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AHW RHA Efficiency Review
Aspen Regional Health Authority

Governance and Accountability Overview

Final Report

July 14, 2006

Audit. Tax. Consulting. Financial Advisory.

Governance and Accountability Overview

Key Components of Governance and Accountability

- The province of Alberta uses a four part accountability framework that includes: 1) a three year Health Plan; 2) Annual Business Plans; 3) Quarterly Performance Reports; and 4) Annual Reports. This framework is to promote:
  - Governance and management of the health region
  - Accountability to the Minister
  - Keeping the public informed
- For this assessment, Deloitte has focused on the three year health plan and the most recent Annual Business Plan to assess the degree to which there is demonstrable evidence that the direction is cascading to the operational level.
- In addition, Deloitte has applied a high level assessment of the Board's role related to:
  - Responsibilities and mandate
  - Structure and organization
  - Processes and information
  - Performance assessment and accountability
  - Organizational culture

ARHA Three-Year and Annual Plan

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Aspen's strategies (2005–2008) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 1	Legislated Responsibility 1
• Albertans Choose Healthier Lifestyles	• Promote and protect the health of the population in the health region and work towards the prevention of disease and injury

Deloitte Observation at the Operational Level

- **Three corresponding strategies identified:**
- **1.1 Healthy Living (8 areas of focus: employees; eating; tobacco free; reduction of alcohol during pregnancy; injury prevention; mental health; immunizations; and prevention and management of chronic diseases)**
  - Generally, expected outcomes are qualitative in nature in spite of concrete performance measures and targets.
  - Community Health Services consultation indicated substantial efforts – although staffing is limited.
  - Consultation process identified that the chronic disease initiative remains in the planning process. Dialysis program in two communities (funded by Capital Health) is noted and emerging Diabetes and Asthma programs. We did not see strong emphasis yet in terms of service standardization or coordination.
  - Initial CDM focus will be Diabetes and Stroke Management – to build on past work.
- **1.2 Regional Plan for Environmental Health**.
  - This process was evidenced through consultation. Lack of information system across region is a limitation.
- **1.3 Health Living campaign for Aspen staff**.
  - Consultation process did demonstrate organizational efforts on this strategy.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Aspen's strategies (2005–2008) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 2	Legislated Responsibility 2
• Albertans' Health is Protected	• Assess on an ongoing basis the health needs of the region.

Deloitte Observation at the Operational Level

Six corresponding strategies identified:

- **2.1 Continual feedback from public.**
- **2.2 Service response based on client need**.
  - Region does demonstrate high effort to serve clients equitably, however, care settings are not always appropriate because of the lack of assisted living, transitional care, dedicated psych beds, outpatient services or community supports.
- **2.3 Ongoing stakeholder collaboration to reduce injuries/deaths from traffic incidents.**
  - Strategy and metrics appears heavily weighted to seatbelt usage only.
- **2.4 Promote safe working environments.**
  - Occupational Health and Safety is taking lead here. Limited resources constrain implementation.
- **2.5 Strengthen community capacity to prevent/reduce youth injuries and deaths from traffic incidents.**
  - Appears to have strong overlap with strategy 2.3.
- **2.6 Enhance regional response for pandemic influenza**.
  - Initiatives are underway.
- Overall, strategy and performance measures / targets in this area are focused on service delivery. Reliance on community needs data appears somewhat limited.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Aspen's strategies (2005–2008) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 3	Legislated Responsibility 3
• Improve Access to Health Services	• Reasonable access to quality health services is provided in and through the health region.

Deloitte Observation at the Operational Level

Ten corresponding strategies identified:

- 3.1 **Selected services within established standards.**
  - Region working toward implementation of standards across the acute and community service sectors. (CTAS, MORE, Community Care service model).
- **3.2 Continual update to Continuing Care plans.**
  - Renewal plans evident. Degree of consistency across region is variable. Gains related to placement wait are noted.
- **3.3 Accurate wait list data.**
  - In process.
- **3.4 Attend major recruitment opportunities. Continued effort on regional workforce plan and reporting system.**
  - The success of this strategy and the cascade to operational level appears minimal. Acute sites in particular struggle with recruitment and retention and associated workload related to securing staff. Work effort is repeated by each manager role.
- **3.5 Increase culturally sensitive delivery.**
  - Community Health Councils are good vehicle to assess success. CHC devoted to Métis Settlement is very effective. Some effectiveness challenges in other CHC's. Aboriginal Liaison role effective way to integrate community specific input and service.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

Health System Goal 3 (continued)	Legislated Responsibility 3 (continued)
• Improve Access to Health Services	• Reasonable access to quality health services is provided in and through the health region.

Deloitte Observation at the Operational Level

- **3.6 Strengthened mental health access.**
  - Reported at community level. Access is reported be an issue in select areas. Admission to active care is commonplace due to the lack of outpatient supports. Intervention through day clinics and home care appear limited. Access to dedicated beds in region an issue. Select sites have on site access of mental health resources where they are co-located which can be helpful. Stronger integration of mental health resources within continuum is suggested.
- **3.7 Enhance access to diabetes care services.**
  - While in place appears to have limited coordination or standardization across region.
- **3.8 Consistent process for telehealth scheduling.**
  - Work has been reported on this and improvements noted. Increased use of clinical telehealth is beginning. Mental health appears to be the most common clinical application. Region should consider increased use.
- **3.9 Continued support for LPCI (Local Primary Care Initiatives).**
  - Initiatives reported as underway. Our consultation suggests that physicians do not completely understand the concept.
- **3.10 Increased sexual health services for "at risk" groups.**
  - Reported as underway by Population Health as part of Core Service delivery, however, limited resources impact implementation.
- The Project Team recognizes that the Aspen strategy to maintain basic and primary services and expand select services. Aspen needs to ensure that expansion does not occur at the cost of other services, unless this is the plan. For example, the lack of full costing for Ortho Program has brought pressures elsewhere.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Aspen's strategies (2005–2008) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 4	Legislated Responsibility 4
• Improve Health Services Outcomes	• Activities and strategies to improve program and facility quality.

Deloitte Observation at the Operational Level

Six corresponding strategies identified:

- **4.1 Enhance quality of care, improve public and client satisfaction and maintain standards; maintain accreditation status; utilize data from current sources in above.**
  - Evidence of quality development processes underway, however largely in plan mode. Aspen will be challenged to cascade required changes at the operational level (particularly in care facility setting given the lack of implementation resources). Much activity ramping up for Accreditation (May 06). Some evidence of program rationalization (no elective deliveries in a few sites). The review team believe that re-assessing clinical service role for select care facilities is warranted and could yield operating efficiencies. Any service rationalization needs to done with access considerations.
- **4.2 Enhance quality of care for mental health and adhere to standards.**
  - Given the integration of mental health services in regional delivery framework, there has been lots of change and integration challenges. The extent to which service standardization is in place is unknown.
- **4.3 Develop Regional Quality Improvement Framework for continuum (regional indicators, performance indicators and best practices).**
  - This is an important need for the region and there is much work to do here. Consistent approaches have not yet cascaded across the region. Again, implementation support is important for implementation success. Quality Improvement Teams are well in place.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Aspen's strategies (2005–2008) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 4 (cont'd)	Legislated Responsibility 4 (cont'd)
• Improve Health Services Outcomes	• Activities and strategies to improve program and facility quality.

Deloitte Observation at the Operational Level

- **4.4 Implement quality improvement process to improve resident care in Continuing Care.**
  - Another important area for the region which is in its early stage. Relationship with Extendicare should be utilized related to metrics adoption and measurement.
- **4.5 Promote awareness of ethics and related decision-making**.
  - Consultation findings identified that the region has undertaken an awareness creation strategy related to ethics.
- **4.6 Implement community care quality improvement process.**
  - Much of the service and process standardization appears to have begun with some achievements already made. Community Health Services appear to have made earlier gains and achievement related to regional integration (for example: shared staffing between communities, resource allocation to enhance service or address gaps). Population Health programming provides the required range of Core Services (mandated) as well as programs for specified communities (Seniors Wellness, Aboriginal Liaison, Show Me, Diabetes Management and Education). Targeted programs can be provided for specific populations – based on need. Again, resourcing remains a challenge for service delivery beyond core.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Aspen's strategies (2005–2008) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 5	Legislated Responsibility 5
• Health System Sustainability	• Determine priorities in the provision of health services in the health region and allocate resources accordingly.

Deloitte Observation at the Operational Level

Two corresponding strategies identified:

- **5.1 Determine strategic priorities. Develop Specialty Centres. Consult with key stakeholders to identify service need.**
  - Consistently, across the region, timely decision-making was identified as a concern. Clearly specialty centres are part of the region's approach to service access.
- **5.2 Provide support and education opportunities for employees.**
  - While the region has a regional education program, there are insufficient staff for this program to have the traction required to create a strong regional approach. The region is without necessary implementation support resources for change initiatives. Moreover, the limited decision-making at the manager level is a serious impediment to both timely and evidence-based decision-making at Aspen.

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Aspen's strategies (2005–2008) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 6	Legislated Responsibility 6
• Create Organizational Excellence	• Promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Deloitte Observation at the Operational Level	**Eleven corresponding strategies identified:** **• 6.1 Support implementation of provincial electronic health record.** **• 6.2 Support implementation of RSHIP - Regional Shared Health Information System** **• 6.3 Maintain and support information technology infrastructure across Region.** **• 6.4 Work with relevant stakeholders, to integrate ground ambulance services.** **• 6.5 Reflect changes in scope of practice for all disciplines.** **• 6.6 Appropriate staff mixes will be established.** **• 6.7 Support the attraction and retention of physicians.** **• 6.8 Enhance awareness of privacy and security issues.** **• 6.9 Improve employee satisfaction.** **• 6.10 Optimize effectiveness of Region.** **• 6.11 Develop strategic communication tools.**

Three Year Plan

Strategy Mapping AH&W Goals & Legislated Responsibility

- Deloitte's review of Aspen's strategies (2005–2008) mapped to health system goals and legislated responsibilities provides the following observations.

Health System Goal 6 (cont'd)	Legislated Responsibility 6 (cont'd)
• Create Organizational Excellence	• Promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Deloitte Observation at the Operational Level	• Given the developmental nature of these strategies, we will comment on them as an aggregate. • The strategies and intended outcomes are all appropriate. To some degree, there is evidence of work taking place already (e.g., EHR, RSHIP, PACS, Technology Infrastructure). Given the large scale planning and implementation for some, Aspen needs to seriously assess its ability to implement. • Increased technology applications (PACS, EMR, Telehealth) require stronger implementation to support rural service environment and associated challenges. • For some of these strategies, Aspen should assess its current strategy and determine the degree to which it is on target (for example: attract/recruit physicians to which staff should be added). • Currently, Aspen appears to face implementation challenges post regionalization and integration. Given the degree of diversity across the region at present, this is a compounding variable for future change.

Three Year Plan

Challenges and Opportunities Section

- Deloitte's review of Aspen's Three Year Plan (2005-2008) provides the following observations.
- Concur with the identified challenges and opportunities related to:
  - Information and Technology;
  - Cost of Services – Sustainability;
  - Wellness and Healthy Living;
  - Access to Services; Mental Health;
  - Quality of Services; Primary Care;
  - Information Access and Privacy;
  - Continuing Care;
  - Diagnostic Services; and
  - Workforce.
- Our consultation findings indicates that:
  - Many of the opportunities identified are well underway, particularly related to Information and Technology, Access to Services, Mental Health, Diagnostic Services areas.
  - Many of the opportunities have not yet received the attention or achieved results required to alleviate many of the current operating challenges. These include: Cost of Services – Sustainability; Quality of Services; Continuing Care; and Workforce.

Annual Plan

Observations

- Deloitte's review of Aspen's Annual Business Plan (2005–2006) provides the following observations related to the extent to which annual direction and activities align to broader strategy.
  - Annual Business Plan (2005-06) does align and support the 3 Year Plan through the development of Tactical Approaches (TA).
  - Tactical Approaches do provide high level activity description of the planned activity to support strategy achievement.
  - While the Annual Plan reflects a more focused plan to cascade strategy to the operational level, our earlier observation that highlights resource limitations to effectively implement change remain.

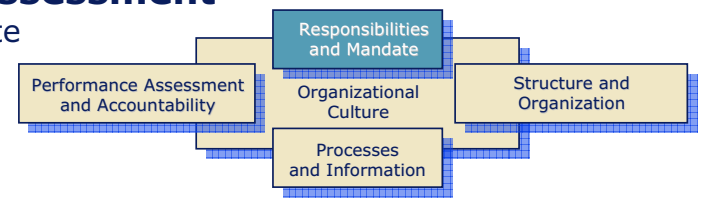
ARHA Governance Assessment

ARHA Governance Assessment
Assessment Areas and Indicators

- The high level assessment of the five areas of governance responsibility included:
  - Responsibilities and mandate
  - Structure and organization
  - Processes and information
  - Performance assessment and accountability
  - Organizational culture

ARHA Governance Assessment

Responsibilities and Mandate



Areas of Assessment	• Understanding of scope, authority and responsibilities (the difference between stewardship and management and setting policy vs. implementing policy) • Involvement in multi-year strategic planning; Involvement in annual planning and budgeting • Involvement in establishing risk management process and aware of procedures to mitigate risk • Ensuring management effectiveness and succession • Communication with key stakeholders
Deloitte Observations	• Board self reports a good level of involvement in key areas of responsibility; Board also reports that it has worked to overcome its initial area-specific focus (former Regions) to develop a renewed "Aspen" perspective • Board receives regular reports from Community Health Councils through CHC documented minutes and CEO; Board endeavors to have a member assigned per CHC • Board devotes substantial time to annual planning and update process; relies on analyst reports; reviews the export/import data to assess needs and changing priorities • Board may want to ensure stronger efforts are applied to management succession planning given the ever-present and increasing need to secure good talented managers, and the expected management retirement in Aspen.

ARHA Governance Assessment

Structure and Organization

Areas of Assessment	• Appropriate number of members and meetings • Appropriate representation of communities • Committee structure • Self assessment • Board understanding of responsibilities
Deloitte Observations	• Currently, one vacancy on Board • Board self reports effective working structure for board and that board members have a good understanding of their responsibility • Board has a focused committee structure and participates in broader regional committee structure (Regional Quality Council, Information Management, Accreditation) • Board meets regularly over the course of year (monthly schedule) • Board reports regular staff presentation to Board meeting (monthly basis) • Board may want to consider stronger representation of senior management as regular participants at Board meetings.

ARHA Governance Assessment

Process and Information

Areas of Assessment	• Board identification of information needs and receives required reporting • Board meetings considered to be appropriate structured (length, frequency, advance circulation of materials, attendance, management ability to respond to enquiry) • Documentation of meetings • Identification of required skill sets/competencies for board members • Formal orientation; ongoing education/development • Board related policies (roles/responsibility; code of conduct; conflict of interest)
Deloitte Observations	• Board self reports good information flow between management and Board • Board receives in-depth monthly CEO report • Formal orientation process for new Board Members • Ongoing development opportunities for Board Members • Board specific policy in place to direct board management

ARHA Governance Assessment

Performance Assessment and Accountability

Areas of Assessment	• Process to assess and monitor organization performance related to financial management, operations, people management, risk and safety • Process to monitor achievement of strategic directions • Self assessment of board performance • Board understanding of liability issues • Process to routinely assess performance of CEO/President
Deloitte Observations	• Board compliant with required reporting • Annual review process in place for CEO • Board reports annual self assessment • Strong financial reporting and control mechanisms in place • Other areas of reporting largely through CEO report. Board may want to consider adopting established metrics for tracking and reporting related to other key areas of reporting (people, operations). • Board may want to consider increased attention and focus on developing a comprehensive HR plan (that includes attraction, recruitment, development, retention, and evaluation) given the growing pressure points in terms of staffing and people management.

ARHA Governance Assessment

Organizational Culture

Areas of Assessment	• Board involvement in setting organization's values and philosophies • Diverse representation from communities within region • Board serving role as policy advocates with government and key stakeholders • Fosters effective board / management relations
Deloitte Observations	• Board self reports significant involvement in value setting and strong relationship with management • Board has secured diverse representation through its 6 Community Health Councils – including a focus on both Métis Settlements and First Nations. • The strongest focus of regionalization appears to be related to the financial management and control component. • The decision-making processes and accountability structure within management roles is not optimal. Given the elapsed time since re-regionalization, the incoming CEO and management team may want to review current role structure, decision-making and accountabilities within organization. • Given the three year time factor since Aspen was formed, it may be time to apply increased energy and effort in other areas of regional structure and requirements (Human Resource Planning and Support, Clinical Care Standardization, Alternative Service Delivery Approaches)

Key Conclusions

Strengths to build on include…

- **Regional roles to support standardization of service delivery and program development**
- **Seasoned staff and managers**
- **A strategic direction that aligns to provincial requirements**
- **Commitment to serve residents close to home**

However, some challenges do exist. Aspen should assess:

- **Number of strategic priorities it can undertake**
- **Resources to support implementation**
- **Business case development process for program development/ expansion**
- **Commitment to serve close to home should be within quality parameters**
- **Service standardization, quality monitoring, risk management in relation to access and rationalization**
- **Management organization structure, roles and decision-making processes**

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AHW RHA Efficiency Review

Aspen Regional Health Authority

Findings and Opportunities

Final Report

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Audit. Tax. Consulting. Financial Advisory.

Property of Alberta Health and Wellness

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Project Overview

Project Overview

Scope, Objectives and Business Drivers

Scope:

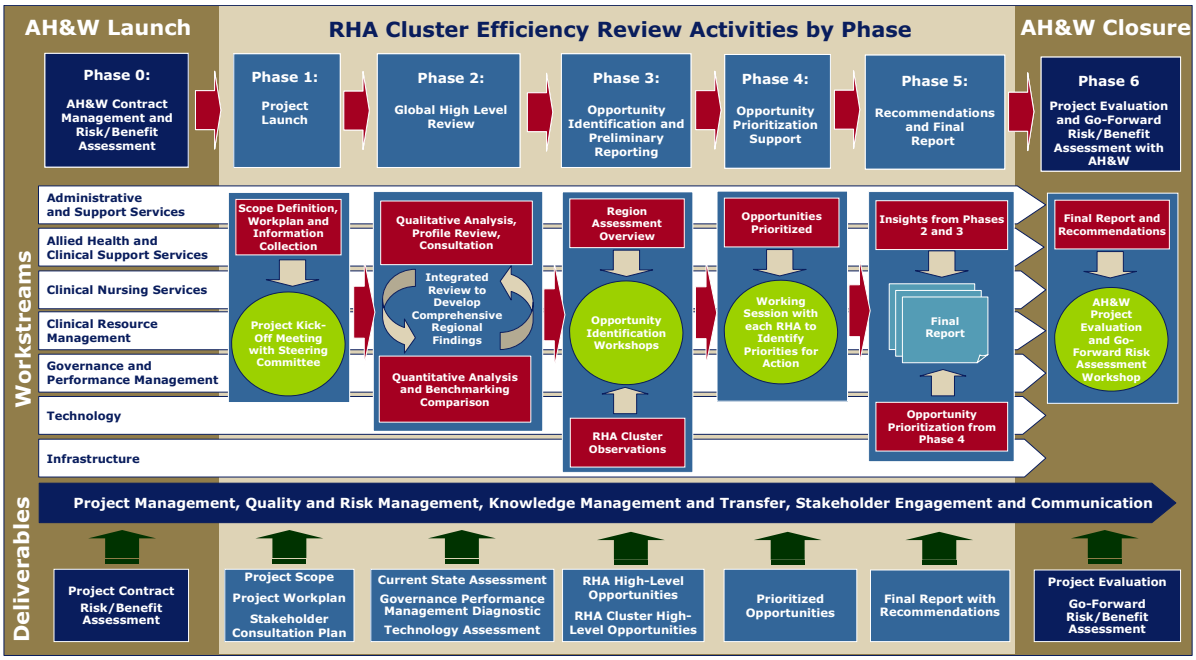
- Alberta Health and Wellness is undertaking an RHA Efficiency Review to identify potential efficiencies and opportunities for improvement within each of the RHAs in the province.
- To achieve this purpose, this Review is focusing its scope on improvements to deployment across five key dimensions:
  - Increases to productivity
  - Improvements to patient flow
  - Improvements to patient outcomes
  - Improvements to financial stewardship
  - Exploration of province-wide opportunities
- The review does include voluntary organizations, but will not be reporting to the voluntary boards.

Project Objectives

- There are three primary objectives that direct the activities of this Review:
  - Identify performance improvement issues and opportunities.
  - Identify productivity and performance improvement strategies and solutions.
  - Provide recommendations to optimize: available resources, operational efficiency, service delivery, safety and quality.

Project Overview
Approach and Timelines

- The diagram below outlines the project approach, and key activities of the review.
- The review started in December 2005, and was completed in June 2006.



Project Overview
Reporting

- This report presents the findings and opportunities identified through the region's review.
- Findings and opportunities are organized into 10 categories of reporting:
  1. Clinical Resource Management
  2. Acute Care
  3. Continuing Care
  4. Community Health Services
  5. Physician Findings and Opportunities
  6. Clinical Support and Allied Health
  7. Corporate and Support Services
  8. Operational Trending and Key Metrics
  9. Human Resources
  10. Infrastructure
- Following the identification and validation of findings and opportunities for each region, two additional activities were completed for this review, which are summarized in the final two sections of the report:
  - Identification of opportunities at a cluster / provincial level.
  - An opportunity prioritization and mapping exercise to support regional planning and go-forward monitoring.

