plan (HIP)

Background:

The NHS is committed to implementing a clinical services model that will provide the best quality of care for residents of the Niagara region. The HIP proposed a number of changes to surgical services. In the review of the HIP, DR. Kitts and his team provided advice that further review and discussion was required to finalize interdependencies and on call requirements between other services within the NHS prior to implementation. Further, the NHS committed to dialogue transparently and openly with physicians during the implementation process to address any outstanding concerns regarding the HIP.

Project Objectives

1. To review the current and HIP proposed configuration of surgical services
2. To determine the optimal allocation/configuration of surgical services to meet the needs of residents of Niagara within the parameters of the planning assumptions

Project Outcomes

1. An agreed upon configuration of Surgical services to be implemented at the 3 large hospital sites prior to October 2012

Scope:

In scope

- General Surgery
- Gynecological Surgery
- Orthopedic Surgery
- Urology

Out of scope

- Ophthalmology
- Dental Surgery
- Plastic Surgery

Planning Principles/Assumptions

1. Any planning scenarios put forward with modifications must be consistent with the planning principles, assumptions and decision matrix as outlined in the HIP .
2. The Greater Niagara General Hospital Master Plan must be taken into consideration.
3. There must be sufficient surgical volume at each site to support Emergency Department coverage 24/7
4. Ophthalmology will consolidate at the Welland site
5. Each of the large sites must have a "Centre of Excellence"

The Terms of Reference for the engagement are appended hereto.

Meetings were held with these Physician Leads

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At almost all meetings there was appropriate administrative attendance
and others.

Issue Identification

Through the meetings outlined above, the following issues were identified;

1. Importance of maintaining enough clinical work to support the anesthesia department and the emergency department at the Welland site.
2. Recognition that the new St. Catharines site cannot accommodate all gynecological services within the operating rooms on the maternal/child unit.
3. Recognition that some original recommendations within the HIP caused concern with physicians regarding the practicality of implementation from an individual physician practice perspective.
4. Physicians ideally should not have in patients at the same time at two in-patient sites.
5. The recognition that the major clinical services will continue to be organized as indicated in the original HIP.

The following recommendations reflect the discussion arising from the individual meetings outlined above. Although there was support

for the recommendations at the service level, further discussion will need to take place between services.

RECOMMENDATIONS:

Welland Site

Anesthesia

There was an understanding that ideally they should be enough clinical work for four and preferably five full-time anesthesiologists at this site.

Anesthesiologists would be encouraged but not mandated to work at other sites. There was an expressed willingness by the anesthesia leadership that some anesthesiologists would do surgical lists at other sites. This was particularly for those who wanted to maintain their skills in certain subspecialty areas of anesthesia such as pediatrics or obstetrics that would not be available at their home site.

Taking call at another site, particularly when necessary due to uncovered nights would be encouraged to but not mandated. The use of on call stipends to encourage mobility is not appropriate.

Emergency physicians and department

It is important that the number of patients seen in at the Welland site emergency exceed 25,000 visits. If the number of visits falls below this number it will have a significant financial impact on the physicians.

Presently there are over 26,000 patient visits and it is anticipated with the continuing shortage of physicians in this area that if anything the number of visits to the Welland site emergency will increase over time.

It is important that the physicians within the emergency department at the Welland site are appropriately certified with similar credentials as at the other two sites, and capable of seeing efficiently the appropriate number of patients in an emergency room.

Regional Clinical Services

Maternal Child / out patient Gynecology Surgery

Maternal Child in-patient will be exclusively situated at the new St. Catharines site. However, there is recognition that there is a not enough capacity at the St. Catharines site to perform all outpatient gynecology surgery on the maternal/child unit. It was agreed that the solution to this was to situate outpatient gynecological surgery at the Welland site.

Obstetrics would be at the new St. Catharines site and probably the physician on-call schedule would change with one physician on call exclusively for 12 or 24 hour shifts. Inpatient gynecology surgery would be done at the St. Catharines site.

It is probable in the future that some obstetricians later into their careers will only do gynecology.

Urology

After further observations it was agreed that in-patient urological surgery should be coordinated as follows:

- **In-patient Urology: St Catharines site**
- **Ambulatory Urology Surgery (with anesthesia): One Site** (WHS)
- **Ambulatory Clinics: At all major 3 sites (cystoscopy, vasectomy, BCGs, etc.)**

This new configuration continues to provide a centre of excellence for day surgery urological procedures at the Welland site, but provides a more practical coverage model for physicians and coverage to all three sites through provision of clinics.