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Clinical Resource Management

Clinical Resource Management
Overview

- Clinical resource management analysis includes CIHI analysis (internal trending of complexity and utilization data and external comparison of utilization data for each program) and the results of the MCAP ® review.
- In conducting an internal review of the complexity and utilization data, a drill-down approach is used to understand changes in utilization efficiency (volume, complexity and utilization efficiency).
  - Analysis is based on 2003-04 and 2004-05 data.
- In conducting an external comparison of utilization data, the goal is to identify potential opportunities to improve utilization in relation to CIHI ELOS and peer performance.
  - A drill-down approach is utilized, which begins with a "gross" assessment of utilization and potentially "conservable days" opportunities by comparing Sunrise's acute ALOS by CMG to the CIHI acute ELOS. The analysis is based on the 2004-05 data.
  - This analysis is then fine tuned to determine the more realistic opportunities related to improved utilization management. A filter is applied that specifies the number of cases required and the minimum variance in ALOS required before an opportunity can be considered realistic. For example, if there were fewer than 10 cases or the conservable days for the CMG are less than .5, it is not considered to be a realistic opportunity.

Top 10 Patient Services (2003-04 to 2004-05)

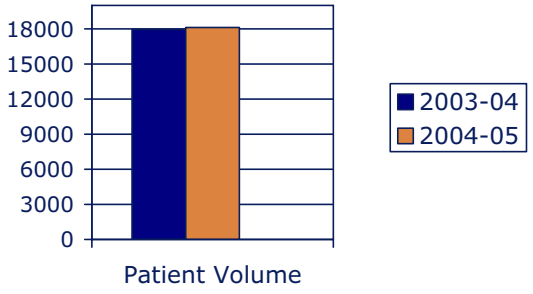
CIHI Abstract Data (Region)

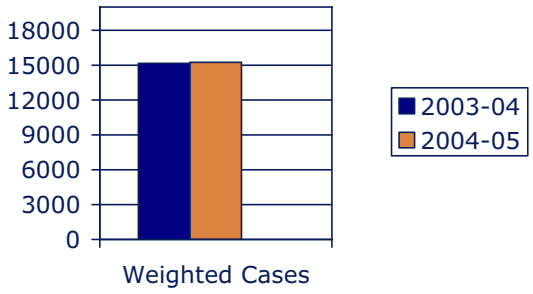
- The Top 10 Patient Services represent 99% of the region's Total Patient Services.
  - General Medicine represents almost 64% and Obstetrics/Newborns almost 21%.
  - It is expected that General Surgery and Orthopaedic Surgery have a stronger proportion given service expansion in these areas.

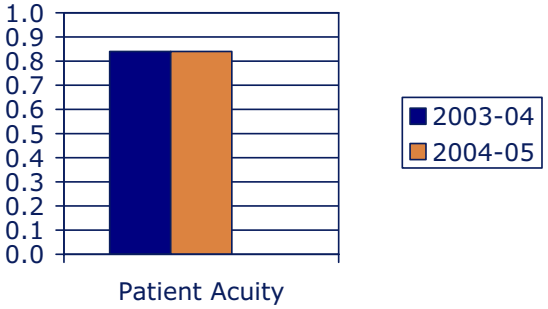
Patient Service	2003-04	2004-05	Two-Year Variance
General Medicine	11,375	11,582	2%
Obs Delivered	1,673	1,687	1%
Newborn	1,646	1,685	2%
Paediatric Medicine	1,178	1,041	-12%
General Surgery	770	834	8%
Obs Antepartum	415	432	4%
Psychiatry	354	380	7%
Palliative Care	205	170	-17%
Alternate Level of Care	167	110	-34%
Obs Aborted	89	82	-8%
Top 10 Patient Services Total	**17,872**	**18,003**	**1%**
Other Patient Services Total	**79**	**116**	**47%**
Region Patient Services Total	**17,951**	**18,119**	**1%**

Patient Volume, Weighted Cases and Patient Acuity

Region Wide





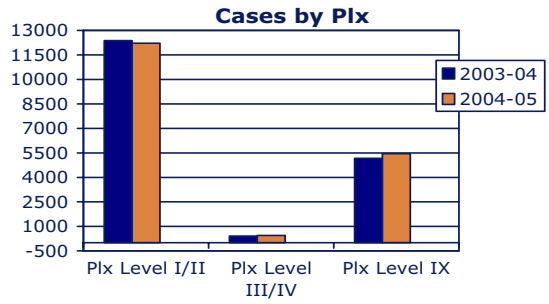


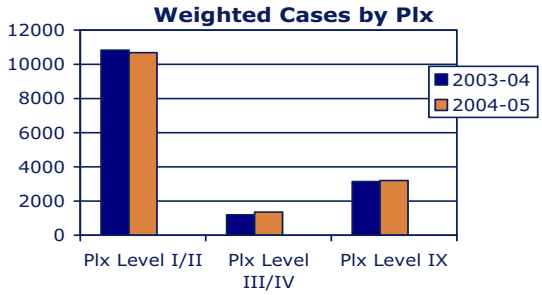
- Regional volume has increased slightly (0.9%).
- Both acuity and weighted cases have remained stable.
- Essentially volumes, patient acuity and weighted cases are flat line.
- Due to unavailability of the 2005-06 data, this analysis is missing the impact of Orthopedics and other clinical program changes in this fiscal year.

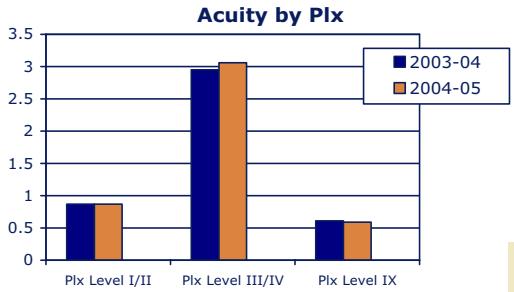
Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05

Patient Volume, Weighted Cases and Patient Acuity

by Plx (Region)







- The majority of patients for the region are Plx level I/II and Plx IX.
- Volumes increased across Plx III/IV and IX levels. Only Plx III/IV had acuity increases (9%). Plx IX had decreased acuity of 3%.
- While the weighted cases for Plx III/IV have risen dramatically (13.3%), the relatively low volume compared to other groupings has not had an impact on weighted cases overall.

Note: Plx further refines case mix groups to reflect additional diagnoses that influence a patient's overall medical condition. These co-morbid conditions may be present at time of admission, or may arise during the hospital stay. Cases are assigned to one of four Plx Levels. Level 1 denotes the absence of co-morbid conditions, while Level 4 denotes the presence of co-morbid conditions that may be potentially life threatening. Level 9 indicates no complexity overlay.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05

CRM – Import/Exports for ARHA

By Complexity for 2003-04 and 2004-05

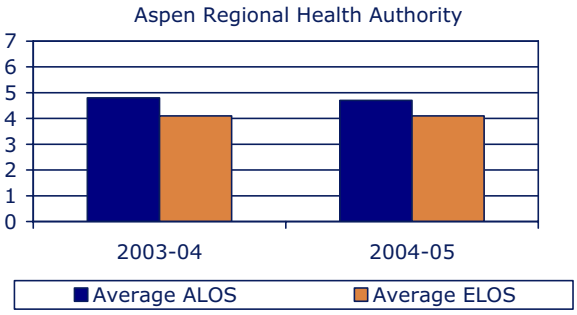
As a % of total Cases for each Plx	2003-04			2004-05		
	Plx I/II	Plx III/IV	Plx IV	Plx I/II	Plx III/IV	Plx IV
% Imports	6%	2%	6%	7%	5%	5%
% Exports	33%	65%	35%	34%	60%	34%

- Overall, 6% of patients are <u>imported</u> into Aspen Health Region in both 2003-04 and 2004-05
  - In 2004-05: 34% of total imported patients are from Capital Health Region and 38% are from other regions.
- Overall, 35% of patients are <u>exported</u> from Aspen Health Region in both 2003-04 and 2004-05
  - In 2004-05: 92% of exports are sent to Capital Health Region
- Observations
  - Imports/Exports as a percentage of total cases has not changed for ARHA in 2003-04 and 2004-05
  - The relative proportion of patients at each Plx Level (as a % of total patients at each Plx for Aspen) being exported has remained relatively constant - it is noted that the proportion of Plx III/IV patient exports decreased by 5% for the same period.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05

Average Length of Stay vs. Expected Length of Stay

as a Region



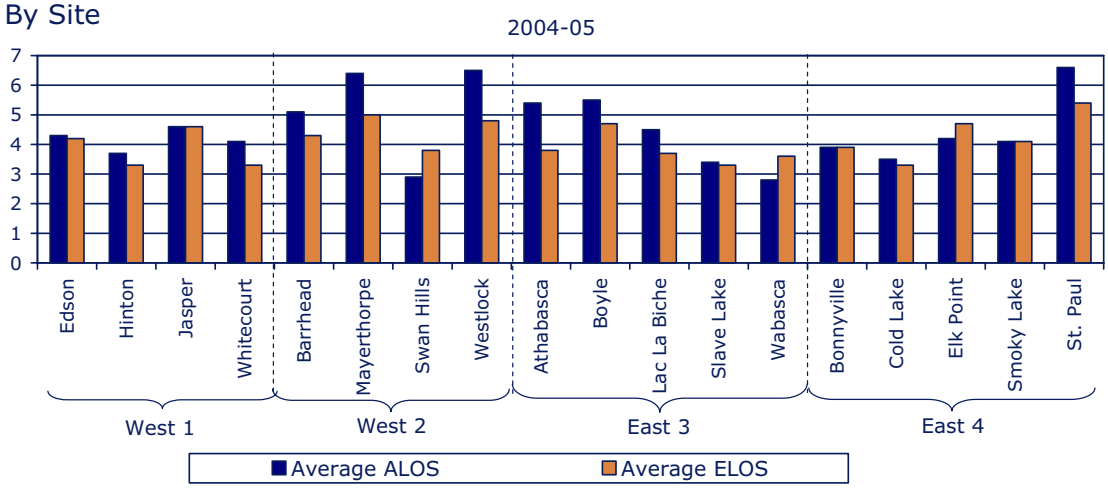
- ARHA's average length of stay (ALOS) is higher than the CIHI expected length of stay (ELOS).
- The gap between average and expected length of stay has stayed relatively constant over the two year period.
- The chart below shows the that Plx Levels I/II and III/IV are driving the ALOS to ELOS gap.

Fiscal Year	Plx Level I/II		Plx Level III/IV		Plx Level IX	
	ALOS	ELOS	ALOS	ELOS	ALOS	ELOS
2003-04	**5.1**	4.0	**14.8**	12.8	**3.4**	3.4
2004-05	**5.0**	4.0	**15.1**	12.8	**3.1**	3.5

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05

Average Length of Stay vs. Expected Length of Stay

By Site



- The facilities driving overall regional ALOS to ELOS gap are:
  - Greater than 1 day gap:
    - Westlock (gap of 1.7)
    - Athabasca (gap of 1.6)
    - Mayerthorpe (gap of 1.4)
    - St. Paul (gap of 1.2)
  - Greater than 0.5 day and less than 1 day:
    - Barrhead (gap of 0.8)
    - Boyle (gap of 0.8)
    - Lac La Biche (gap of 0.8)
- Only Swan Hills and Wabasca demonstrate an ALOS < ELOS, suggesting patients are transported out.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05

Top 10 CMGs by Potential Days Savable in 2004-05

as a Region

CMG	CMG Description	Total Cases	Total Acute Days	Average Length of Stay	CIHI Expected Length of Stay	ALOS - ELOS Gap	Potential Days Savable
851	OTH FACTORS CAUSE HOSPITALIZ	931	9221	9.9	5.2	4.7	4,345
847	OTHER SPECIFIED AFTERCARE	212	3405	16.1	9.1	7.0	1,473
841	REHABILITATION	112	2661	23.8	16.9	6.8	763
222	HEART FAILURE	374	2970	7.9	6.1	1.9	707
483	DIABETES	301	1915	6.4	4.8	1.5	447
279	DIGESTIVE SYSTEM MALIGNANCY	42	726	17.3	6.7	10.6	443
485	NUTRITIONAL AND MISCELLANEOUS METABOLIC DISORDERS	209	1237	5.9	4.1	1.8	379
772	DEMENTIA WITH OR WITHOUT DELIRIUM WITH AXIS III DIAGNOSIS	30	798	26.6	15.3	11.3	338
138	RESPIRATORY NEOPLASMS	64	781	12.2	7.9	4.3	276
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	224	1680	7.5	6.5	1.0	235
Top 10 Region CMGs Total		2,499	25,394	133.5	82.7	50.8	9,406
Other 284 Region CMGs Total		15,620	59,313	1,800.6	1,639.4	151.2	3,892
Total Region CMGs		18,119	84,707	1,934.1	1,722.1	212.0	13,298

- The leading CMG for savable days is "Other Factors". Coding improvements are required to identify appropriate strategies for length of stay. Given the occurrence of CMG's related to Heart Failure, Diabetes, and Chronic Obstruction Pulmonary Disease – suggests stronger chronic disease management strategies.
- The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05; CIHI CHAP Reports

Top 10 CMGs by Potential Days Savable in 2004-05

West 1 Breakdown

CMG	CMG Description	Total Cases	Total Acute Days	Average Length of Stay	CIHI Expected Length of Stay	ALOS - ELOS Gap	Potential Days Savable
851	Other Factors Causing Hospitalization	144	892	6.2	4.3	1.9	277
485	Nutritional and Miscellaneous Metabolic Disorders	38	398	10.5	4.0	6.5	246
847	Other Specified Aftercare	45	625	13.9	8.5	5.4	243
841	Rehabilitation	24	567	23.6	16.2	7.4	179
399	Orthopaedic Aftercare	13	231	17.8	7.2	10.6	138
783	Psychoactive Substance Dependence	18	194	10.8	4.4	6.4	115
138	Respiratory Neoplasms	14	225	16.1	8.4	7.7	108
222	Heart Failure	53	394	7.4	5.6	1.8	97
142	Chronic Bronchitis	58	438	7.6	5.9	1.7	97
447	Cellulitis	31	234	7.5	5.0	2.6	81
Top 10 West 1 CMGs Total		438	4,198				1,579

- The leading CMG for savable days is "Other Factors Causing Hospitalization". Coding improvements are required to identify appropriate strategies for length of stay. The next highest CMG cluster is Nutritional and Miscellaneous Metabolic Disorders.
- Note: The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05; CIHI CHAP Reports

Top 10 CMGs by Potential Days Savable in 2004-05

West 2 Breakdown

CMG	CMG Description	Total Cases	Total Acute Days	Average Length of Stay	CIHI Expected Length of Stay	ALOS - ELOS Gap	Potential Days Savable
851	Other Factors Causing Hospitalization	322	3,548	11.0	6.2	4.8	1,536
847	Other Specified Aftercare	74	1,290	17.4	9.4	8.1	596
222	Heart Failure	100	896	9.0	5.8	3.1	312
772	Dementia with or without Delirium with Axis III Diagnosis	14	468	33.4	15.3	18.1	254
140	Chronic Obstructive Pulmonary Disease (COPD)	48	471	9.8	7.0	2.9	137
842	Signs and Symptoms	35	333	9.5	5.7	3.8	134
142	Chronic Bronchitis	106	751	7.1	6.0	1.1	114
483	Diabetes	69	464	6.7	5.2	1.5	105
143	Simple Pneumonia and Pleurisy	134	837	6.2	5.5	0.7	95
409	Back Pain (MNRH)	34	247	7.3	4.7	2.5	86
Top 10 West 2 CMGs Total		936	9,305				3,368

- The leading CMG for savable days is "Other Factors Causing Hospitalization" and "Other Specified Aftercare". Coding improvements are required to identify appropriate strategies for length of stay.
- Note: The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05; CIHI CHAP Reports

Top 10 CMGs by Potential Days Savable in 2004-05

East 3 Breakdown

CMG	CMG Description	Total Cases	Total Acute Days	Average Length of Stay	CIHI Expected Length of Stay	ALOS - ELOS Gap	Potential Days Savable
851	Other Factors Causing Hospitalization	208	2,581	12.4	4.3	8.1	1,687
841	Rehabilitation	25	844	33.8	16.1	17.7	442
483	Diabetes	124	898	7.2	4.9	2.3	291
680	Femur or Pelvic Fractures and Dislocations	19	396	20.8	8.2	12.7	241
279	Digestive System Malignancy	13	301	23.2	5.9	17.2	224
536	Urinary Obstruction (MNRH)	51	224	4.4	1.8	2.6	130
485	Nutritional and Miscellaneous Metabolic Disorders	78	409	5.2	4.0	1.3	99
773	Dementia with or without Delirium without Axis III Diagnosis	13	239	18.4	10.8	7.6	99
208	AMI without Cardiac Cath without Specified Cardiac Conditions	18	185	10.3	5.7	4.6	83
846	Aftercare following Surgery or treatment	14	155	11.1	6.2	4.9	68
Top 10 East 3 CMGs Total		563	2,363				3,363

- The leading CMG for savable days is "Other Factors Causing Hospitalization" and "Rehab". Coding improvements are required to identify appropriate strategies for length of stay.
- Note: The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05; CIHI CHAP Reports

Top 10 CMGs by Potential Days Savable in 2004-05

East 4 Breakdown

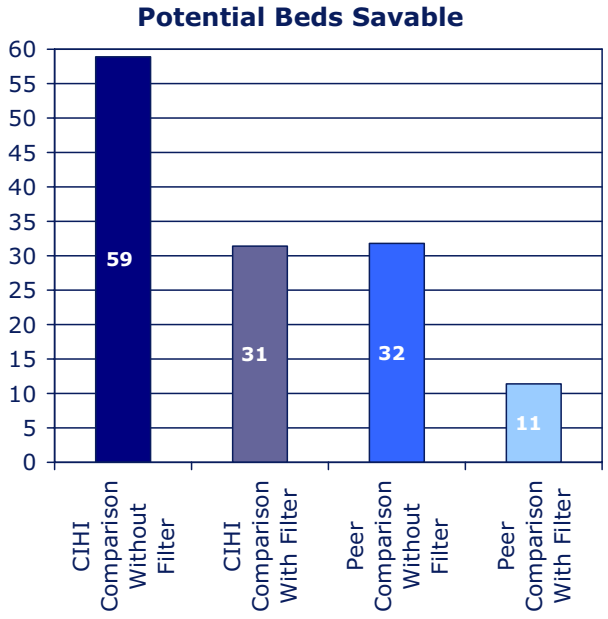
CMG	CMG Description	Total Cases	Total Acute Days	Average Length of Stay	CIHI Expected Length of Stay	ALOS - ELOS Gap	Potential Days Savable
851	Other Factors Causing Hospitalization	257	2,200	8.6	5.3	3.3	845
847	Other Specified Aftercare	58	1,142	19.7	9.7	9.9	577
222	Heart Failure	155	1,270	8.2	6.4	1.8	278
841	Rehabilitation	45	985	21.9	18.0	3.9	175
783	Psychoactive Substance Dependence	69	433	6.3	4.6	1.7	119
138	Respiratory Neoplasms	21	260	12.4	7.8	4.6	97
483	Diabetes	62	380	6.1	4.9	1.3	78
791	Anxiety Disorders (MNRH)	22	177	8.0	5.1	3.0	65
398	Other Inflammatory Arthritis	12	131	10.9	5.5	5.4	65
102	Dysequilibrium	46	190	4.1	2.9	1.2	57
Top 10 East 4 CMGs Total		747	7,168				2,354

- The leading CMG for savable days is "Other Factors Causing Hospitalization" and "Other Specified Aftercare". Coding improvements are required to identify appropriate strategies for length of stay.
- Note: The savable days calculation includes only those cases where the gap between actual length of stay was greater than 0.5 of a day, and the number of cases per CMG was greater than 10.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05; CIHI CHAP Reports

Beds Savable in 2004-05

as a Region



- Comparison of ALOS to CIHI expected length of stay suggests that the region could save as many as 31 beds.
- When compared to peers, using the same filter process, the region can save 11 beds.
  - Given the small bed size of sites, and that many sites have potential bed savings of less than 1, just over half of this opportunity is feasible.
  - Next slide identifies where bed opportunity is greatest.

- Note: The filter excludes cases where the gap between actual length of stay was less than 0.5 of a day, and the number of cases per CMG was less than 10. Estimated bed savings are based on 100% occupancy.

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05; CIHI CHAP Reports

Beds Savable in 2004-05

By Site

Sub-Region	Site	CIHI Comparison Without Filter	CIHI Comparison With Filter	Peer Comparison Without Filter	Peer Comparison With Filter
West 1	Edson Healthcare Centre	2.3	1.0	1.0	0.1
	Hinton Healthcare Centre	3.2	1.6	1.6	0.4
	Seton - Jasper Healthcare Centre	0.9	0.2	0.7	0.1
	Whitecourt Healthcare Centre	3.7	1.7	2.6	1.0
West 2	Barrhead Health Care Centre	5.0	3.2	1.5	0.4
	Mayerthorpe Healthcare Centre	4.0	2.4	1.9	0.6
	Swan Hills Healthcare Centre	0.1	-	0.1	-
	Westlock Healthcare Centre	8.3	4.6	4.3	1.4
East 3	Athabasca Health Care Centre	6.1	3.5	2.6	0.8
	Boyle Health Care Centre	3.4	1.8	2.7	1.4
	Slave Lake Healthcare Centre	2.4	1.0	0.7	-
	Wabasca/Desmarais Healthcare Centre	0.7	0.1	0.4	-
	William J. Cadzow - Lac La Biche Healthcare Centre	4.8	3.0	2.3	1.0
East 4	Bonnyville Healthcare Centre	2.8	1.5	1.7	0.5
	Cold Lake Healthcare Centre	2.5	0.9	1.0	0.2
	Elk Point Healthcare Centre	0.7	-	0.5	-
	George McDougall - Smoky Lake Healthcare Centre	1.0	0.6	0.4	0.1
	St. Therese - St. Paul Healthcare Centre	6.9	4.3	5.7	3.5
Grand Total		58.9	31.4	31.8	11.4

Source: Alberta Health & Wellness CIHI DAD, 2003-04 and 2004-05; CIHI CHAP Reports

MCAP Overview

Process

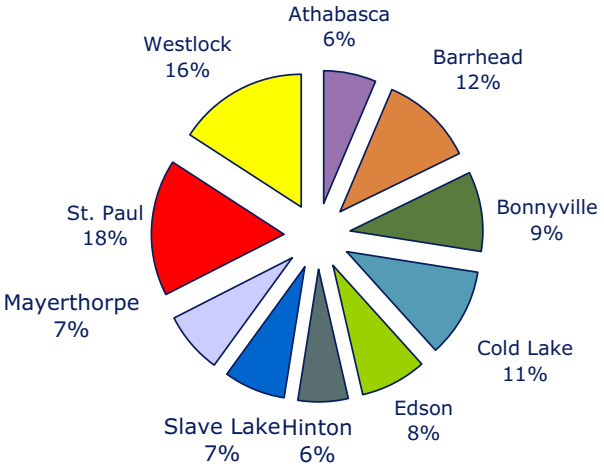
- An MCAP® review was conducted to:
  - Gain a better understanding of patients' required levels of care and their specific care needs and the impact these needs have on inpatient bed utilization.
  - Identify system issues why patients are not at appropriate level of care.
- MCAP® is a utilization management tool that uses rigorous scientifically researched and validated criteria to review the intensity of services required for any given patient and determine the appropriate level of care required.
- The tool uses a "service-driven methodology" and focuses on the treatment plan/services ordered for that day.
- By avoiding the placement of patients at too high or low of a care level, health care managers can be assured that patients will receive the highest possible quality of care and will move through the health care system in the shortest possible time.
- The review was conducted by Registered Nurses certified in MCAP®. They reviewed the charts of all admitted inpatients in the Acute Care settings between February 6 - 16, 2006.
- Using MCAP® criteria, the following three key questions were asked of each admitted patient:
  - Does the patient require the level of care (i.e. Long Term Care, Acute Care, Intensive Care, etc.) they are receiving?
  - If not, what level of care does the patient require?
  - Why is the patient not at the level of care they require?

Patient Profile

RHA Acute Care

- 190 patients were reviewed at selected acute care sites within Aspen RHA, which represents 72% of the total acute care bed capacity (267 beds) across the sites reviewed.
  - The average patient age was 64 years;
  - 56% of patients were female and 44% were male.

Site	Total Number of Beds	Number of Beds Reviewed
Athabasca HCC	26	12
Barrhead HCC	34	22
Bonnyville HCC	23	18
Cold Lake HCC	22	21
Edson HCC	19	15
Hinton HCC	21	12
Mayerthorpe HCC	24	14
Slave Lake HCC	14	14
St. Paul HCC	40	32
Westlock HCC	45	30
Grand Total	**267**	**190**



Patient Service Profile

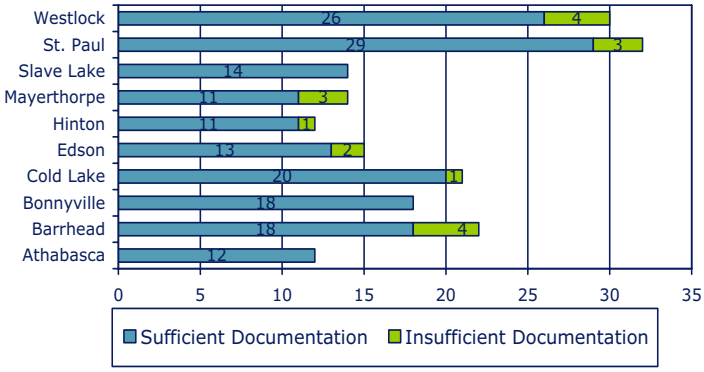
by Site

Site	Patient Service	Number of Beds Reviewed
Athabasca HCC	Combined Medical/Surgical	12
Barrhead HCC	Combined Medical/Surgical	22
Bonnyville HCC	Combined Medical/Surgical	18
Cold Lake HCC	Combined Medical/Surgical/ Obstetrics	21
Edson HCC	Combined Medical/Surgical	15
Hinton HCC	Combined Medical/Surgical	12
Mayerthorpe HCC	Combined Medical/Surgical	14

Site	Patient Service	Number of Beds Reviewed
Slave Lake HCC	Combined Medical/Surgical	14
Slave Lake HCC Total		**14**
St. Paul HCC	Combined Medical/Surgical	25
	Psychiatry	7
St. Paul HCC Total		**32**
Westlock HCC	Combined Medical/Surgical	13
	Combined Medical/Surgical/ Obstetrics	17
Westlock HCC Total		**30**
Grand Total		**190**

Patients with Insufficient Physician Documentation

ARHA Acute Care

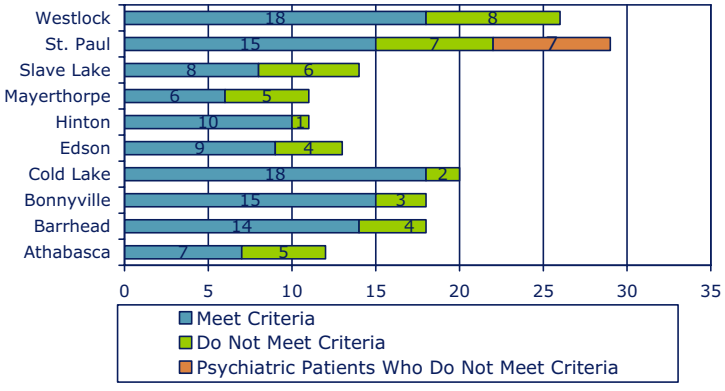


- Overall, 18 out of the 190 reviewed patients (or 9%) had insufficient physician documentation.
- In these situations, our clinical team is unable to appropriately determine if the patient meets clinical criteria for admission.
- This percentage of patients with insufficient physician documentation suggests an opportunity for improvement in charting.

Site	Percent with Insufficient Documentation
Athabasca HCC	0%
Barrhead HCC	18%
Bonnyville HCC	0%
Cold Lake HCC	5%
Edson HCC	13%
Hinton HCC	8%
Mayerthorpe HCC	21%
Slave Lake HCC	0%
St. Paul HCC	9%
Westlock HCC	13%
Total	9%

Patients Who Meet Clinical Criteria for Admission

ARHA Acute Care

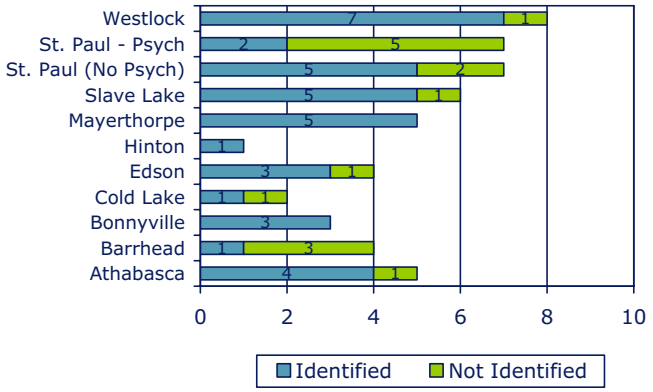


- For patients with sufficient documentation, the clinical team determined that 120 out of 172 patients reviewed (or 70%) met clinical criteria for admission to the service they were on.
- As shown in table (upper right), there is a significant percentage range by site.
- In comparing these results to our experience with other regions and hospitals in Canada, Aspen is in line with peers.
  - Our observed average for patients in the most appropriate care setting ranges between 65-75%.

Site	Percent at Appropriate Level
Athabasca HCC	58%
Barrhead HCC	78%
Bonnyville HCC	83%
Cold Lake HCC	90%
Edson HCC	69%
Hinton HCC	91%
Mayerthorpe HCC	55%
Slave Lake HCC	57%
St. Paul HCC	52%
Westlock HCC	69%
Total	70%

Patients Identified - Requiring Different Level of Care

ARHA Acute Care



- Of the 52 patients who did ***not*** meet clinical criteria, 37 (71%) were already identified by the facility as requiring a different level of care.
- This indicates an opportunity for improvement in the early identification of those patients require a different level of care and applies to about 29% of patients who did not meet criteria.

Site	Percent Identified as Requiring a Different Level of Care
Athabasca HCC	80%
Barrhead HCC	25%
Bonnyville HCC	100%
Cold Lake HCC	50%
Edson HCC	75%
Hinton HCC	100%
Mayerthorpe HCC	100%
Slave Lake HCC	83%
St. Paul – No Psych	50%
St. Paul – Psych	29%
Westlock HCC	88%
Total	71%

Required Level of Care

ARHA Acute Care

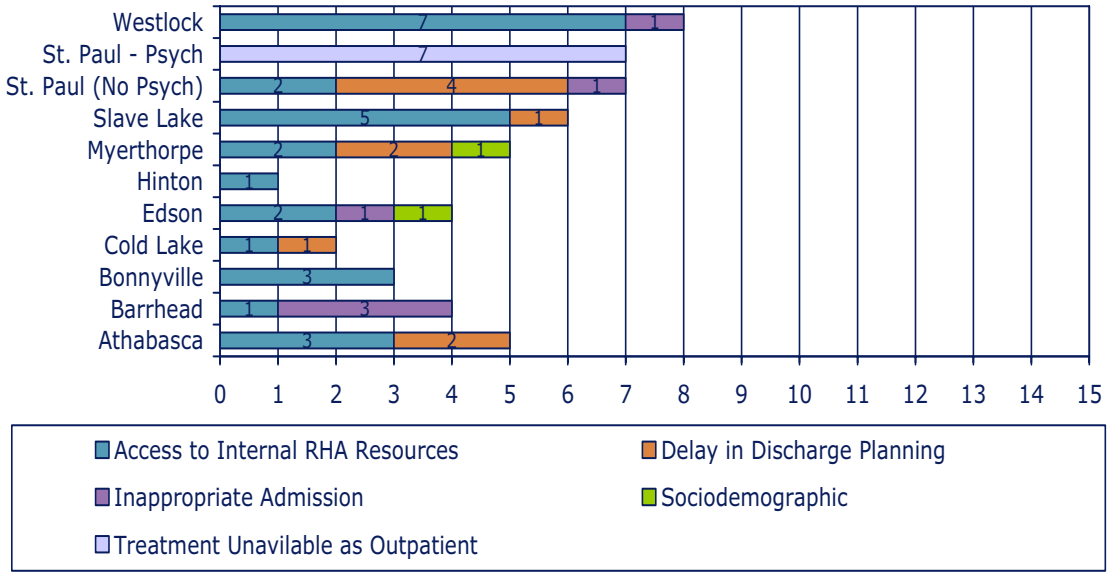
- For 52 patients who did not meet clinical criteria for admission, the most frequently identified care level was Continuing Care, Rehabilitation and Outpatient (related to Psychiatry).

Required Level of Care	Athabasca	Barrhead	Bonnyville	Cold Lake	Edson	Hinton	Mayer-thorpe	Slave Lake	St. Paul	Westlock	Total
Rehab		1			1	1	1	1	2	2	9
Palliative		1								1	2
Continuing Care	4		3	1	1		3	4	1	5	22
Lodge				1							1
Home Care	1				2			1	2		6
Outpatient									7		7
Home		2					1		2		5
Total	5	4	3	2	4	1	5	6	14	8	52

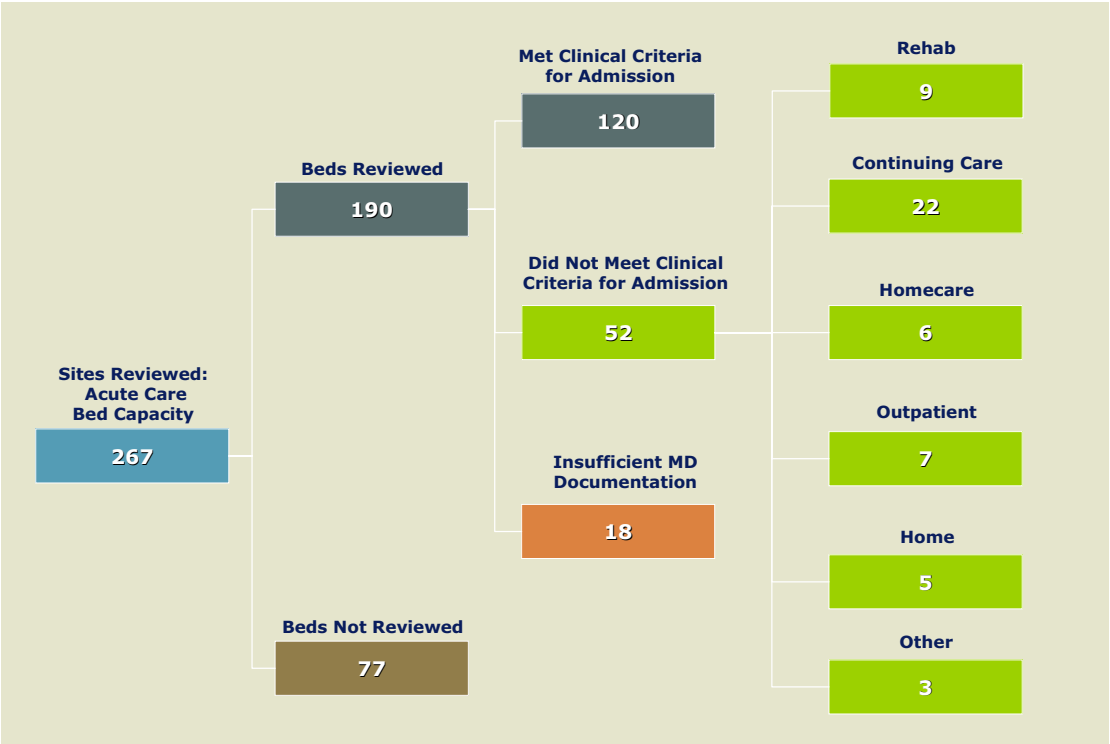
Reasons Patients Did Not Meet Clinical Criteria

ARHA Acute Care

- Of these same 52 patients who did ***not*** meet clinical criteria, 27 (or 52%) were due to challenges in accessing different levels of care or resources available within the region.



Acute Care Profile Summary: February 6 – 16, 2006



Clinical Resource Management Opportunities

Opportunities	Findings
1. Ensure alignment of resources to support increased acuity	• Cases and Weighted cases for Plx Level III/IV patients have increased between 2003-04 and 2004-05. • Exports of Plx Level III/IV patients have decreased for the same period • These findings support the anecdotal evidence that higher acuity patients are being repatriated to ARHA.
2. Improvements to Regional Coding and Abstracting	• Analysis identified CMG 851 (Other Factors Causing Hospitalization) and CMG 847 (Other Specified Aftercare) as having the highest potential days savable. • The high presence of these CMGs suggest additional coding and abstracting focus is required to help the region more discreetly identify and manage this patient volume.
3. Improve MD Documentation in Inpatient Charts	• The MCAP® review found 9% of inpatient charts could not be not assessed for eligibility for admission due to insufficient physician documentation. • Where this occurs, there is a heavy requirement and reliance on verbal communication between the physician and the team to support care management. • The heavy reliance on verbal communication has potential risk issues for patient outcome, and potential for increased length of stay without clear discharge direction.
4. Refocus Mental Health planning on broader continuum of care	• CRM analysis shows that on MCAP® assessment day, most of unqualified admissions would have benefited from outpatient service. • Examination of mental health programming to ensure non-bedded health services are accessible as viable alternatives to service. • Mental Health Plan and approved innovations projects may support alternative settings and services.
5. Examine regional admission/ discharge process and role creation to support patient flow process	• 2 FTE Placement Coordinators exist to support single point of entry placement. However, consulting team believes there is limited dedicated resources within inpatient facilities to support inpatient discharge and planning processes in acute care setting. Inpatient discharge function for acute care patients largely falls to the Nursing Supervisor. • Region reports plans to augment the Social Work complement to a total of 4 across the region. • The plan is to allocate 1 FTE of Social Work support to each area. The roles will follow the other discipline reporting model and report through Community Health Services. • Improved awareness of and education on admission/discharge leading practices to staff will support realization of reduced length of stay.

Clinical Resource Management Opportunities

Opportunities	Findings
6. Expand functional planning to include alternative service settings and non-acute service delivery and link to the Community Health Needs Assessment	• Clinical Resource Management findings show a need within ARHA for alternative levels of care settings to support patient flow, maximize use of acute resources, and support leading practice. ARHA's future planning does reflect movement to alternative care settings, however, increased attention in this area appears warranted. – For 42% of patients who were not at the required level of care, the required level of care identified through the MCAP® process was related to Continuing Care. – Of the 52 patients who did not meet clinical criteria for admission to the service they were on, 52% were due to challenges in accessing different levels of care or resources available within the region. – Limited use of Adult Day Care Programming for Senior population. • Admittedly, the Region will continue to struggle to attract private LTC operators which further supports its need to assess its own internal capacity to deal with this need.
7. Support policy development that enables the availability of incremental levels of continuing care for residents living in the community	• The MCAP® review suggested that a high proportion of the patients reviewed who required a different level of care best fit the needs of a continuing care setting. • Increasingly, continuing care is not a static concept and is evolving to align and support individual and family need and desires. This creates challenges for the region in determining what the need is and how resources should be deployed.
8. Assess feasibility of shifting acute beds to continuing care status where there is low acute occupancy coupled with lengthy placement waits.	• Several facilities experiencing LOS challenges due to long inpatient stays while patients wait for Continuing Care placement.
9. Targeted assessment of CMG's driving conservable beds analysis with a focus on using CDM to divert admissions related to chronic disease	• Approximately 2.8% (11 beds) of acute bed capacity could be saved if ARHA's ALOS by CMG was in line with the peer ALOS. • Several of the LOS opportunities relate to the chronic disease conditions (Heart Failure, Diabetes, COPD) suggesting renewed emphasis and direction for CDM.

Deloitte.

Acute Care Sites Review

Acute Care Sites Review

Process Overview

- Our review of acute care sites included:
  - Site consultation according the sites agreed upon with Senior Management and AH&W
  - Profile review and follow-up
  - Nursing staff comparison
- Key site findings, associated opportunities and staffing comparison results are provided for all acute care sites by areas:
  - West 1
  - West 2
  - East 3
  - East 4
- Findings and opportunities are identified from consultation, utilization and staffing analysis. Given the similar operating models, strengths and challenges seen across facilities, we are grouping findings and opportunities into two categories:
  - Site specific opportunities including potential staffing efficiency or investment
  - Cross regional opportunities

Nursing Staffing Comparison and Consultation

Process Overview

- The relative efficiency of patient/resident care services was assessed based on a comparative analysis of staffing levels and skill mix for each inpatient care unit using three key inputs:
  - GRASP Systems International Database (using the Canadian section of the database)
  - Deloitte Peer Database
  - Unit Staffing Schedule/Pattern
- As an indicator of variance from the benchmark, the difference in hours per patient day (HPPD) is reflected using an FTE estimate for illustrative purposes.
- To gain an understanding of the clinical requirements and environment on each unit, profiles were completed and consultation was conducted with clinical leadership.
- For each patient care unit, the following analysis was then conducted:
  - Total nursing unit producing personnel (UPP) worked hours per patient day/visit (HPPD).
  - Nursing UPP Worked Hours include direct patient care hours provided by RNs, LPNs, and certain percentage of Health Care Aides. UPP hours include regular worked, relief, and overtime, and exclude benefit hours (i.e., vacation and absenteeism).
  - HPPD were calculated using actual worked hours (not budgeted) for 2004-05 and 2005-06 YTD, and then compared to comparable peer units based on the profiles completed by each program/unit.
  - All units are shown at the 50th percentile. In some units, adjustments have been made to better reflect patient mix/care requirements.
- Staffing opportunities are identified based on comparative analysis and the clinical team's understanding of minimum staffing requirements. Staffing opportunities are not stand alone, and need to be considered in the context of other opportunities identified for each clinical area.

West 1

- Acute Care

Peer Staffing Comparative Analysis

Edson Healthcare Centre

Opportunities	Findings
1. There is opportunity for significant investment in the acute and ER/OPD departments at Edson, however this needs to be reviewed in conjunction with primary care physician coverage in the community. 2. Staffing investments should be considered with respect to the planned redevelopment of the site.	• Projected increase in patient days and visits to the ER/OPD as a large increase in population over the past few years due to increased activity in the oil and gas sector. • Limited information on the nature of the ER/OPD visits • Acute care staff provide support to the Continuing Care. • There are usually 2 or more patients waiting for placement in LTC at any given time. The average wait for a Lodge bed is between 4 - 6 months, resulting in extended waits in Acute Care until a bed is available in LTC. • There has been an increase in the number of surgical cases from visiting specialists. • Staffing comparison suggests potential investment in Acute Units and ER and some efficiency in surgical day care/OR. See opportunity comment.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2005-06 YTD	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 05-06 YTD
Acute Nursing	19.0	20.0	5.2	5.5	1.2
Emergency / OPD	4.2	3.8	0.3	0.9	6.6
Surgical Day Care	1.5	1.5	9.2	4.9	(0.7)
Operating Room	0.3	0.3	12.2	4.1	(0.2)

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Hinton Healthcare Centre

Opportunities	Findings
1. An efficiency opportunity exists in the combined OR, recovery room and surgical day care. At this time the efficiency target is equivalent to 3.8 FTE and indicates an opportunity to increase OR/SDC volumes within the current staffing complement. 2. The potential investment opportunity in ambulatory needs to be reviewed in conjunction with primary care physician coverage in the community.	• Strong Alberta economy in oil and gas in Hinton. In 2004 there were 4000 persons living in camps. This increased to 7000 persons in 2005. • Strong Maternal Newborn Program with trained facility nurses and Physicians specialized in epidural anesthesia and caesarian sections with an increasing maternity catchment area. This accounts for the 24.8% increase in newborns over 2004. • All RNs are cross-trained and are required to work in all areas of Acute Care. • Staffing efficiency findings suggest up to 3.8 FTE in the OR/Surgical Day Care areas. A potential investment of 1.3 FTE is noted in Ambulatory care.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2004-05	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2004-05
Acute Nursing	22.2	22.7	7.3	6.3	(3.0)
Emergency	2.7	1.0	0.4	0.9	3.1
Operating Room	3.7	3.2	14.7	4.9	(2.4)
Surgical Day Care	2.0	1.9	14.4	4.1	(1.4)
Ambulatory Care	1.2	1.7	0.6	1.2	1.3

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Other Rural Sites Not Visited

Site	Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2004-05	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2004-05
Jasper – Seton Hospital	Acute Nursing	11.0	10.4	11.4	5.1	(2.4)
	Emergency	4.4	4.4	0.9	0.9	0.0
Comments	• Profile reports combined staffing for acute, ER/OPD and RN supports for Continuing Care as needed. Minimum staffing requirement negates full staffing efficiency. Potential savings of up to 2.4 FTE where at times the facility can work at 2 RN over 24 hour coverage model. This is dependant on seasonal fluctuations and the ability to manage peaks in workload.					
Whitecourt	Acute Nursing	14.9	14.9	5.6	6.0	1.7
	Emergency	7.3	7.3	0.6	0.9	4.0
	Surgical Day Care	0.9	0.9	3.6	4.3	0.2
	Operating Room	0.1	0.1	4.0	4.1	0.0
Comments	• Physician shortage in community drives ER volume and the staffing investment should be seen in the light of many of the ER visits being low acuity clinic visits.					