Orthopedics

As stated in the original HIP orthopedic surgery at the Welland site should be moved to the Greater Niagara General site to create a Center of Excellence. This move would provide the following benefits:

1. A larger concentration (7) of surgeons allows the creation of less frequent call for each surgeon and therefore a better lifestyle .
2. The ability to look seriously at creating a trauma room for urgent surgery to do cases that can be done during the day instead of the evening and nights. This room is for not only orthopedic surgery but other surgical services.
3. To respond to the increased graduation of sub specialty orthopedic surgeons, a core group of at least seven surgeons at the GNG site would allow sub-specialization that could be encouraged and managed appropriately.
4. This move would benefit from the planned upgrade of surgical facilities at GNG.

General Surgery

In-patient General Surgery services would be available 24 / 7 at the three in-patient sites.

Other issues that need to be addressed

1. ***Scope of dentistry at GNG.*** There was a feeling that the scope and amount of dental surgery performed at this site should be reviewed.
2. ***Ongoing on-call consultants response***- At some sites and with in some specialties there was, expressed by several physician leaders, the concern that there is a failure to respond by the on-call specialist when requested by the emergency department or for in-house consultations. This is the situation, if it is true, that needs to be addressed and corrected immediately.
3. ***On-call responsibilities*** -- It is important that when physicians are on call that they understand their responsibilities, particularly the scope of their responsibilities and what the expectations are if they are receiving HOCC on call stipends.
4. ***Access to hospital resources*** -- There is an understanding that access to hospital resources, including the operating room, is directly related to the physician's hospital privileges and responsibilities such as taking call. There will need to be a review, for example, with the physician when there is a reduction of their on call responsibilities for any reason. With this review serious consideration must be given to reducing their present access to hospital resources such as reducing their existing operating time.
5. ***Pediatric services*** -- A review of pediatric services was out of the scope of this review. However, based on discussions that took place during the perioperative meetings, what age would be used to define a pediatric patient within the surgical service was raised as a

concern. The age of a pediatric patient must be decided to address which pediatric services would be provided at the other sites other than the primary pediatric site at the St. Catharines site. Some hospitals in Ontario have a maximum age of 18 for a pediatric patient but other hospitals in Ontario will see patients age 13 and over as adults at the adult hospital. This pediatric age issue needs to be addressed by the stakeholders.

Other observations

1. The Welland site would be the site of most outpatient surgery and as such an efficient excellent outpatient surgical facility and viable for the long term.
2. Other sites would continue to do out patient surgery albeit on a much smaller scale. Appropriate surgical equipment would be needed at these sites. One of a kind expensive equipment would be at only one site.
. 3. During these meetings and a review of present surgical data indicated that these proposed moves were possible within infrastructure but more detailed planning needs to be undertaken working with medical departments. .
4. As a result of any service realignment, NHS physicians, including anesthesiologists, should have access to hospital resources in order to make reasonable comparable specialty incomes – a physician should not be disadvantaged. Once services are realigned, medical departments must realign their service provision model including physician resources accordingly to provide a regional service.

5. Physicians should have the ability to work at other sites to maintain their skills in a subspecialty area. However, it is recognized that in the future in some specialties there will be the development of increasing concentration of individual physicians' subspecialty skills.
6. The provision of internal medicine services needs to be addressed as to the scope of services at each site, the MRP status and responsibility , recruitment and interaction with hospitalists.
7. Once the HIP is fully implemented, transportation will continue to be an issue in the absence of an inter-municipal transportation system and the NHS should look carefully at the feasibility of creating an inter site transportation system.
8. An algorithm should be developed to help in the decision of which service a patient from emergency should be admitted to. This is a particular issue with the hospitalist service and their ability to manage or not very sick patients . There should be a 24/7 dispute resolution process for those unusual cases where there is conflict as to which service should admit the patient.
9. Inter site ED-to-ED or UCC-to-ED patient transfers for inpatient admission or consults should be direct and seamless and not require routine triage/reassessment at the receiving sites ED with the understanding that a transfer of accountability between care providers has occurred
10. Admit-no-bed is an on going issue that should be reviewed on a regular basis particularly for the need to create appropriate policies.
11. 24/7 on call support for the Fort Erie and Port Colborne sites should be clearly identified.

12. Availability of after hour consultant services within an appropriate response time needs to be addressed with consistent similar expectations at all appropriate sites.
13. The type of clinics to be provided at sites, if any, will have to studied.
14. These proposed recommendations if implemented, along with the HIP, will require a strong ongoing communication plan.
15. A robust manpower and recruitment plan with appropriate resources needs to be established to ensure the recruitment of the best physicians to NHS.
16. Specialists and consultants who are on call for any site should have the required equipment to provide adequate services when appropriate . At times there is an expectation that some patients will need to be transferred to another site, that site better equipped to handle more complicated illnesses.