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

West 2

- Acute Care

Peer Staffing Comparative Analysis

Barrhead Healthcare Centre

Opportunities	Findings
1. Staffing investment of 4.9 FTE in acute care and ER/OPD should be considered related to ER/OPD volumes, and in light of proposed facility redevelopment and functional planning.	• Acute Nursing and ER requirement drives increase in staffing. • 34 Acute beds, 2 LDRP with 134 deliveries. Anecdotally it is reported that the busiest time is between 1700 hrs and 2200 hrs as patients are sent to ER for tests, with X-ray volume perpetuating a lot of overtime. • Transfers to Edmonton require on occasion an RN to accompany as there is only 1 ACLS EMS in the town • This site has been marked for redevelopment. In light of physician resource issues in this area of the region, there is an opportunity to review the consolidation of certain patient services between Westlock and Barrhead. • Inefficient layout as the ER/OPD is a long way from acute units making it more of a challenge to provide cross-coverage. • Acute skill mix is 67% and LPNs are not yet practicing at full scope related to administration of medications, however there is a plan in place to address this.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2004-05	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2004-05
Acute Nursing	22.6	22.8	4.1	4.7	3.0
Emergency	5.2	5.4	0.7	0.9	1.9
Surgical Day Care	2.3	2.2	10.2	4.9	(1.2)
Operating Room	1.4	1.4	2.3	4.1	1.1
Ambulatory Care	1.3	1.2	1.7	1.2	(0.4)

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Mayerthorpe Healthcare Centre

Opportunities	Findings
1. There is a staffing investment equivalent to 4.1 FTE in ER/OPD that is driven by the increase in volumes, however this needs to be reviewed in conjunction with primary care physician coverage in the community.	• Farming community with an increasing aging population and seasonal variations in ER volumes. • Limited obstetrics at this site. • 25 acute bed facility with an average 55% occupancy. Staff in acute support the ER in the evening, who reportedly run evening clinics 1600 – 1800 hrs, and 1930 – 2200 hrs appointments in evening walk-in clinics. • ER is staffed on the day shift for 4 hours but relies on the acute unit staffing on the evening and night shift. Night shift RN covers acute and ER services.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2004-05	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2004-05
Acute Nursing	14.1	14.7	4.6	4.8	0.6
Emergency / OPD	4.2	4.0	0.5	0.9	4.1
Surgical Day Care	0.3	0.3	6.3	4.9	(0.1)

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Westlock Healthcare Centre

Opportunities	Findings
1. Consider staffing investment equivalent to 5.0 FTEs to support ER/OPD visits, however this needs to be reviewed in conjunction with primary care physician coverage in the community. 2. There is an efficiency opportunity in Surgical Day Care that is equivalent to 1.6 FTE due to the potential for additional capacity. This indicates that there is an opportunity to further increase surgical cases within the current staffing complement.	• Poorly designed department with no triage function so there is a need to review the workflow in this area. There is a mix of patient services in a very congested area making it difficult to determine staffing requirements of these patient. Need to review the location of Orthopaedics that is currently adjacent to the OPD department in the former Palliative care rooms. • A 21% projected increase in ER/OPD volumes for 2005-06. • Orthopaedic cases account for 25% of all cases for 2004-05. • There has been a significant investment in staffing in acute care, OR and SDC to support the Orthopaedic program. It is recommended that staffing levels remain constant given anticipated volume increases for orthopedics with a review at year end.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2005-06 YTD	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 05-06 YTD
Acute Nursing	30.3	37.7	5.1	5.1	0.0
Emergency / OPD	5.1	5.3	0.5	1.0	5.0
Surgical Day Care	3.8	5.7	6.9	4.9	(1.6)
Operating Room	0.9	1.5	4.1	4.1	0.0

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Other Rural Sites Not Visited

Site	Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2004-05	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2004-05
Swan Hills	Acute Nursing	3.0	3.0	12.1	4.8	(1.7) See Below
	Emergency	7.1	7.1	2.8	0.9	(4.7) See Below
Comments	• Minimum staffing requirement for the services provided negates staffing efficiency due to low occupancy. • Swan Hills should undergo a facility role review although the Region reports that this has been done. Region identifies that only significant savings available through closure which is not an acceptable solution given access requirements.					

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

East 3
- Acute Care

Peer Staffing Comparative Analysis
Athabasca Healthcare Centre

Opportunities	Findings
1. Strengthen discharge planning and utilization management procedures and improve linkages between the hospital and home care staff.	• Home care nurse generally links with hospital staff once a week to discuss patients who are ready for discharge, unless asked to go mid-week. Delays in initiating discharge planning can result in longer acute length of stays, which is supported by MCAP® review and analysis of ALOS vs. ELOS.
2. Any recommendation around investments in this facility needs to be considered in light of the recommendation that the region complete a review of this facility's role. 3. Any staffing investment opportunity needs to be considered in the context of an adjusted HPPD to reflect the number of patients awaiting placement in the community.	• Facility is underutilized –Approximately half of the available space in the acute care facility is in use for patient care. –70% occupancy in staffed acute beds. –Low surgical and obstetrical volumes. • Consultation findings indicated that a substantial volume of inpatient days are related to "awaiting placement", and are supported by MCAP® findings on day of visit.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2004-05	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 05-06 YTD
Acute Nursing	17.7	18.2	4.3	4.8	2.1
Emergency	5.0	5.3	1.2	0.9	(1.3)

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Slave Lake Healthcare Centre

Opportunities	Findings
1. Explore alternative service setting for clinic visits seen in the ER.	• Anecdotally it is reported that there is limited access to after hours physician clinic appointments in the community which is driving ER volume. • Data collection around time seen in the ER/OPD would assist the facility in better understanding the workload issues in the ER in light of any potential staffing investments or alternative delivery models.
2. Consider reallocation of acute beds funding to meet longstanding Continuing Care needs in the community. 3. There is a small efficiency opportunity in the OR/SDC, equivalent to 0.9 FTE, which suggests that there is an opportunity to increase volume capacity in the OR with the current staffing complement.	• Substantial number of acute patients waiting for Continuing Care (seen in MCAP®). Continuing Care provides 4 hours of recreation therapy activities to acute care patients waiting placement. • Currently operating at 15 of the 25 acute beds open with the addition of 2 SDC beds, 2 L&D rooms and a Palliative care room. This additional bed capacity suggests an opportunity to look at a different service model to utilize additional physical capacity. • Consultation findings indicate that staffing was not reduced for unused acute care beds – although Region indicates that bed reduction was undertaken given staff shortages and that staffing now aligns to safe staffing levels.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2004-05	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2004-05
Acute Nursing	18.0	17.9	5.8	5.2	(1.8)
Emergency	6.2	6.7	0.8	0.9	1.8
Surgical Day Care	1.0	1.0	14.3	4.9	(0.7)
Operating Room	0.2	0.3	14.7	4.1	(0.2)

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Other Rural Sites Not Visited

Site	Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2005-06 YTD	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06 YTD
Boyle	Acute Nursing	9.8	10.4	4.5	4.8	0.8
	Emergency	2.4	2.6	0.8	0.9	0.2
Comments	• There is a potential staffing investment of 1.0 for the acute care services in Boyle, however as this site was not reviewed, the appropriate utilization of the acute beds is not known.					
Lac La Biche	Acute Nursing	19.3	20.2	4.6	5.0	1.6
	Emergency	8.6	8.9	0.8	0.9	1.7
	Surgical Day Care	0.8	0.6	12.0	4.9	(0.4)
	Operating Room	0.3	0.3	9.3	4.1	(0.2)
Comments	• Anecdotally, it is reported that there are between 3-5 patients at any given time awaiting placement. Consider reallocation of acute beds to continuing care beds to resolve bed blocking issue.					

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Other Rural Sites Not Visited

Site	Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2005-06 YTD	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06 YTD
Wabasca - Desmarais	Acute Nursing	8.2	7.8	9.9	5.4	(3.5)
	Emergency	3.0	4.2	0.6	0.9	1.8
Comments	• Remote northern community with unique challenges. Most of the professional staff have spouses who are working for other service sectors such as the RCMP and teachers. The average of stay is approximately 2 years. • Facility currently staffed 2 RNs and 1 LPN providing coverage for 16 hours a day during the busier day and evening times. In addition the evening RN shift is used to offset replacement costs. • Average daily census is 5 patients. • Staff savings not feasible given minimum staffing requirements and inability to find casual relief for this facility.					

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

East 4

- Acute Care

Peer Staffing Comparative Analysis

Bonnyville Healthcare Centre (St. Paul)

Opportunities	Findings
1. There is a considerable staffing investment opportunity in the acute and ER areas, however this needs to be reviewed in conjunction with primary care physician coverage in the community. 2. This staffing investment should be considered in line with a clinical service role review.	• High volume ER/OPD, and obstetrics. There is a projected 10% growth in patient and ER/OPD visits. • ICU/CCU patients from Cold Lake are sent to Bonnyville when Cold Lake has no capacity. It is anticipated that there will be an increase in the number of physicians in the community with admitting privileges. • An orthopaedic surgeon is currently shared between Bonnyville and Cold Lake with an approximate annual caseload of 210 and further expansion planned. • Facility redevelopment is well underway with master plan development completed, however some concerns remain, related to not allocating appropriate Triage space and functionality in the plan. • At times there are acute admissions waiting for Continuing Care placement (supported by MCAP®) and this should be considered in light of any staffing investment in acute care.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2005-06 YTD	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06 YTD
Acute Nursing	20.4	21.8	4.3	5.2	4.8
Emergency	10.6	10.7	0.6	0.9	5.1
Surgical Day Care	1.8	2.4	5.2	4.9	(0.1)
Operating Room	0.6	0.8	6.5	4.1	(0.3)
Ambulatory Care	3.0	3.4	1.1	1.2	0.4

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Cold Lake Healthcare Centre

Opportunities	Findings
1. Staffing in acute care needs to be monitored as activity and volumes increase, given the trend is towards higher worked hours.	• Consultation findings indicate that the repatriation of patients back to Saskatchewan is a challenge and increases LOS. • Acuity is high in the acute care units and the number of obstetrical deliveries is increasing. • There has been an increase in the number of worked hours for 2005-06 which is likely due to the introduction of the orthopaedic program.
2. There is a significant investment in the ER/OPD to address volume and workload. 3. Increase senior management dialogue with CFB Cold Lake to create stronger alignment and integration with CFB physician resources.	• The location of ER relative to acute care negates any ability to have staff from acute support the ER. This is an issue especially at night when there is one RN on staff in the ER. • There is no clerical support in the ER increasing the non-nursing duties performed by nurses. • ER physical capacity has been exceeded by the increase in the number of patients. There is a projected 17% increase in ER/OPD volumes for 2005-06. • CFB Cold Lake Physicians do not take call after 1700 hrs, which drives after hour, weekend and holiday workload at hospital.

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2004-05	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06 YTD
Acute Nursing	20.1	20.1	5.4	5.4	0.0
Emergency	9.9	11.6	0.7	1.1	7.2
Surgical Day Care	1.6	1.6	7.6	4.9	(0.6)
Operating Room	1.0	1.1	8.3	4.1	(0.6)

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

St. Therese Healthcare Centre (St. Paul)

Opportunities	Findings
1. Functional and master plan study required.	• Functional planning required for inpatient facility given outdated and inappropriate facility design for current inpatient use.
2. There is a staffing investment opportunity in acute care equivalent to 1.9 FTE. This might be offset by the number of patients at St. Therese's who require an alternative level of care.	• Acute care had medically managed detoxification patients that are not accepted in the psychiatric unit. • There are always between 2-3 patients awaiting placement in continuing care. The wait list for the LTC unit at St. Paul's is currently at 15. Estimated waiting time for placement is between 6 weeks to 3 months. (Supported by MCAP® review).

Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2005-06 YTD	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06 YTD
Acute Nursing	25.3	24.6	4.6	5.0	1.9
Psychiatry	9.1	9.5	5.3	5.1	(0.4)
Emergency	8.2	8.1	0.8	0.9	1.1
Surgical Day Care	1.6	1.4	4.9	4.9	-
Operating Room	0.3	0.3	3.9	4.1	-

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Other Rural Sites Not Visited

Site	Unit/Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HPPD 2005-06 YTD	Recom'd HPPD	Recom'd FTE (Effic.)/ Re-Invest. 2005-06 YTD
Elk Point	Acute Nursing	10.7	10.5	6.1	5.3	(1.4)
	Emergency	1.6	1.6	0.5	0.9	1.2
Comments	• No staffing opportunity at Elk point.					
Smoky Lake	Acute Nursing	9.6	9.8	6.0	5.0	(2.0) See Below
	Emergency	2.3	2.3	1.0	0.9	(0.1) See below
Comments	• Minimum staffing requirements negates staffing opportunity.					

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Cross Region Opportunities

Cross Region Opportunities

Opportunities	Findings
1. Conduct a clinical service role review to determine the feasibility of the delivery of services by cluster: – Conduct a Community Needs Assessment; – Assess current programming, hours of operation, capacity, critical mass, and patient safety issues at both the area and regional levels; – Identify centres of excellence (Hinton and Cold Lake); – Conduct master and functional planning exercises based outcomes of clinical service role review.	• Low surgical volumes in certain sites. • Proximity of some facilities suggests assessment of critical mass and potential service rationalization/re-alignment. • Low occupancy is a challenge in achieving staffing efficiencies. • High percentage of acute admissions waiting for continuing care (supported by MCAP®). • Some facilities have surplus bed capacity to support additional continuing care requirements. • Region's feedback is that it has worked since its inception to balance service rationalization with political factors and access.
2. Conduct regional assessment of CTAS used in the ER Department to determine resources, capital investment, education support, and policies/procedures required to standardize its use as a risk/management tool.	• Triage data is not fully appreciated as a risk management tool. • The majority of sites do not yet triage patients and where Triage is performed there are issues around coding practice. • Triage space inadequate in most facilities. • Master planning exercises conducted in some facilities do not appear to support triage function in new facility design.

Cross Region Opportunities

Opportunities	Findings
3. Conduct a regional assessment of the ER volumes and the required staffing. 4. A Community Needs Assessment will assist the region in identifying the challenges in accessing primary care within the region and the resulting impact to ER departments.	• When reviewing staffing opportunities in the ER/OPD departments, it appears that there is a total investment of 42.8 FTEs across the region. • Lack of Triage data and the associated workload compounds the ability of the region to fully understand the type of patients being seen and the required resource allocation. • Staffing workload between ER and acute care units is often blurred and therefore may influence the findings of the comparative staffing analysis.
5. The Region needs to reassess the impact analysis and business case development process to ensure that it is grounded in Community Needs Assessment data and sufficient cost impact data in both acute and community sectors	• Orthopaedic cost impact analysis reported to have had significant impact on resources (beds, staff). Impact analysis did not deal with the service complexity involved. • Increased staffing to respond to Orthopaedic program development, primarily in acute setting.

Cross Region Opportunities

Opportunities	Findings
6. Reassess value of psychiatry inpatient bed expansion vs. other service models across the region. 7. Conduct service model and caseload review for Mental Health Therapists to explore stronger linkages and support to the inpatient service.	• Accessing mental health services is problematic for all facilities in the region. • Different service models for mental health services exist within the region: West patients go to Ponoka, despite the existence of a regional facility located in St. Paul. The decision-making process around citing Mental Health beds at St. Therese was incomplete and did not factor in challenges around human resources, geography and physical plant capabilities. • The expansion to increase to a 20 bed unit is underway. Rationale for bedded expansion vs. other service models is unclear. The Region relies on inpatient capacity as its primary service response given lack of other resources. • Psychiatry is serviced by 1 Psychiatrist with plans for future recruitment of an additional resource. • No concrete plans are in place to secure additional qualified staff for the new unit. • None of the inpatients reviewed through MCAP® were qualified for acute admission and could have benefited from outpatient services. • Access to community-based mental health programs appears to be limited and stronger linkage to outpatient support post discharge appears required. • Region reports recent addition of funding to address need to increase outpatient service (Crisis Intervention Team).

Cross Region Opportunities

Opportunities	Findings
8. Increase support to enable Human Resources strategy and programming to fulfill its status as a corporate priority. (See HR section later in Report.)	• Region indicates that HR strategy is a corporate priority, however staffing resources to enable occurrence appear limited. • High complement of senior staff. • Limited succession planning demonstrated in region. • Limited coordinated recruitment strategies for key clinical roles. • Difficulty recruiting staff to select areas given housing challenges, especially in Hinton and Edson, which requires a heightened regional response. • High casualization of the workforce in the acute sites (full time complement is low: 6 acute sites are less than 20%, 6 acute sites are between 21 and 30%, and 10 acute sites are between 31% and 40%). • Span of control varies across the region.
9. Explore concept of establishing rural academic centres in Aspen (Cold Lake for East and Hinton for West) with increased relationship with rural training streams (physicians) and nursing schools in the North.	• Hinton reports stronger physician relationships and resourcing through its strong academic relationships. • Active teaching program with rural family medicine programs, which provides three residents most of the time and provides a steady stream of both permanent staff and locums. • Serves as a good model for regional expansion. • Region reports that its data indicates that Aspen is largest participant in rural training program and that it has well established relationship with nursing program.

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Cross Region Opportunities

Opportunities	Findings
10. Explore alternative service models to support patient flow and access to care.	• Somewhat premature placement in continuing care given lack of alternative levels of care such as assisted living care environments. • Anecdotal reporting of increased hours of home care provided in lodge settings to maintain residents in place. • No transitional care beds available within region. • Limited use of adult day program for medical or mental health needs. • Increased use of telehealth for clinical applications is on the rise but slow .
11. Need for stronger discharge planning focus and support in acute care across the region	• Exceedingly limited Social Work resources to support discharge planning. • Discharge planning function is primarily performed by nursing staff. • Varied interface with community – home care staff and the hospitals. • Current plan and reported approval to augment Social Work complement in region by 2.5 FTE. Clear role responsibility will be required.
12. Homecare Caseload Review	• Reported mismatch between some community offices in terms of caseload and FTE. • Assess homecare practice variation as driver of caseload.

Deloitte.

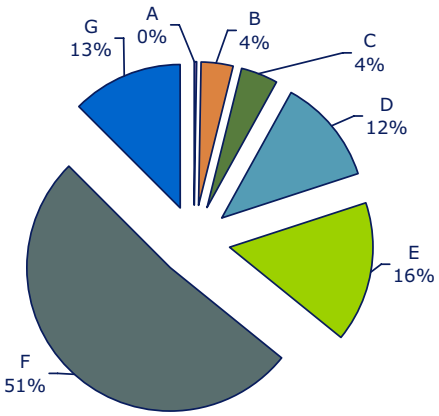
Continuing Care

Continuing Care Activity Analysis

ARHA Weighted Cases by Classification

Classification	Spring 2005 Continuing Care Weighted Cases	Spring 2005 Proportion of Total Cases	Proportion Variance Fall 2002 to Spring 2005
A	278	0%	200%
B	2,679	4%	17%
C	3,163	4%	-17%
D	9,084	12%	2%
E	12,092	16%	9%
F	39,420	51%	-7%
G	9,613	13%	7%
ARHA Total	76,329	100%	-2%

Proportion of Weighted Cases by Classification



Source: Alberta Health & Wellness LTC Database

- 80% of ARHA's continuing care weighted cases are distributed across classifications E, F and G as of Spring 2005.
  - Overall, proportion of weighted cases across all classification have remained relatively constant.
  - The proportion of F weighted cases have decreased the greatest from 55%in Fall 2002 to 52% in Spring 2005.
  - The decrease in weighted cases in C and F have been the primary drivers of an overall decrease in weighted cases of 2%.

Peer Staffing Comparative Analysis

Aspen Summary – All Continuing Care Facilities

Opportunities	Findings
1. Identify the total HPRD for all care roles involved in continuing care (PT, OT, Recreation, Social Work) to determine true gap before any potential staffing adjustments are made.	• Actual Hour Per Resident Day (HPRD) does not reflect the level of rehabilitation support provided by Physiotherapy, Occupational Therapy or Recreational Therapy. • Reported data for residential rehabilitation indicates varied levels of discipline support: – West 1: OT is 10% and PT is 18% – West 2: OT is 78% and PT is 45% – East 3: OT is 25% and PT is 24% – East 4: OT is 38% and PT is 29% • Where roles like Rehab Assistants (PT or OT) and Recreation Aides have a blended function with Health Care Aides/Nursing Aides, this combination is not factored in the actual HPRD value and should be considered as part of 3.4 HPRD target pursuit. • Potential staffing adjustments must consider the model of care and roles of all disciplines.

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Aspen Summary – All Continuing Care Facilities

Opportunities	Findings
2. Examine staffing allocations across continuing care facilities with respect to recent AHW target of 3.4 HPRD, and in the context of continuing care HR plan.	• In West 1, Edson and Seton facilities demonstrate relatively consistent levels of staffing. • In West 2, Westlock has higher HPRD than Keir CCC or Mayerthorpe • In East 3, Slave Lake has higher HPRD than Athabasca and Lac La Biche • In East 4, all facilities are relatively close, with Radway having the highest HPRD of all sites. • In terms of resident classification in Levels E, F and G: – West 1 has 78% of residents across Levels E, F and G – West 2 has 80% of residents across Levels E, F and G – East 3 has 89% of residents across Levels E, F and G – East 4 has 80% of residents across Levels E, F and G • This resident classification system suggests the target of 3.4 HPRD of combined nursing and personal care staffing is appropriate.
3. Develop a targeted HR plan for continuing care, as part of the broader regional HR strategy	• Continuing care has had difficulty in attracting and retaining aide staff, as salaries are no longer competitive relative to other market opportunities for staff.

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database, Grasp Database

Peer Staffing Comparative Analysis

Aspen Summary – All Continuing Care Facilities

Area	Site	Actual FTEs 2005-06	Actual Total Paid HPRD 2005-06	AHW Recom'd 3.4 HPRD @ 100 CMI	Recom'd FTE Effic.)/ Re-Invest. 2005-06
West 1	Edson Healthcare Centre	29.0	3.4	3.1	(2.7)
	Seton Hospital - Jasper	10.1	3.6	2.3	(3.5)
West 2	Dr. Keir Continuing Care Centre	71.5	3.4	3.0	(8.2)
	Mayerthorpe Healthcare Centre	19.4	3.5	3.3	(1.4)
	Westlock Long Term Care Centre	68.1	3.6	3.5	(1.1)
East 3	Athabasca Healthcare Centre	14.9	3.5	2.9	(2.5)
	Slave Lake Healthcare Centre	15.6	4.4	3.2	(4.1)
	Lac La Biche Healthcare Centre	29.1	3.8	3.2	(4.2)
East 4	Bonnyville Healthcare Centre	18.1	3.3	3.7	2.3
	Cold Lake Healthcare Centre	19.8	3.4	3.1	(1.7)
	Elk Point Healthcare Centre	20.3	3.7	3.0	(3.5)
	George McDougall Smoky Lake Healthcare Centre	34.4	3.4	3.3	(1.1)
	Radway Continuing Care Centre	17.9	5.0	3.5	(5.3)
	St. Therese Healthcare Centre	19.2	3.5	3.0	(3.0)

*Note: Full Year 2005-06 data was provided by the region for FTEs and HPRD calculations. The AHW Recom'd 3.4 HPRD @ 100 CMI is calculated using the Spring 2005 CMI for each facility.

Source: ARHA 2004-05, 2005-06 Oct YTD Payroll, Deloitte Database

Mental Health

West 1

- Mental Health

Mental Health Outpatient Activity

West 1

- West 1 Enrolments decreased by 2% between 2002-03 and 2004-05, while Events decreased by 3% for the same period, driven by a decline in volumes for Edson Mental Health Clinic.
- This decrease is offset by significant increases for Whitecourt and Hinton Mental Health Clinics of roughly 20%.

Clinics	Enrolments			Events		
	2002-03	2004-05	3-Year Variance	2002-03	2004-05	3-Year Variance
Edson Mental Health Clinic	590	493	-16%	4,337	3,121	-28%
Hinton Mental Health Clinic	420	423	1%	2,884	3,491	21%
Jasper Mental Health Clinic	54	65	20%	684	483	-29%
Whitecourt MH Clinic	435	486	12%	2,662	3,187	20%
Grand Total	1,499	1,467	-2%	10,567	10,282	-3%

Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity

West 1 – Events by Type

Type of Event	Type of Activity	2002-03	2003-04	2004-05	3-Year Variance
Face-to-Face	Assessment	1,406	1,257	1,328	-6%
	Consultation	544	391	584	7%
	Therapeutic Intervention	6,528	6,117	6,845	5%
Face-to-Face Total		8,478	7,765	8,757	3%
Telephone		740	351	309	-58%
Videoconference		-	15	26	n/a
Not Specified		1,349	1,244	1,190	-12%
Grand Total		10,567	9,375	10,282	-3%

- As demonstrated above, outpatient mental health activity in West 1 has been decreasing over the past three years by 3% - driven primarily by reductions in telephone-based events.
- The apparent absence of group interventions as a common service response strategy is noted. It is unknown if this is a coding issue.
- The observed 12% decline in Events that are "Not Specified" indicates that the accuracy for event coding in this sub-region has increased.

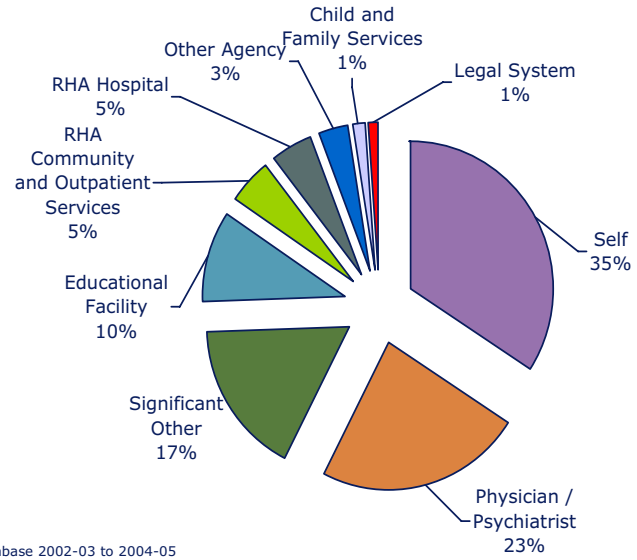
Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity

West 1 - Top 10 Referral Sources

- Top 10 referral sources for ARHA mental health enrolments represent almost 98% of total. Self-Referral, at 35% in 2004-05 is the most common referral source.

West 1 - Top 10 Enrolment Referral Sources



Source: ARMHIS Database 2002-03 to 2004-05

West 2

- Mental Health

Mental Health Outpatient Activity
West 2

- West 2 Enrolments increased by 16% between 2002-03 and 2004-05, while Events decreased by 13% for the same period.
- Increases in Enrolment volumes have been driven by the top 3 clinics while declines in Event volumes have been driven by Westlock, Barrhead and Onoway respectively; Swan Hills Mental Health Clinic has shown the greatest decline in Events on a 3-year % variance basis.
- Given the substantive decline, the issue of data capture and consistency is raised.

Clinics	Enrolments			Events		
	2002-03	2004-05	3-Year Variance	2002-03	2004-05	3-Year Variance
Barrhead Mental Health Clinic	379	430	13%	3,496	3,278	-6%
Mayerthorpe Mental Health Clinic	202	259	28%	1,380	1,195	-13%
Onoway Mental Health	216	225	4%	1,538	1,325	-14%
Swan Hills Mental Health Clinic	46	55	20%	464	296	-36%
Westlock Mental Health Clinic	320	383	20%	2,847	2,390	-16%
Grand Total	1,163	1,352	16%	9,725	8,484	-13%

Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity
West 2 – Events by Type

Type of Event	Type of Activity	2002-03	2003-04	2004-05	3-Year Variance
Face-to-Face	Assessment	1,167	818	901	-23%
	Consultation	1,164	1,192	1,195	3%
	Group Work	14			n/a
	Therapeutic Intervention	5,373	5,989	5,538	3%
Face-to-Face Total		7,718	7,999	7,634	-1%
Telephone		1,007	610	456	-55%
Videoconference		-	1	3	n/a
Not Specified		1,000	534	391	-61%
Grand Total		9,725	9,144	8,484	-13%

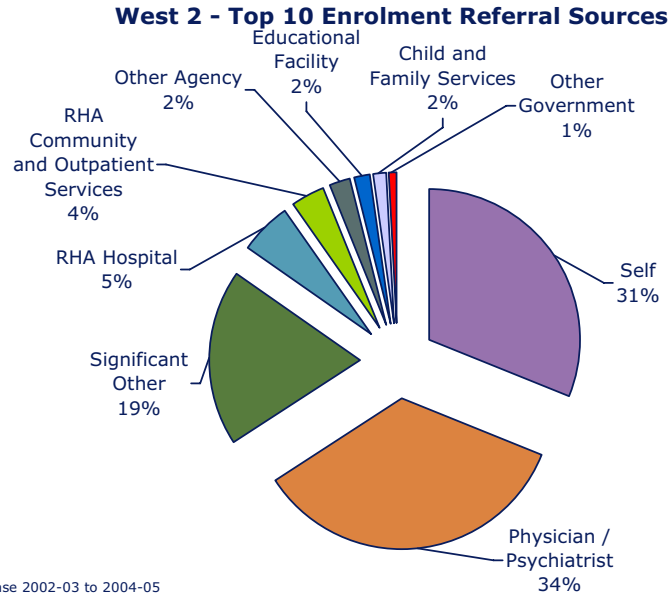
- As demonstrated above, outpatient mental health activity in West 2 has decreased over three years by 13% - driven primarily by reductions in telephone-based events.
- The absence of group intervention volumes also requires further investigation to determine if this service doesn't exist, or if there is a reporting anomaly.
- A significant decline in Events that are "Not Specified" indicates that the accuracy for event coding in this sub-region has increased, notwithstanding the query related to group work.

Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity

West 2 - Top 10 Referral Sources

- Top 10 referral sources for ARHA mental health enrolments represent almost 98% of total. Physician/Psychiatrist is the highest referral source, followed by self-referral at 31% in 2004-05.



Source: ARMHIS Database 2002-03 to 2004-05

East 3

- Mental Health

Mental Health Outpatient Activity
East 3

- East 3 Enrolments increased by 4% between 2002-03 and 2004-05, while Events increased by 1% for the same period.
- Increased Enrolments and event volumes have been driven by Lac La Biche mental health clinic.

Clinics	Enrolments			Events		
	2002-03	2004-05	3-Year Variance	2002-03	2004-05	3-Year Variance
Athabasca Mental Health Clinic	372	360	-3%	3,480	2,909	-16%
Lac La Biche Mental Health Clinic	376	404	7%	3,724	4,548	22%
Slave Lake Mental Health Clinic	87	107	23%	722	509	-30%
Grand Total	835	871	4%	7,926	7,966	1%

Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity
East 3 – Events by Type

Type of Event	Type of Activity	2002-03	2003-04	2004-05	3-Year Variance
Face-to-Face	Assessment	680	689	743	9%
	Consultation	327	294	344	5%
	Group Work	25		5	-80%
	Therapeutic Intervention	3,431	3,330	3,780	10%
Face-to-Face Total		4,463	4,313	4,872	9%
Telephone		657	663	657	0%
Videoconference		-	9	10	n/a
Not Specified		2,806	2,079	2,427	-14%
Grand Total		7,926	7,064	7,966	1%

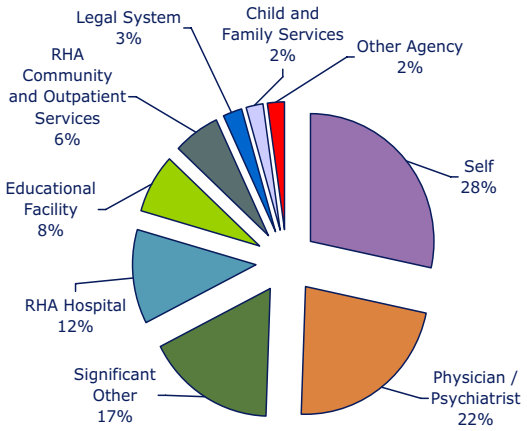
- As demonstrated above, outpatient mental health activity in East 3 increased slightly over the past three years by 1%, driven primarily by an increase in therapeutic intervention-based events.
- The absence of group intervention volumes also requires further investigation to determine if this service doesn't exist, or if there is a reporting anomaly.
- The observed 14% decline in Events that are "Not Specified" indicates that the accuracy for event coding in this sub-region has increased.

Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity
East 3 - Top 10 Referral Sources

- Top 10 referral sources for ARHA mental health enrolments represent almost 98% of total. Self-Referral, at 28% in 2004-05 is the most common referral source.

East 3 - Top 10 Enrolment Referral Sources



Source: ARMHIS Database 2002-03 to 2004-05

East 4
- Mental Health

Mental Health Outpatient Activity
East 4

- East 4 Enrolments increased by 16% between 2002-03 and 2004-05, while Event volumes were flat for the same period
- Enrolment and Event volumes were driven primarily by increased volumes for St. Paul Mental Health Clinic.
- Bonnyville and Cold Lake Event volumes have declined for the same period

Clinics	Enrolments			Events		
	2002-03	2004-05	3-Year Variance	2002-03	2004-05	3-Year Variance
Bonnyville Mental Health Clinic	584	631	8%	8,872	7,970	-10%
Cold Lake MH Clinic	484	551	14%	5,336	5,208	-2%
St. Paul Mental Health Clinic	572	715	25%	3,743	4,722	26%
Grand Total	1,640	1,897	16%	17,951	17,900	0%

Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity
Events by Type – East 4

Type of Event	Type of Activity	2002-03	2003-04	2004-05	3-Year Variance
Face-to-Face	Assessment	1,333	1,235	1,139	-15%
	Consultation	1,828	1,537	1,641	-10%
	Group Work	119	112	2	-98%
	Therapeutic Intervention	4,712	5,589	5,112	8%
Face-to-Face Total		7,992	8,473	7,894	-1%
Telephone		1,476	1,103	1,011	-32%
Not Specified		8,483	10,712	8,995	6%
Grand Total		17,951	20,288	17,900	0%

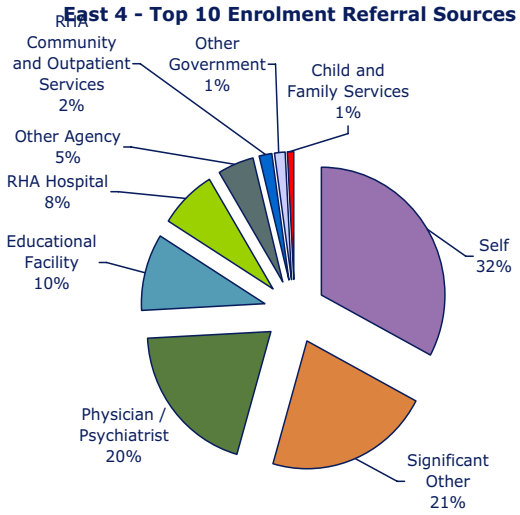
- East 4 outpatient mental health activity has been flat over the past three years.
- The absence of group intervention volumes also requires further investigation to determine if this service doesn't exist, or if there is a reporting anomaly.
- The observed 6% increase in Events that are "Not Specified" implies an opportunity to examine the accuracy of event coding.
- There is a notable jump in activity during 2003-04, also driven by Events that are "Not Specified.

Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Outpatient Activity

East 4 - Top 10 Referral Sources

- Top 10 referral sources for ARHA mental health enrolments represent almost 98% of total. Self-Referral, at 32% in 2004-05 is the most common referral source.



Source: ARMHIS Database 2002-03 to 2004-05

Mental Health Staff Trending and Opportunities

Area Description	Actual FTEs 2003-04	Actual FTEs 2004-05	Actual FTEs 2004-05 projected	% Change
Region-wide	79.6	79.3	78.3	-1.7%
West 1	21.8	22.3	20.8	-4.3%
West 2	15.1	17.0	17.4	15.2%
East 3	18.7	18.5	18.3	-2.6%
East 4	24.0	21.6	21.8	-9.2%

Source: ARHA Payroll Data

Opportunities	Findings
1. Conduct a comprehensive review of regional mental health services to determine the most appropriate alignment of resources across the continuum to meet client needs.	• Region reports that Mental Health plan does identify continuum of care considerations. • The inpatient psychiatry, located at St. Therese Hospital in St. Paul, is currently under renovation to expand beds. Our MCAP® assessment of this unit indicated that none of the admitted patients (7) were qualified for inpatient admission. • Discussion with the Psychiatrist and staff indicates no outpatient service is available and that there are limited mental health community services. The inpatient unit then becomes the "default" provider. • Given the far east location of psychiatric beds, West 1 and 2 will likely continue to access services in Edmonton or Ponoka before traveling further east to St. Paul. • Mental Health does appear to one of the most common clinical user groups for Telehealth. • The Mental Health Program is threatened by a lack of staff to serve the expanded capacity. – Psychiatrists, as there is currently only 1 psychiatrist at St. Therese, however there is a indication that an additional psychiatrist may be on staff within a year. – The same concern exists for nursing.
2. Develop a targeted mental health resource strategy to address current and anticipated capacity, staffing, physician and education requirements for expanded service at St. Therese's.	

Home Care

Home Care Services Findings and Opportunities

Area Description	Actual FTEs 2003-04	Actual FTEs 2004-05	Actual HPPD 2005-06	% Change
Region-wide	198.6	211.9	218.9	10%
West 1	41.0	41.3	41.8	2%
West 2	46.9	53.9	58.0	24%
East 3	33.4	35.2	36.6	10%
East 4	77.3	81.4	82.4	7%

Source: Payroll Data ARHA

Opportunities	Findings
1. Develop and implement workload measurement, and caseload tracking and reporting for home care to enable management decision making.	• Consultation findings suggests that there is limited monitoring of activity or volume of Home Care services which is supported by a lack of available data from the region. • This lack of information is resulting in management challenges with respect to resource management, planning and program development. • Reports of mismatch between caseload/FTE assignments. • Caseload auditing may suggest practice differences across the region.
2. Develop a targeted recruitment and retention plan for PCAs, that is integrated into the broader regional HR strategy.	• Similar to continuing care, home care is faced with a significant challenge in attracting and retaining PCAs due to market competition and low salaries. Although this finding was noted in our interviews, Human Resource reports that postings have not yet shown this concern.
3. Develop standardized discharge and process across region.	• Home care role in discharge planning and placement coordination is reported to vary throughout the region, which can have a negative impact on resource management and care delivery.
4. Expand alternative service model like Adult Day Programs and other transitional supports. Assess the required investments to enable success, such as transportation.	• Adult Day Programs, where they are implemented, have been reported to be a very successful strategy to support elderly in home. • There has been limited uptake in this alternative service model across region. • Available and accessible transportation is a necessary enabler for client attendance. Given the cross-jurisdictional nature of transportation, RHA should continue its advocacy role related to transportation.

Population Health

Population Health Staff Trending and Opportunities

Area Description	Actual FTEs 2003-04	Actual FTEs 2004-05	Actual FTEs 2004-05 projected	% Change
Region-wide	89.8	85.7	84.3	-6%
West 1	24.3	21.3	20.1	-17%
West 2	16.5	15.7	16.6	1%
East 3	28.7	28.1	27.7	-3%
East 4	20.4	20.7	19.9	-2%

Source: Payroll Data ARHA

Opportunities	Findings
1. Explore options for increased use of telehealth in service delivery, with impact assessment of the relative costs/benefits to align resources to this service delivery model.	• Population Health programming is divided between core services, programs in specified communities, targeted programs for high risk/need. • All regions have population elements that are hard to reach and hard to serve. • Project based funding creates challenges for service sustainability.
2. Assess service standardization across Region, in alignment with a regional community health needs assessment.	• Population Health leadership is largely focused at Regional Coordinator role. Other roles that have a leadership part to play have many other areas of focus (VP's with very large responsibility and similar scenario for CHS Managers and Supervisors). • Some concern about matrix model limiting program development and innovation at community office level. • Analysis indicates that there are over 80 FTEs dedicated to population health, but in the absence of workload/activity data or a community health needs assessment, the appropriateness of this level of resourcing is difficult to determine.

Environmental Health

Environmental Health Staff Trending

Area Description	Actual FTEs 2003-04	Actual FTEs 2004-05	Actual HPPD 2005-06	% Change
Region-wide	13.3	13.1	14.2	7%

Source: Payroll Data ARHA

Opportunities	Findings
1. Assess staffing need in Environmental Health to ensure appropriate staffing levels.	• Service not integrated within broader Community Health Services given the high regulatory requirements. • Transient work force and camps across region increase workload for PHI staff. • Manual reporting – lack of information system to support reporting and trending.

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Physician Findings and Opportunities

Physician Findings and Opportunities
Introduction

- The review process incorporated several direct consultations with physicians, which have yielded a number of findings and opportunities.
- Physician-related findings and opportunities have been clustered into the following five key areas, which also have linkage to opportunities identified across other areas of the region:

Physician Governance and Leadership

Physician Human Resources Planning and Management

Quality, Risk and Performance Management

Program Review and Organization

Physician Findings and Opportunities

Physician Findings and Opportunities

Governance and Leadership

Findings

- Consultation findings suggest there are gaps in physician accountability related to adherence with by-laws and medical policies/procedures. These gaps contribute to challenges in overall physician governance and leadership in the region.
- In consultation, Chiefs did not consistently identify their role definition and accountability framework, however, the Region reports that chief roles have been defined are reported in MAC minutes and are reflected in medical staff bylaws.
- Variation in leadership roles and definitions suggests a need for greater alignment between current physician leadership structures/supports and requirements of the region.
- Consultation identified a sense of apathy among the physician group. The Region acknowledges that physician shortages play a role in securing physician engagement.

Opportunities

1. Conduct an externally led review of MAC governance structure/mechanisms with specific attention to by-law adherence/alignment.
2. Identify physician leadership requirements and conduct an alignment exercise to determine gaps.
3. Create a medical leadership accountability framework – which includes examining current organizational and reporting structures, and current/potential roles and responsibilities for Chiefs in the management and decision making process at a program, site, and regional level.

Physician Findings and Opportunities

Physician Human Resources

Findings

- The region is facing several physician recruitment/retention issues and current staffing shortages.
- A broader physician HR strategy is lacking. Areas of focus should be alignment of physician skill mix with care and service delivery priorities for the region, and exploration of alternative remuneration strategies to attract and retain physicians.
- Limited education structure to facilitate advanced physician training and maintenance of certification.
- Physician recruitment and service expansion is reported to occur without full consideration of physician impact on other clinical services (i.e. nursing, allied health, community health), space availability, bed capacity, equipment requirements, IT/IS requirements, etc.
- Strong IMG population. Region is addressing this issue, however, consultation suggests continued efforts are required to continue to address and support cross-cultural considerations.

Opportunities

1. Continue to develop a regional Physician Human Resource Strategy that links to the HR and regional strategy, and is focused on Physician resource gaps, skills management and education, alignment/realignment of current resources to core service delivery needs, recruitment/retention.
2. Continue to explore alternative payment models for physicians in the region, with an objective to improve resourcing, and linkage to care/service delivery model.
    - As part of this opportunity, explore alternate staffing models in the consideration of physician AFP options – e.g. APN/NP model in ER and community health clinics.
3. Continue to develop a regional, comprehensive Physician Impact Assessment process for physician recruitment needs planning, and in assessment when new physicians are being considered and when services are being expanded or developed. This assessment needs to be linked to the region's strategic directions for its clinical programs, and needs to consider broad programming impacts (human resources, infrastructure, funding, etc.)
    - Physician Impact Assessments should be considered in the context of a regional needs assessment.

Physician Findings and Opportunities

Quality, Risk, and Performance Management

Findings

- Substantial efforts made over the last few years in this area. Region reports gains made in patient safety, incident reporting, QI teams.
- Lacking an assessment framework for MD quality, performance, or competencies; which is compounded by a lack of required funding or resources available to maintain education and certification.
- Recognize preliminary efforts underway by the region on standardized protocols or care paths, and the goal to continue these efforts. Consultation findings suggest limited physician support of established standardized protocols or paths, and a need for greater physician accountability for developing and maintaining consistent standards of practice across region. Also, no standardized utilization tools.
- There is need for a physician risk management framework to assess and proactively manage physician-related issues and risks at the service, site, community and regional levels.
- Significant apathy is apparent among the physician group, reducing their engagement, support and buy-in to quality and risk management issues.

Opportunities

1. Create an accountability framework with evaluation and quality/risk/performance management tools for Physicians, which is integrated into the broader regional framework.
   - Continued and significant education is required at all levels of the organization to promote a quality culture. While the region has undertaken substantial effort in this regard, it must continue its emphasis in this regard.
2. Develop a regional approach and support for CME, based on a sustainable business model, and integrated with the physician recruitment and retention strategy and broader regional education function.
   - Given proximity to academic centre, CME credits should be mandatory to maintain privilege.
3. Develop a clinical adoption strategy for standardized, peer reviewed protocols and care maps for key conditions (e.g. pneumonia, cellulitis, congestive heart failure, and MI management).

Physician Findings and Opportunities

Clinical Program Frameworks and Review

Findings

- Varied adoption of leading practices within Maternal/Child, Orthopedics, and General Surgery services.
- CTAS implementation inconsistent across the region (which has quality of care and efficiency issues as well).
- Requirement to examine laboratory services regionally – focusing on testing menu, resource duplication, supporting IT/IS, quality and performance management, and procurement.
- Observed inconsistencies were also noted with respect to the pharmaceutical formulary, and inventory control across the region.
- Need for increased attention and review of critical mass for select clinical areas supports need for Clinical Service Role review, particularly in communities of relatively close proximity.

Opportunities

1. Alignment diagnostic along leading practices for Maternal/Child, Orthopedics, and General Surgery services - requirement for alignment with centres of excellence models.
2. CTAS strategy requirement that considers space configuration, human resources, and training/education needed to ensure region-wide adoption.
   - Triage needs to be fully implemented and supported with properly trained resources. Rural modifiers may need to be considered especially in centres with volumes of less than 15,000 ER visits (not to include booked patients). Space should be configured to accommodate Triage in a standardized and functional manner.
3. Regional laboratory review: standardized menu, consolidation of resources, LIS, group purchasing, quality monitoring, repatriation
4. Regional pharmacy review to examine opportunities for formulary standardization, stricter inventory management and control, and PIXIS

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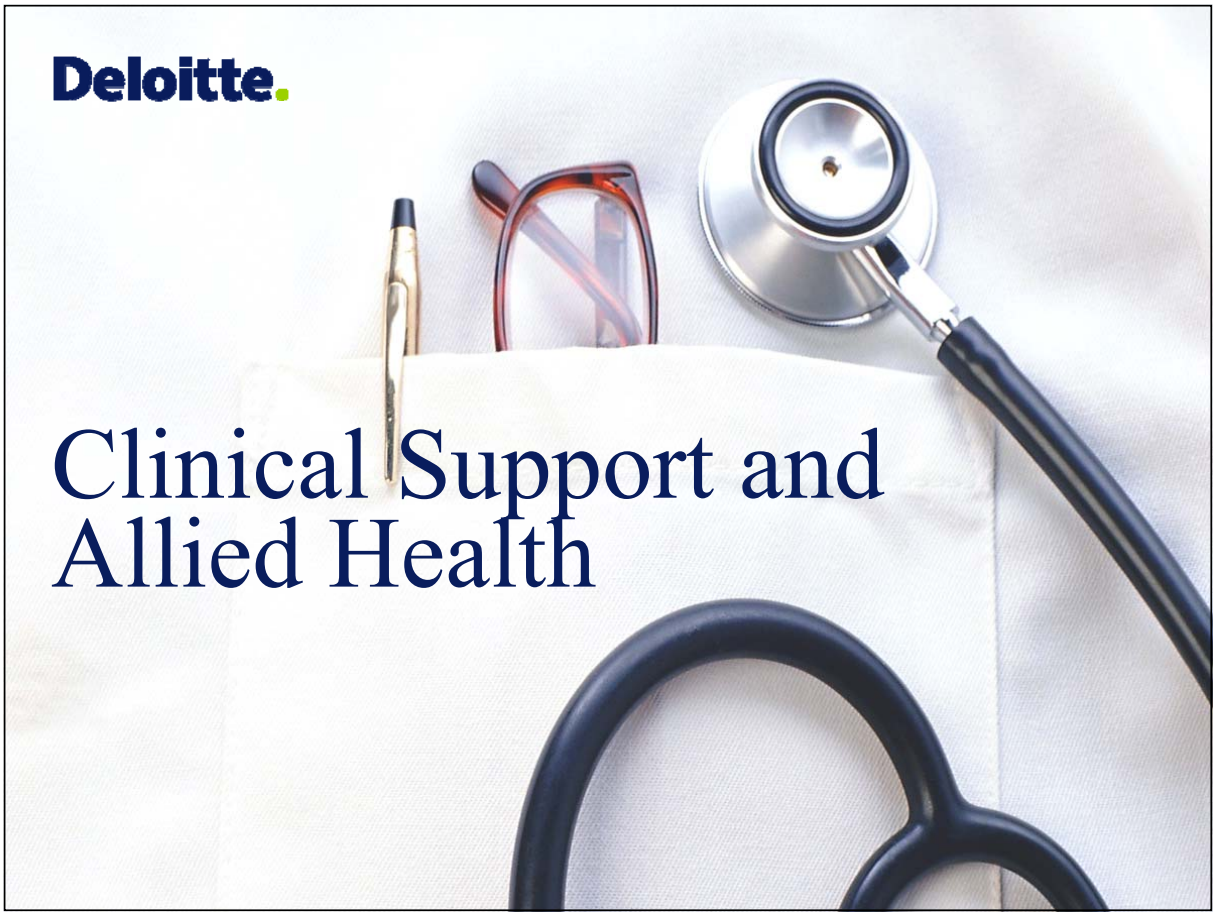


Clinical Support and Allied Health

Peer Staffing Comparative Analysis

Process Overview

- To understand the relative efficiency of the Clinical Support and Allied Health services, we conducted a comparative analysis with a number of comparable health regions from Alberta, British Columbia, Manitoba, and Saskatchewan
- Fiscal 2004-05 data for ARHA was used for peer comparison, as this represents a full year of staffing, but reference to observed 2005-06 YTD staffing levels are also provided
- The efficiency analysis assessed peer staffing based on a comparison of actual total paid hours per adjusted patient day (HAPD) for each "discipline" within the organization (based on MIS functional centre alignment).
  - Although many of the allied health disciplines in the region are aligned to clinical programs, an MIS-based alignment for comparison was used to ensure an 'apples-to-apples' comparison to peers.
- The adjustment factor increases the base of inpatient clinical activity to better reflect the span of inpatient, outpatient, continuing care and community clinical activity.
- The results across the comparator group were considered with the following "rules" applied at the departmental level:
  - Values among the comparator group that were well outside the range (e.g. outliers) were eliminated from the analysis.
  - For Clinical Support and Allied Health Services, the FTE efficiency opportunity was identified compared to the 50th percentile to reflect a more realistic level of clinical resourcing to support patient care needs.
- Staffing opportunities are identified based on comparative analysis and the team's understanding of minimum staffing requirements. Staffing opportunities are not stand alone, however, and need to be considered in the context of other opportunities identified for each area.
- The benchmarking information should be used as input to management decision-making, rather than as a decision in and of itself.

Peer Staffing Comparative Analysis

Clinical Support Services Areas Reviewed

MIS Code	MIS Description
71410	Clinical Laboratory
71415	Diagnostic Imaging
71435	Respiratory Therapy
71440	Pharmacy
71445	Clinical Nutrition
71450	Physiotherapy
71455	Occupational Therapy
71460	Audiology And Speech/Language Pathology
71470	Social Work
71485	Recreation

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Clinical Laboratory

Opportunities	Findings
1. Review and assess benefit in adopting a regional laboratory management model that organizes lab service by cluster.	• Legacy lab operations still in place; limited evidence of regional programming in place; levels of staffing varied across region. Single lab site not appropriate. More could be done in cluster model. • Comparative analysis shows that Aspen has considerably more staffing than peers; hence the potential benefit in exploring different regional model. • Labs indicated staffing challenges in terms of vacancies, attraction and recruitment
2. Develop standardized regional menu	• Lab menu varied by site – continued evidence of legacy operations.
3. Conduct a Targeted Lab Review in Region to support stronger centralization of lab function. – Focus of review should include: required service levels, staffing (including CLXT impact and requirements), hours of operation and enabler requirements related to Information Technology and equipment.	• Regional gains and efficiencies not yet achieved in lab operations. • Many Labs across region have inadequate space. • Equipment issues.
4. Develop staffing plan based on regional model to address potential staff savings (identified as up to 18 FTE's at the midpoint comparison level).	• Staffing comparison suggests current lab operating model is not efficient. Given the region's size, there are limitations to efficiency. Service organization and delivery by cluster may yield efficiencies. • FTE savings is not achievable in the current operating model.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Clinical Laboratory	118	125.7	0.44	0.03	0.82	0.37	See above (18.0)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Diagnostic Imaging

Opportunities	Findings
1. Review and assess benefit in adopting a regional Diagnostic Imaging management model that plans, organizes and provides DI service by cluster.	• Legacy DI operations are still in place. • Department indicated staffing challenges in terms of vacancies, attraction and recruitment. For example, Ultrasound Clinical Lead role is largely functioning in a staff capacity. • Equipment and facility (space) issues across region.
	• Region is too broad for single role (Area 3 Director) providing regional leadership in addition to her Area 3 role related to facilities and community health services. • Same concern applies to the practice support roles across the region. • Reported extended hours of operation will put DI over benchmark performance in terms of staffing efficiency.
2. Assess future operating savings related to film and staffing with fuller adoption of PACS across Region.	• Limited PACS installation does not enable operating efficiencies related to supply cost (film) and staffing.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Diagnostic Imaging	70.7	79.5	0.26	0.09	0.35	0.26	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Respiratory Therapy

Opportunities	Findings
1. Ensure consistent range of services supported by Respiratory Therapy available across Region.	• Respiratory Therapy is primarily community-based service, which is appropriate for types of facilities and service across Region. • Staffing by Area (1 through 4) is varied suggesting some legacy operations holdover.
2. No FTE investment opportunity at this time.	• Aspen's comparison against peer set produces high staff investment result of 10.8. This result is largely driven by critical care presence in other regions. Hence, there is no investment opportunity in Respiratory Therapy at this time. • Where internal medicine increases presence and a site assumes key / lead role, Aspen should consider investment at that time.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Respiratory Therapy	5.8	6.8	0.02	0.01	0.12	0.06	See above 10.8

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Pharmacy

Opportunities	Findings
1. Review and assess benefit in adopting a regional pharmacy management model that organizes pharmacy service by cluster: – Develop standardized formulary – Develop standardized procedures for inventory control	• Legacy Pharmacy operations still in place; limited evidence of regional programming in place; levels of staffing varied across region. Single pharmacy location not appropriate, however more could be done in cluster model. This may mean limited function at select sites and enhanced function at others and potential for regional management role. • Department indicated staffing challenges in terms of vacancies, attraction and recruitment. • Equipment and facility (space) issues across region. Some sites in very small cramped locations. • IS / IT investment for stronger regional model is significant.
	• Region is too broad for single role (Area 3 Director) providing regional leadership in addition to her Area 3 role related to facilities and community health services. • Same concern applies to the practice support roles across the region. • Staffing comparison suggests some staff savings may be possible, however efficiencies not possible until service model realigned. • Highly variant practice across region.
2. Develop staffing plan based on regional service model.	• Staffing comparison suggests current operating model is very close to mid point level of staffing performance (small opportunity of 2 FTE savings). Given size of region, there are limitations to efficiency, however service organization and delivery by cluster should yield efficiencies. • FTE savings not achievable in current operating model.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Pharmacy	28.9	29.5	0.12	0.07	0.20	0.12	See above (2.0)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Clinical Nutrition

Opportunities	Findings
1. Review and assess benefit in adopting a regional Clinical Nutrition management model that organizes service by cluster: – Region should assess the greatest area of need for staffing investment based on the varied staffing levels within Region.	• Clinical Nutrition is primarily community-based service, which is appropriate for types of facilities and service across Region. • Services are provided for continuing care and acute care facilities, as required. • Staffing is somewhat varied by Area (1 through 4) suggesting some legacy operations holdover.
2. Develop staffing plan based on regional service model.	• Staffing comparison against peer midpoint suggests required staffing investment of approximately 3 FTE. • Additional staffing should be assessed in light of regional model and value in resources to support community and Chronic Disease Management programming. • FTE investment should be considered to support future service delivery.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Clinical Nutrition	9.4	9.5	0.03	0.01	0.06	0.05	See above 3.1

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Physiotherapy

Opportunities	Findings
1. Conduct a Targeted Rehab Review in Region to determine if current level of investment is desirable and contributes to the desired patient flow and continuum of care needs. – Focus of review should include: required service levels (current and future), model of care, staffing (including mix and potential re-allocation – if appropriate), hours of operation, and professional practice. – Assess staffing requirements in light of further review	• Physiotherapy function and discipline is housed in Community Health Services. Staff are deployed to the continuum (acute care, continuing care, and community care). • Reported data suggests that Physiotherapy provides approximately 33% of its work effort to residential care, 50% for community and outpatient and 17% for inpatient. • Physiotherapy operates with a staff split of approximately 55% professional staff and 45% assistant staff. • Mixed reaction among care facilities at the management model which does not have on-site staff reporting to Facility Managers. • Staffing appears highest in West 2, followed by East 4 suggesting the impact of ortho and possible legacy staffing. However, crude comparison of FTE to visits suggest that West 1 and 2 are working at lower levels of throughput than the East 3 and 4. • Staffing comparison suggests current operating model is well above midpoint level of staffing performance (high opportunity of 20 FTE savings). Data shows that there are 0 FTE within staffing numbers related to SHIP. Targeted review of Rehab is required before staffing adjustments made – particularly in light of reported challenges to serve orthopaedic and emerging initiatives such as Regional Stroke.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Physiotherapy	63.6	59.0	0.24	0.09	0.30	0.16	See above (20.6)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Occupational Therapy

Opportunities	Findings
1. Conduct a Targeted Rehab Review in Region to support if current level of investment is desirable and contributes to the desired patient flow and continuum of care needs. – Focus of review should include: required service levels (current and future), model of care, staffing (including mix and potential re-allocation – if appropriate), hours of operation, and professional practice. – Assess staffing requirements in light of further review	• Occupational Therapy function and discipline is housed in Community Health Services. Staff are deployed to the continuum (acute care, continuing care, and community care). • Reported data suggests that Physiotherapy provides approximately 52% of its work effort to residential care, 41% for community and outpatient and 7% for inpatient. • Occupational Therapy operates with a staff split of approximately 75% professional staff and 25% assistant staff.. • Mixed reaction among care facilities at the management model which does not have on-site staff reporting to Facility Managers. • Staffing levels appear highest in West 2 and East 4 suggesting the impact of ortho and possible legacy staffing. • Staffing comparison suggests current operating model is well above midpoint level of staffing performance (high opportunity of 13.8 FTE savings). Data shows that 9.8 FTE within staffing numbers include 9.8 FTE for SHIP. Targeted review of Rehab is required before staffing adjustments made – particularly in light of reported challenges to serve orthopaedic and emerging initiatives such as Regional Stroke.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Occupational Therapy	40.1	43.0	0.15	0.07	0.17	0.10	See above (13.8)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Audiology & Speech Language Pathology

Opportunities	Findings
1. Conduct a Targeted Rehab Review in Region to support if current level of investment is desirable and contributes to the desired patient flow and continuum of care needs. – Focus of review should include: required service levels (current and future), model of care, staffing (including mix and potential re-allocation – if appropriate), hours of operation, and professional practice.	• Speech and Language Therapy and Audiology functions and disciplines are housed in Community Health Services. Staff are deployed to the continuum (acute care, continuing care, and community care). • One community has used Telehealth to support SLP delivery. • Staffing in Area 4 is highest, probably driven the Audiology program. • Speech and Language Practice Lead is vacant. • Region is too broad for single role to provide practice support across region. • Staffing comparison suggests current operating model is well above midpoint level of staffing performance (high opportunity of 7.6 FTE savings). Data shows that 6.3 FTE within staffing numbers include 9.8 FTE for SHIP. Targeted review of Rehab is required before staffing adjustments made – particularly in light of recruitment and retention challenges.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Audiology & Speech Language Pathology	32.0	36.7	0.13	0.04	0.21	0.10	See above (7.6)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Social Work

Opportunities	Findings
1. Determine a region wide process and structure to support patient flow and discharge planning 2. Reassess the planned upward adjustment to Social Work or similar roles (in light of reported investment opportunity) to support patient flow and discharge requirements. 3. Reassess organizational placement and reporting model for dedicated patient flow and discharge support roles.	• Staffing comparison suggests staffing investment of approximately 6 FTE is required. • Social Work currently work only in Area 1 and provide a blend of both acute inpatient and community based service support. • Existence of two Placement Coordinators in Region are available resources for placement and other support as required. • Limited dedicated resources to support inpatient discharge and planning processes in acute care setting. Discharge function for acute care patients largely falls to the Nursing Supervisor. • Region reports plans to augment the Social Work complement to a total of 4 across region. • The plan is to allocate 1FTE of Social Work support to each area. The roles will follow the other discipline reporting model and report through Community Health Services. – This reporting structure raises concerns about role focus in terms of patient flow. • The primary function and role for Social Work was unclear – although most expect the role is to focus on patient flow, care planning and discharge.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Social Work	1.5	1.4	0.1	0.003	0.04	0.03	See above 6.3

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Recreation

Opportunities	Findings
1. No opportunity at regional level.	• Recreation roles are primarily supporting continuing care residents. • Recreation staff will also support long stay patients in acute care who are waiting placement. • Given the increased emphasis on continuing care delivery, staffing efficiencies are not warranted in this group. • Ensure the recreation staffing contribution is included in the Hour Per Resident Day determination against the provincial target (see Continuing Care section of this report).

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Recreation	29.6	31.2	0.11	0.03	0.11	0.10	See above (3.7)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Process Overview

- To understand the relative efficiency of the Corporate and Support Services, we conducted a comparative analysis with a number of comparable health regions from Alberta, British Columbia, Manitoba, and Saskatchewan
- Fiscal 2004-05 data for ARHA was used for peer comparison, as this represents a full year of staffing, but reference to observed 2005-06 YTD staffing levels are also provided
- The efficiency analysis assessed peer staffing based on a comparison of actual total paid hours per adjusted patient day (HAPD) for each "department" within the organization (based on MIS functional centre alignment).
- The adjustment factor increases the base of inpatient clinical activity to better reflect the span of inpatient, outpatient, continuing care and community clinical activity.
- The results across the comparator group were considered with the following "rules" applied at the departmental level:
  - Values among the comparator group that were well outside the range (e.g. outliers) were eliminated from the analysis.
  - Given the northern geographic challenges faced by the region, the FTE efficiency opportunity for all Corporate, Support, Clinical Support and Allied Health Services was identified compared to the peer 50th percentile level of staffing performance.
- Staffing opportunities are identified based on comparative analysis and the team's understanding of minimum staffing requirements. Staffing opportunities are not stand alone, however, and need to be considered in the context of other opportunities identified for each area.
- The benchmarking information should be used as input to management decision-making, rather than as a decision in and of itself.

Peer Staffing Comparative Analysis

Administrative and Non-Clinical Support Services Areas Reviewed

MIS Code	MIS Description	MIS Code	MIS Description
71105	General Admin	71150	Laundry And Linen
71110	Administration	71153	Plant Admin
71205	Nursing Admin - Acute	71155	Plant Operation
71170	Nursing Admin	71165	Plant Maintenance
71305	Nursing Admin - Ambulatory	71175	Bio-Medical Engineering/Medical Physics
71505	Community Svcs Admin	71180	Registration
71115	Finance	71130	Communications
71120	Human Resources/Personnel	71190	Health Records
71125	Systems Support	71195	Patient/Resident Food Services
71135	Materiel Management	71910	Non-Patient Food
71145	Housekeeping		

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

General and Nursing Administration Combined Areas

Opportunities	Findings
1. Review matrix model in terms of: – Management roles and responsibilities – Role overlap – Accountability framework for decision-making – Span of control for Director roles (who have site and regional responsibility) – Establishing corporate critical mass	• Matrix model is a heavier management model, which is exacerbated by the size of the Region. • High degree of role overlap between a number of roles: – Regional Coordinators, Clinical Leads, Community Health Services Manager, Community Health Supervisors on community side – Area Directors, Facility Managers, Community Health Service Managers, Regional Coordinators • Area focus appears to be reasonable method to drive operations. • Area Director role have very broad responsibilities (facility and community oversight and regional responsibilities) with significant travel requirements • Very low level of staff resource investment to support implementation – particularly evident at the facility level (both acute and continuing care). • Very low number of "out of scope" roles. • Very low level of organizational investment in areas such as decision support, quality, performance and risk management. • Lack of standardized staff ratio to supervisor requirements • Number of out of scope vs. in scope supervisors varies across region – appears related to legacy operations • The corporate structure also follows a decentralized model, which creates challenges for direction setting and maintaining critical mass. Where the region considers further centralization of corporate resources, investment in facilities may be required.
2. Increase support for regional implementation initiatives that allow change to cascade to the operational level	
3. Review / restructure Medical / Legal / Quality portfolio to create two roles (1 for Medical and 1 for Performance Management (Quality, Risk, Legal) – Do not replace the current Medical Director vacancy (in light of the above reorganization)	
4. Review span of control across region for both clinical and operating support areas.	
5. Review need and allocation of practice support roles for Nursing.	• Limited dedicated professional practice support roles for Nursing

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
General & Nursing Admin. Combined	76.8	78.3	0.33	0.09	0.44	0.39	See above 15.2

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Finance

Opportunities	Findings
1. Shift accountability to management for budget development, thereby enabling Finance to play stronger consultative / advisor / decision support role.	• Staffing comparison shows no staff savings opportunity. • Finance Department quite focused on transactional activities (Accounts Payable/Receivable, Budget Development). • Region wide policies and procedures are in place. • Do provide peer review data quarterly to Managers. Unsure the extent to which data is used. • Financial reporting in community side is rolled up by community – thereby making variance tracking by service stream difficult. Finance runs additional report to sort out variance. • Consultation indicated that budget development is done by Finance – with limited management involvement at the cost centre level. This may contribute to limited accountability. • Organization appears heavily oriented to centralized control of financial management – as evidenced by middle manager level having little involvement, responsibility and accountability.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Finance	38.4	38.8	0.14	0.05	0.19	0.14	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Human Resources

Opportunities	Findings
1. Re-assess the predominantly decentralized approach to HR management. 2. Provide additional investment of at least 3 FTE in HR to support stronger centralized roles and strategic focus on recruitment, workforce planning, external partnerships, and developing innovative models at both the staff and physician level. 3. Increase support and work effort with local communities and physicians to strengthen recruitment and retention. 4. Assess partnership potential with other Northern Regions.	• Staffing comparison shows an investment opportunity of approximately 3 FTEs to bring staffing in line with mid point. • Decentralized approach has been adopted to support various areas by providing closer local support, however, it negates any potential for broader HR critical mass and requires a stronger generalist function. • Currently outsource disability management – with plans to bring back in. • Human Resources requires much stronger profile and role if it is to support the escalating and critical people needs in ARHA and begin to adopt a strategic role vs. transactional. • While the department is under-resourced to support managers in areas such as recruitment, the workload downloaded to the Manager level is high. The result is inconsistent HR practices across the Region. • Moreover, the lack of centralized resources to support recruitment creates substantial duplication of work effort among Managers who are recruiting roles from a very limited pool. • Physician recruitment is missing as is a workforce plan with key demographics, skills inventory, and location. • Given the pressing HR issues, the organization may want to resource it above the midpoint level (for example at or near the 75th percentile).

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Human Resources	15.9	17.7	0.06	0.03	0.13	0.07	See above 3.0

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Education

Opportunities	Findings
1. Determine most critical areas for staff training investment.	• Staffing comparison against peer midpoint suggests required staffing investment of approximately 3.7 FTEs. • Finding supports the reported low level of education resource availability for training and development • Education resources are focused on the planning, programming and coordinating function, which is understandable given their resourcing. • Education delivery at the operational level is downloaded to the managers and select staff, which creates risk in terms of standard delivery or delivery at all.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Education	6.5	8.9	0.02	0.01	0.06	0.04	See above 3.7

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Systems Support (IS/IT)

Opportunities	Findings
1. No staff savings opportunity 2. ARHA should expand collaborative initiatives with other Regions – particularly in North. 3. Stronger regional interface and collaboration related to IT prioritization and implementation support.	• Staffing comparison against peer midpoint suggests some staff savings opportunity. However, in light of increasing work effort related to IS / IT requirements, staff reduction is not advisable. • ARHA still struggling with legacy systems and lack of integrated data. • RSHIP initiative has and will continue to require large amount of work effort across region. • Proposed reconfiguration of staffing to support Technology Applications vs. Projects. This plan will prevent project requirements cannibalizing the day to day operational support requirements.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Systems Support	18.8	19.9	0.07	0.04	0.17	0.06	See above (2.5)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Materiel Management

Opportunities	Findings
1. Where region adopts stronger regional management model for Food Services, explore Materials Management supporting consolidation of purchase for these areas.	• Staffing comparison shows no staff savings opportunity. • Department has moved to regionalize across the former 4 entities: – Purchasing is consolidated at Westlock – Use of regional forms – Regionalized contracting out – Use of regional hubs for inventory (hub and spoke such as Slave Lake) • Reported progress on: controlled inventory, inventory backlog. • Do not purchase for Food, Pharmacy. • Maintenance does some of own purchase (parts and oxygen). • Director reports untapped opportunity related to Laundry, Food Services and Maintenance.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Materiel Management	50.4	52.0	0.19	0.06	0.43	0.19	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Housekeeping

Opportunities	Findings
1. Review and assess benefit in adopting a regional housekeeping management model that focuses on standardization across region.	• Limited regional management approach to staffing, standards, procedures
2. Assess span of control across region.	• Facilities visited were very clean, clear of hallway obstacles and in excellent condition (regardless of facility age). • Wide variation in staff supervision across sites – where supervision occurs by: – Facility Manager – Out of Scope Supervisor for various areas (Housekeeping, Laundry, Plant) – In Scope Supervisor (Housekeeping, Laundry, Plant)
3. No staffing investment opportunity	• Housekeeping's comparison against peer set is problematic given the large number of Aspen sites that are either leased or located in provincial buildings. Non-Aspen housekeeping sites are not provided in this comparison, hence Aspen staffing appears artificially low.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Housekeeping	135.0	133.6	0.5	0.24	0.62	0.59	No investment

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Laundry & Linen

Opportunities	Findings
1. Review and assess benefit in adopting a regional laundry management model that organizes laundry service by cluster: – Consider alternative service model for laundry that creates regional laundry centres following cluster / area framework (Athabasca model). – Avoid future capital cost requirements to replace laundry units at each site.	• Generally, all sites visited provide laundry service with the exception of Slave Lake that receives laundry service from Athabasca. • Frequent role blending between Laundry and Central Sterilizing and Distribution functions. However, equivalent FTE's reported in Laundry is 57.6 across Region. • Generally, laundry equipment across sites visited appeared in good working order.
2. Assess staffing saving potential through adoption of alternative service model (above).	• Staffing comparison analysis indicates a potential staff savings of approximately 7.4 FTE.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Laundry & Linen	57.7	59.5	0.21	0.07	0.21	0.19	See above (7.4)

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Health Records, Telecom and Patient Registration Combined

Opportunities	Findings
1. Assess investment required as ARHA adopts stronger Decision Support function.	• Created blended area for staffing comparison based on role blending across facilities and regions. • State of health records departments widely varied across region (from extremely well organized in well designed space to remarkably cramped in very poor space) • Continued progress on the Electronic Health Record will dramatically change service function and staffing requirements. • No savings identified in staffing comparison analysis. Note: the blend of Health Records with Patient Registration and Telecommunications may offset required investment in Heath Records to support decision-support functionality.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Health Rec., Telecom Pt Reg. Combined	168.2	171.0	0.44	0.14	0.49	0.44	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Plant Operations, Maintenance and Biomedical Engineering Combined

Opportunities	Findings
1. Review and assess benefit in adopting a regional Plant Maintenance and Operations management model that manages by cluster: – Consider alternative service model for staffing, workload planning that incorporate both demand and preventative maintainence.	• Facilities visited, regardless of age, were well maintained and appeared in good condition. • Wide variation in staff supervision across sites – where supervision occurs by: – Facility Manager – Out of Scope Supervisor for various areas (Housekeeping, Laundry, Plant) – In Scope Supervisor (Housekeeping, Laundry, Plant) • Reported wide variation in staffing across Regions (FTE / square metre space) • All sites visited had on-site maintenance support. Degree of area management (Areas 1, 2, 3, 4) varied. • Legacy Plant Maintenance / Operations still in place; limited evidence of regional management / programming in place. More could be done in cluster model.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Plant Ops, Main., and Biomed.	68.9	67.2	0.26	0.21	0.42	0.26	2.0

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Peer Staffing Comparative Analysis

Patient and Non-Patient Food Services Combined

Opportunities	Findings
1. Review and assess benefit in adopting a regional food services management model that manages by cluster: – Consider alternative service model for food that creates regional food production centres following cluster / area framework. Requires food production changes to include rethermalization. – Avoid future capital cost requirements to replace food production capacity at each site.	• All sites visited provide on site food production. Wabasca and Slave Lake are noted as an exception in that it uses contract management. • Duplication of administrative support function across region (purchasing, menu development). • Commonly Food Services Department does patient food, retail food, and Meals on Wheels support. • Staffing comparison analysis does not suggest any staff savings opportunity. • Legacy Food operations still in place; limited evidence of regional programming in place. Single food production location not appropriate, however more could be done in cluster model.

Area Description	Actual FTEs 2004-05	Actual FTEs 2005-06 YTD	Actual HAPD 2004-05	Alberta Peer HAPD MIN	Alberta Peer HAPD MAX	National Peer 50th Percentile HAPD	Potential FTE (Effic.)/ Re-Invest.
Pt. & Non-Pt. Food Services Combined	174.7	157.5	0.65	0.36	0.79	0.65	-

Source: Alberta H&W MIS 2004-05, Deloitte Benchmarking Database 2003-04 & 2004-05, ARHA Payroll Data 2004-05

Deloitte.

Operational Trending and Analysis

Operational Trending and Key Metrics
- Overview

- Through the peer staffing comparison, this review has already explored opportunities for efficiency and effectiveness across 70% of the organization's operational spending.
- Other key cost drivers for consideration include:
  - Sick and Overtime premium costs
  - Non-Salary Discretionary Supplies and Sundries
  - Medical/Surgical Supply Costs
  - Drugs and Medical Gas Supply Costs
  - Food Supply Costs
- Further examination of each of these costs will be presented over the following slides.
- In addition, an overall review of where the region is investing its operating dollars across the continuum of care will be presented relative to peers.

Sick Time and Overtime Summary

Service Area	Total FTEs 2004-05	Sick Time % of Total Paid 2004-05	Sick Time % of Total Paid 2005-06	Potential FTE Savings 2004-05
Administration & Support Services	758	3.5%	3.5%	7.1
Nursing	1,031	3.7%	3.6%	6.3
Allied Health	468	2.4%	2.9%	3.1
Community & Social Services	485	2.9%	3.7%	2.2

Service Area	Total FTEs 2004-05	Overtime % of Total Paid 2004-05	Overtime % of Total Paid 2005-06	Potential $ Savings 2004-05
Administration & Support Services	759	0.6%	0.8%	$84,773
Nursing	1,031	2.4%	3.1%	$439,670
Allied Health	468	0.9%	0.9%	$137,905
Community & Social Services	485	0.8%	1.0%	$14,307

- Sick time and overtime rates remained relatively constant from 2004-05 to 2005-06.
- By examining the internal sick and overtime averages by service area, opportunities for improvement can be realized by shifting departments to perform at the area-specific sick and overtime averages.
- Analysis suggests:
  - Potential improvement in over 8.0 FTEs of reduced sick time hours, and
  - Approximately $676,655 in overtime premium cost savings.
  - Both of these issues need to be explored within a broader HR framework for change.

Source: ARHA Payroll 2004-05, 2005-06 Oct ytd.

Non-Salary Discretionary Supplies and Sundries

- An analysis of non-salary discretionary accounts was conducted to identify spending variations as well as to understand the large increase in sundry expenses.
- Discretionary accounts are identified as those non-salary costs that are not directly related to patient care, and over which management is able to exert some degree of control.
- Overall, 2005-06 Projected data suggests that non-salary discretionary costs may increase by as much as $1.7 million, or 13%, between 2003-04 and 2005-06 Projected.
  - The main drivers of the increase include Travel Expenses, Professional Fees and Departmental Sundries for the same period.
- Continued management monitoring of these costs to compare year-end 2005-06 actuals to projected numbers is suggested. Where year-end actual costs demonstrate similar spend levels, the organization will need to evaluate the balance of non-salary discretionary spending relative to core service delivery.

Account	2003-04	2004-05	2005-06 Projected	Variance 2003-04 to 2005-06 Projected
Travel Expenses	$6,105,963	$7,020,515	$7,270,674	19%
Rental - Land/Buildings	$1,560,870	$1,595,180	$1,653,189	6%
Office & General Supplies	$1,477,314	$1,594,628	$1,615,439	9%
Departmental Sundries	$1,311,994	$1,501,369	$1,513,333	15%
Insurance	$894,330	$977,962	$958,505	7%
Professional Fees	$342,184	$491,233	$624,921	83%

Source: ARHA General Ledger 2003-04, 2004-05, 2005-06 Oct ytd.

Med/Surg, Drugs and Food Supply Costs

- Medical/Surgical, Drugs and Food Supply expenses were examined relative to adjusted patient days for ARHA and other rural RHAs in Alberta.
- ARHA is at the lower end of the spectrum with respect to Medical / Surgical supply costs (per adjusted patient day).
- In comparison to peers, ARHA was found to be midrange among the rural Alberta RHAs for Food and Dietary Supply costs/APD and Drug and Medical Gas costs/APD in 2004-05.

Supply Costs as a % of Total Expenses	2004-05 Actual Expenses	2004-05 Expense/APD	Alberta Peers Expense/APD MIN	Alberta Peers Expense/APD MAX
Medical/Surgical Supplies	$3,761,260	$12.56	$10.11	$29.32
Drugs and Medical Gases	$3,672,295	$12.26	$5.13	$19.92
Food and Dietary Supplies	$2,999,834	$10.0	$5.23	$14.35

Source: AHW MIS Database 2004-05

Financial Profile Across the Care Continuum

- A financial profile of ARHA relative to other regions in Alberta is presented below, which examines the % of total expenses currently allocated across different dimensions of the organization.
- As observed through this analysis, ARHA has one of the higher % of total operating expenses Allied Health, which supports the staffing comparison findings of potential opportunities for savings in these areas.
- Conversely, ARHA is currently spending the lowest % of total operating expenses on Corporate Services, Acute Nursing, and Telehealth relative to other rural RHAs in Alberta.

Components of Regional Operational Expenses	2004-05 % of Total Expenses	Alberta Peers % of Total Operating Expenses MIN	Alberta Peers % of Total Operating Expenses MAX
Corporate Services	6.3%	6.3%	12.4%
Support Services	22.2%	15.6%	22.2%
Acute Nursing	14.9%	14.9%	26.2%
Residential Nursing	13.2%	4.6%	18.2%
Emergency, Day and Ambulatory Services	8.2%	4.4%	8.2%
Telehealth	0.0%	0.0%	0.3%
Allied Health	17.5%	13.8%	17.8%
Community Health Services	15.0%	10.9%	15.9%
Marketed Services	0.5%	0.0%	1.2%
Undistributed	2.3%	2.1%	5.6%

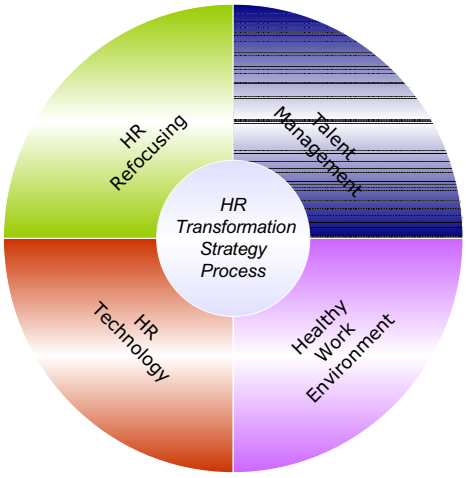
Source: AHW MIS Database 2004-05

Human Resources Strategy and Management

Overview

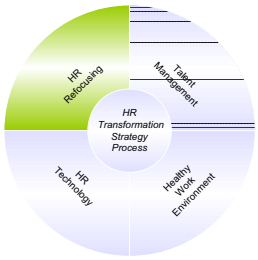
- Our findings are based on a review of relevant documentation and consultation. From these, we will identify opportunities for Regions to consider. Our model for review, findings reporting and opportunity identification follows a four part framework:

- ***Human Resources Re-focus*** – efforts to enhance HR capacity and capability to support service and management priorities of the Region.
- ***Talent Management*** – the integration of processes, programs, technologies and staff to Develop, Deploy and Connect workforce.
  - Develop – builds employees' capabilities as required by organization – either currently or for the future.
  - Deploy – ensures candidates are attracted, and recruited to roles and that recruitment is well aligned to strategic and operational needs.
  - Connect – cultivates high quality work relationships and culture that fosters engagement, productivity and innovation.
- ***Human Resources Technology –*** focuses on the extent to which technology supports the HR capacity and consistency in practice across Region.
- ***Healthy Work Environment*** – encompasses the physical and psychosocial work environment. Healthy work environment practices exist where culture and practices converge to create improvements for staff that cascade to the patient and community level.



Human Resources Strategy and Management

HR Refocusing



Findings

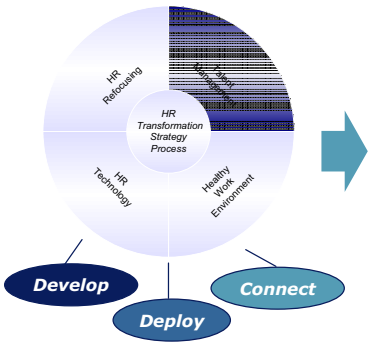
- HR department is insufficiently resourced to support strategic function. Hence, Department is largely transactional in nature.
- Decentralized HR staffing model requires a generalist focus and prevents critical mass of HR expertise.
- HR does function according to regional standards and processes. Client stakeholders report need for increased HR support.
- Limited external partnerships and alliances to support strategic initiatives.

Opportunities

1. Refocus Human Resources strategy and programming to support its performance and outcomes as a corporate priority.
   - Shift HR from current decentralized model to stronger centralized, strategic oriented resource.
   - HR to play stronger role directing its people management to support the business requirements.
2. Develop an evaluation strategy with metrics, KPI's, and scorecards to assess effectiveness.
3. Establish or increase external partnerships and alliances to support strategic initiatives.
4. Where substantial external focus is required, collaborate with AH&W and other Northern Regions to jointly create a "Northern Solution".

Human Resources Strategy and Management

Talent Management



Findings

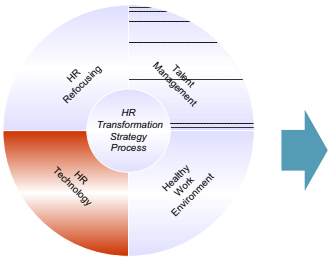
- ARHA is not well positioned to compete or attract scarce health care resources; limited HR capacity to support recruitment.
- Limited education infrastructure (resources and roles) to support staff and management development.
- No formal succession planning – yet significant number of staff and management roles will exit organization in foreseeable future.
- Legacy cultures very evident. Quality/performance management culture or mindsets not strong.
- High casualization of workforce threatens service delivery.

Opportunities

1. Identify critical workforce elements required to actualize ARHA strategy and developed focused workforce recruitment and development on these roles (physicians, RN's, rehabilitation professionals)
2. Assess the Region's current talent quotient, required competencies, and market availability of required talent. Develop internal and external strategy to grow or secure talent.
3. Explore concept of establishing rural academic centres in Aspen (two locations Cold Lake for East and Hinton for West) with more formal relationship with rural training streams (physicians) and nursing school in North.
4. Ensure that Region is sufficiently resourced to manage people issues at community level and that middle management possess required competencies.
5. Increase focus on culture, front-line supervisory skills, workforce communities, and communications to establish a stronger "connectivity" between workforce and Region as a whole.

Human Resources Strategy and Management

HR Technology



Findings

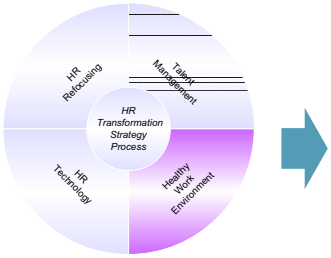
- Region is growing technology applications to leverage and support stronger centralization model.
- Limited technology application for staff development
- HR management issues related to staffing, recruitment, absenteeism are currently manual. Region continues to explore increased applications.

Opportunities

1. Continue efforts to use HRIS to support management and staff development
2. Increased E-learning and online development for staff – particularly for mandatory annual training
3. On line Performance Management processes for staff

Human Resources Strategy and Management

Health Work Environment



Findings

- Employ outsourced contract to provide disability management – which is under review to bring in-house. ARHA needs to be certain that it can replicate expertise
- HR Department / OH&S does support awareness campaigns for staff related to healthy work environment.
- Given the breadth of the Region, healthy workplace initiatives need to cascade to the site and community office level. As stated earlier, the middle management level do not have capacity to implement.
- Limited OH&S presence in Region.
- Levels of staff satisfaction is reported low but reliant on anecdotal reporting as no staff satisfaction done since new Aspen. One now underway.

Opportunities

1. Re-assess the current plan to bring disability management in-house.
2. Involve OH&S in broader organizational risk management approach to identify workplace safety risks to patients and staff, and in developing related mitigation strategies.
3. Continue effort to assess staff satisfaction with implementation process to act on findings
4. Continued effort to involve front line staff in healthy workplace initiatives

Deloitte.

Infrastructure

Regional Infrastructure Alignment
Overview

- Our review of regional infrastructure is intended as a high level assessment of how well infrastructure is aligned to support operations.
- Where there are opportunities for improvement to infrastructure, these opportunities will be identified for the region's consideration.
- The review has focused on the key high level opportunities across two dimensions of regional infrastructure, with findings and opportunities based on consultation, document review and related analysis:

Facilities and Equipment

Facilities and Equipment

- High-level consultation findings, on-site observations, and analysis of availability Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
1. Facility renewal plans should be linked to outcomes of clinical service role review for region and be done at the Area Level at a minimum.	• Many facilities have master plans and / or are in process of functional programming. • Potential risk is that facility renewal follow a site based approach vs. a broader area-wide or region-wide plan. • Limited application of alternative settings of care to support patient flow (transitional care, day programs, …)
2. Assess feasibility of co-locating community health services in or adjacent to health centres during time of HCC redevelopment.	• Facilities that have community health services co-located report improved communication, facilitated patient flow.
3. Redevelopment of ER Departments to support triage function and effective patient flow.	• Many sites have inadequate waiting space that does not offer line-of-sight to Triage Desk • Exposed, cramped triage areas for patient information exchange • Difficult access routes in many facilities • Undersized space for use in many facilities

Facilities and Equipment

- High-level consultation findings, on-site observations, and analysis of availability Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
4. Explore options to partner with physicians in co-locating physicians' clinics to hospital sites or adjacent locations as part of overall physician recruitment and retention planning.	• Numerous sites have high ER volume as a result of limited access to physicians in community
5. Engage clinical stakeholders to develop a regional strategy and resource plan to further leverage use of telehealth in clinical service delivery.	• Several opportunities have been identified for increased use of telehealth in clinical service delivery. • The region is currently lacking physician champions to drive increased use of telehealth in clinical service delivery.
6. Reassess need for additional inpatient beds vs. outpatient services psychiatry at St. Therese's (St. Paul)	• Utilization findings for psychiatry unit at St. Therese's (St. Paul) suggest higher need for outpatient services

Facilities and Equipment

- High-level consultation findings, on-site observations, and analysis of availability Alberta Infrastructure data for regional facilities and equipment identified the following key findings and opportunities:

Opportunities	Findings
8. Reassess bed replacement policy and practice in Region.	• Condition of patient / resident beds are poor in many facilities • Reported policy that bed replacement is a facility / community fundraising responsibility is out of line with equipment replacement practice.

9. Equipment acquisition plans should align with clinical service role review and regional management models across clinical support departments.	• Current equipment use largely reflects a site-based approach. A stronger regional service delivery approach may identify different needs. Area of focus should include:
	  • Beds and Lifts
	  • Monitors
	  • Diagnostic Imaging
	  • Laboratory
	  • Pharmacy
	  • Telehealth

Technology

Leveraging the Value of Information Technology through IT Governance

- Information and the Technology that supports it often represent the most valuable but least understood asset in an organization.
- The essential elements of IT governance are to ensure that value is received from spending on technology and then to control and safeguard information.
- The purpose of an IT governance framework is to institutionalize good practices that ensure an organizations IT investment supports business objectives. These objectives are identified through the Aspen Health Region's mission statement

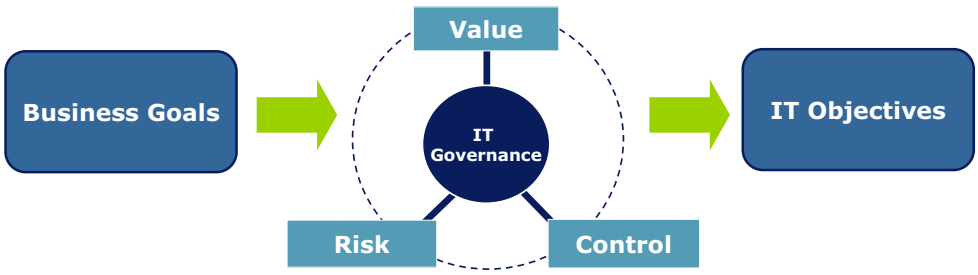
  To provide accessible and sustainable health services to Aspen citizens.

  And involves:

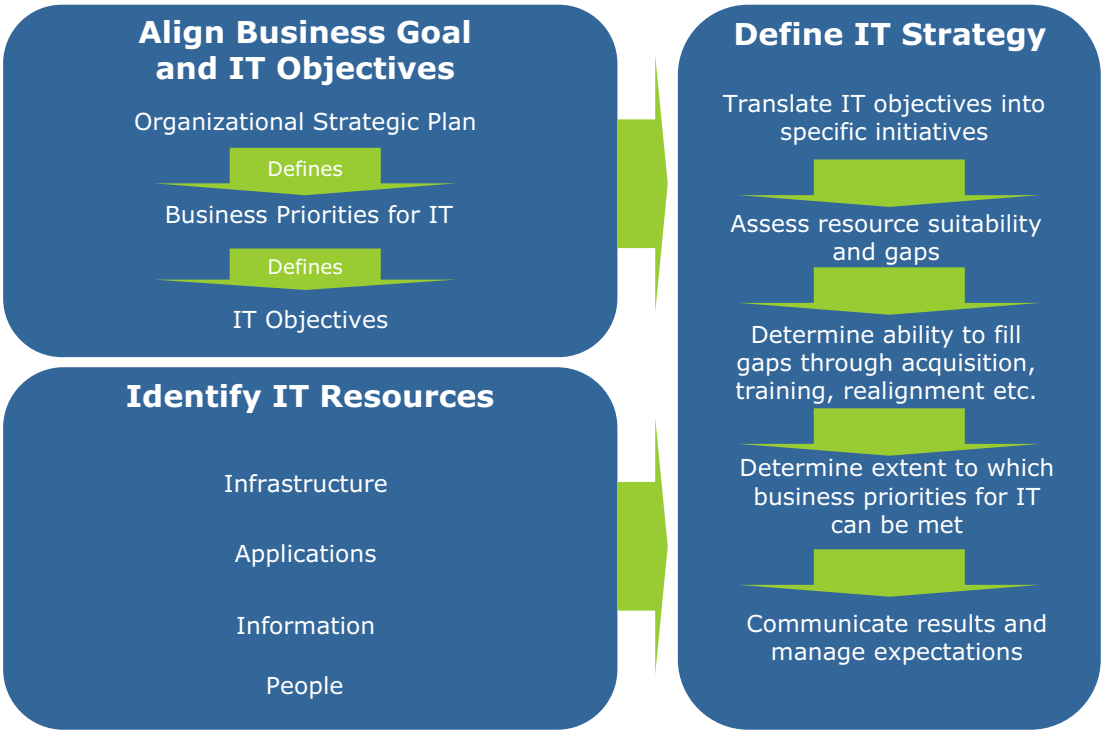
  - ensuring senior management and frontline providers are involved in determining the direction and goals of the IT department
  - evaluation of service delivery from two perspectives, the total cost of technology operations and monitoring of project outcomes
  - ongoing support and maintenance intended to safeguard the value of existing assets and knowledge in the regional facilities.
- Available IT resources, including infrastructure, applications, information and people, should be optimized to the organization's mission.
- Organizations need to satisfy the quality, fiduciary and security requirements of IT information and infrastructure as for all other assets.
- To discharge these responsibilities, as well as to achieve objectives, the status of the evolving enterprise architecture must be known.

What is IT Governance?

- IT governance consists of leadership, organizational structures and processes that are designed to support an organization's strategies and objectives to increase stakeholder value.
- Clear responsibility for the direction of IT requirements is necessary to successfully deliver services that support the enterprise's strategy.
- Monitoring success in delivering against business requirements, requires that management put a framework in place to measure achievements against goals.
- IT governance transforms business goals into IT objectives through consideration of value, risk and control.



Determination of IT Activities



Technology

- Findings and observations for the technology workstream are intended to identify the degree to which IT investments and resulting initiatives support the goals of the region, and the degree to which they are executed efficiently and effectively.
- The following key documents were reviewed in support of the Technology review for ARHA:
  - Facility Profiles – Aspen Facilities
  - Facility Profiles – Aspen IT
  - Consultation Findings
  - Aspen Health Plan Information Template – Information Services
  - IT Organization Chart
- Information has been summarized in five key focus areas:

Technology Categories	Key Questions
Strategic Alignment	• Is the IT strategy aligned to support the business? • Is there a clear understanding of how IT is supporting the RHA's business objectives?
Resource Alignment	• Is the RHA achieving optimum use of its IT resources? • Is the RHA investing in the appropriate IT resources?
Value Delivery	• Does the RHA perceive value from their IT investments? • Is IT delivering the promised benefits?
Risk Management	• Are IT risks understood and being managed?
Quality Management	• Is the quality of IT systems appropriate for business needs? • Is there a framework within which to measure the achievement of IT goals?

1. Strategic Alignment

Leading Practice Attributes	• The organization focuses on ensuring the linkage of business and IT plans; on defining, maintaining and validating the IT value proposition; and on aligning IT operations with enterprise operations.
Deloitte Findings and Observations	• Aspen has drafted a business plan for the Information Systems department that outlines key strategies, tactical approaches, targets and measures, expected outcomes/objectives and timeline to achieve objectives. • The draft plan is an important and promising milestone for the region, as it clearly outlines the key IT priorities required to align to the region's business objectives. • Business users across the organization report a high level of awareness of IT initiatives, with specific focus on the RSHIP Meditech implementation. • Further consideration of physician clinic IT integration into the new Meditech implementation will be important for alignment to broader stakeholder needs to meet care delivery requirements.
Potential Opportunities	1. When finalizing the IT strategic planning to support the alignment of business goals and requirements with realistic IT initiatives, consider the following: – Involve relevant stakeholders in the identification of IT objectives and in the prioritization of IT initiatives – Ensure that the strategic plan is in sufficient detail to support tactical IT plans and to allow for the evaluation of performance against the plan. – Ensure that the plans considers IT staffing levels and skill sets aligned to the proposed IT initiatives. – Revisit the strategic plan annually to adjust for changes in the focus and direction of service delivery in the region.

2. Resource Alignment

Leading Practice Attributes	• The organization is focused on the optimal investment in, and the proper management of, critical IT resources: applications, information, infrastructure and people including the optimization of knowledge and infrastructure.
Deloitte Findings and Observations	• Aspen has 12 FTEs, some of which are on secondment in the Regional IS Department to support 20 geographically dispersed sites. • With the large number of new IT initiatives there is an increasing demand on IT services. • A proposal has been made to restructure the IS department, and Aspen is proposing to add 5 more FTEs. • Several different departments in the region have asked for an intranet to streamline inter- and intra-department communications. • The quality of the help desk phone system has been raised as impacting the ability of the help desk to deliver service. • Concern over available training to support Meditech users has been raised by some facilities. • IT is currently reviewing its departmental organization structure to determine allocation of staff across implementation efforts and ongoing operations requirements.
Potential Opportunities	1. Investigate the benefit of procuring new remote support tools, including software/patch deployment and network monitoring to increase the efficiency of the help desk. 2. Explore the possibilities and options to replace the existing helpdesk phone system. 3. Investigate the use of basic collaboration tools and SuperNet to satisfy the initial need for an intranet. 4. Evaluate the effectiveness of existing training plans. 5. Communicate the training plan to users across the region to support their resource planning and comfort with pending technology changes. 6. Continue review of departmental organization structure to ensure appropriate alignment of resources to maintain ongoing operations and support implementation initiatives.

3. Value Delivery

Leading Practice Attributes	• The organization executes the value proposition throughout the delivery cycle, ensuring that IT delivers the promised benefits against the strategy, concentrating on optimising costs and proving the intrinsic value of IT.
Deloitte Findings and Observations	• Business users are seeing value from being involved in the Meditech implementation. This involvement has increased confidence in achieving value upon full roll out. • The region reports that challenges with respect to organization awareness of IT initiatives, such as the Meditech implementation, include limited training resources to support business users. • Some stakeholders report challenges with insufficient hardware to support business activities – e.g. some sites do not have adequate computers for users. Inadequate business user hardware to support IT initiatives will impede the ability of some sites to benefit from these initiatives. The region reports a recent infrastructure upgrade, which should address some of these challenges. • The region reports the need for region-wide reporting functionality to generate meaningful reports to track and improve service delivery. • Satisfaction with the current regional IT support service has been reported.
Potential Opportunities	1. Continue to upgrade IT hardware infrastructure to support business user's access to IT capabilities in the region. 2. Review Meditech's reporting capacity and assess its ability to meet stated reporting needs. Where requirements have been determined to be valid, determine the path and prioritization for meeting the requirements of users with regard to reporting.

4. Risk Management

Leading Practice Attributes	• The organization requires risk awareness by senior corporate officers, a clear understanding of the enterprise's appetite for risk, understanding of compliance requirements, transparency about the significant risks to the enterprise, and embedding of risk management responsibilities into the organization.
Deloitte Findings and Observations	• Many applications used daily are simple and basic. Some users have limited access to the computers at work or still work on paper. There is no measure of the computer proficiency level of the users, which is a potential risk to end-user uptake during implementation. • IT training and education is noted as one of the greatest risks for ARHA, where there is limited support to provide training and education to business users for the Meditech implementation, and for general project management skills within IT. There are no mitigation strategies in place yet for the region. • Many parts of ARHA are reported to have a very high expectation of Meditech. There was no indication of any assessment of the impact that the Meditech implementation may have on overall region information management or operational process.
Potential Opportunities	1. Perform a risk assessment on the impact of the Meditech implementation(s), including a plan for mitigating the identified risks. 2. Explore opportunity to create a dedicated Change Management group for the ARHA implementation to support end-user change management, communications, and training, which are linked closely to a broader regional education strategy and infrastructure. 3. Assess the skill level of potential users within the facilities to ensure that each site will respond to training and transition to new systems, thus avoiding a negative impact on service delivery.

5. Quality Management

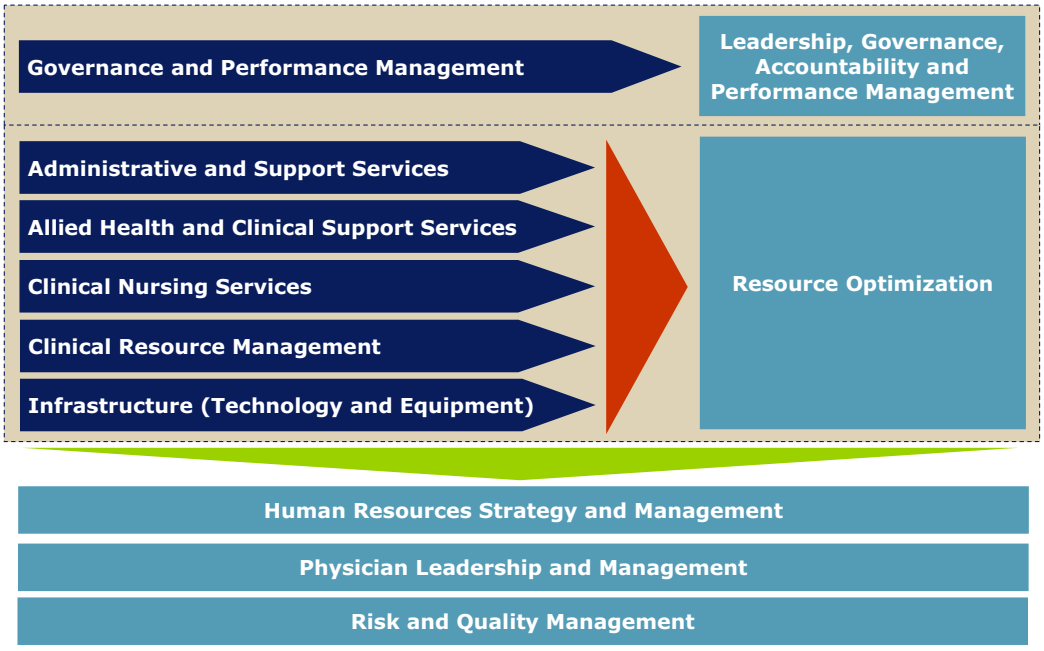
Leading Practice Attributes	• The organization utilizes a system of performance measurement to track and monitor strategy implementation, project completion, resource usage, process performance and service delivery, using, for example, balanced scorecards that translate strategy into action to achieve goals measurable beyond conventional accounting.
Deloitte Findings and Observations	• Aspen reports the recent development of a quality improvement framework for information management, but the need for enhanced ability to measure performance of its IT function was identified, which is needed to support the high level implementation and operations activities. • Continued enhancement of quality and performance management processes will support the region in identifying, achieving buy-in to, and achieving potential benefits from IT initiatives. • This is especially important to consider given the current Meditech implementation, as limited development of a benefits realization framework through RSHIP has been identified – resulting in the region needing to develop this framework through its own initiative.
Potential Opportunities	1. Continue to develop and enhance a quality improvement framework and associated processes, which will provide: – Development of a benefits realization framework that defines the cost, benefits, strategy, policies, and service levels of each IT initiative. – Ability to measure objectively the satisfaction of management, the users, and other stakeholders. – A clear path to further improvement of IT service to ARHA.

Cluster 1 Opportunities
Introduction

- Having reviewed three regional health authorities concurrently, we have identified opportunities that are common across the three regions.
- We have identified common opportunities as 'Cluster Opportunities', and they are based on of the following three criteria:
  - Where the opportunity requires a *solution larger than 1 Region's capacity* (as it may require cross-region collaboration, provincial collaboration or investment).
  - Where a *cross region collaboration* and solution development will *deliver greater value (either qualitative or quantitative)* than if pursued by 1 Region independently.
  - Where individual regions are *without the current resources or talent* and/or will have challenge attracting and recruiting individuals or securing resources independently.
- Further, Cluster Opportunities may become 'Provincial Opportunities', where the opportunities will have application to more than the three northern regions.
- These Cluster Opportunities have been accepted by AHW, although a timeline for moving forward has yet to be determined by the province.

Cluster 1 Opportunities
Reporting Framework

- Cluster 1 Opportunities are identified in five key areas of reporting, which have been aligned to the project workstreams, as shown below:



Cluster 1 Opportunities
Resource Optimization

I. Develop strategy to promote expanded clinical application and adoption of Telehealth to respond to growing clinical needs (strategy to include sourcing clinical expertise external to regions to support Telehealth delivery).

II. Adopt a stronger standardized approach to Chronic Disease Management, supported by clinical expertise and links to Telehealth, which can be customized within Regions.

III. Explore shared service model for core corporate services as a strategy to enhance effectiveness, avoid cost, and achieve efficiency:
- Finance and Decision Support
- Human Resources (includes physician issues)
- Information Systems and Support
- Supply Chain Services
- Management and Leadership Training

IV. Develop and implement workload measurement and caseload tracking and reporting for home care to enable management decision-making and cross-regional comparisons.

V. Develop and implement workload measurement and reporting for Population Health and Environmental Health to enable management decision-making and cross-regional comparisons.

Cluster 1 Opportunities
Leadership, Governance, Accountability and Performance Management

I. Strengthen capability and resource allocation to position Health Human Resource (HHR) Strategy and Management as top priority for organization. (See next section.)

II. Collaborate in the development or procurement of leadership and management development and training based on identified need or gaps.

III. Increase attention and effort to creating board awareness and education on responsibilities and liabilities.

IV. Enhance broad regional reporting requirements to include ongoing monitoring of IT strategic initiatives, to ensure ongoing alignment of IT to business priorities and objectives.

V. Develop a Northern Response Strategy for the three Regions that includes:
- Increasing effort on building and growing external partnerships, primarily focused on industry and academia, focused on attraction, recruitment, retention, housing and reimbursement.
- Reviewing the accountability framework and interface requirements between regional governance model and appropriate operational structure given the size and geography of Northern Regions.
- Developing alternative funding mechanisms that attracts and retains critical workforce segments (physicians, registered nurses, pharmacists, …) and high talent management pool.
- Determining the appropriate funding / resource support for the growing service delivery pressures in the North as well as the impact of rapid industry growth (high population growth, transient and shadow population).
- Support for the more frequent requirement to conduct a community health needs assessment to be able to respond to the dynamic and growing challenges in the North.

Cluster 1 Opportunities
Human Resources Strategy and Management

I. Explore northern collaboration for comprehensive Health Human Resources (HHR) strategy development that includes HR refocus, talent management, HR technology and a focus on healthy work environments.

II. Ensure that HHR strategy, management and implementation includes the physician component and is focused on:
- Workforce/resource gaps, skills management and education;
- Alignment/realignment of current resources to core service delivery needs;
- Attraction/recruitment/retention of a talent workforce; and
- Enhanced business case approach to cost impact analysis related to physician recruitment and service repatriation.

III. Define talent strategy to ensure effective leadership in place (from governance to front line delivery) to support change in complex environment.

IV. Review current agreement language and requirements in the AHW-AMA-RHA Agreement and staffing union labour agreements, which limit the Regions' ability to provide service in an increasingly challenged environment.

V. Explore concept of establishing stronger rural academic centres across the three Northern regions as a mechanism to ensure steady human resource stream (includes physicians, nurses and other health care disciplines).

Cluster 1 Opportunities
Physician Leadership and Management

Our observations and identified opportunities reflect common and emerging physician practice across the country. Where these five opportunities are seen as desirable by AHW, the province will have to explore different remuneration models that support and lever physician behaviour and desired change.

I. Review MAC governance structure and mechanisms with specific attention to by-law adherence and alignment.

II. Develop a medical leadership accountability framework and leadership requirements (which includes examining current organizational and reporting structures, and current /potential roles and responsibilities for Chiefs in the management and decision-making process at the site and regional levels).

III. Create a Physician accountability framework with evaluation and quality/risk/performance management tools for Physicians which is integrated into the broader regional performance management framework.

IV. Explore alternative payment models for physicians with the objective to improve resourcing and linkage to care/service delivery model. (As part of this opportunity, explore alternate staffing models in consideration of physician AFT options – e.g., APN/NP model in ER and other primary care models.)

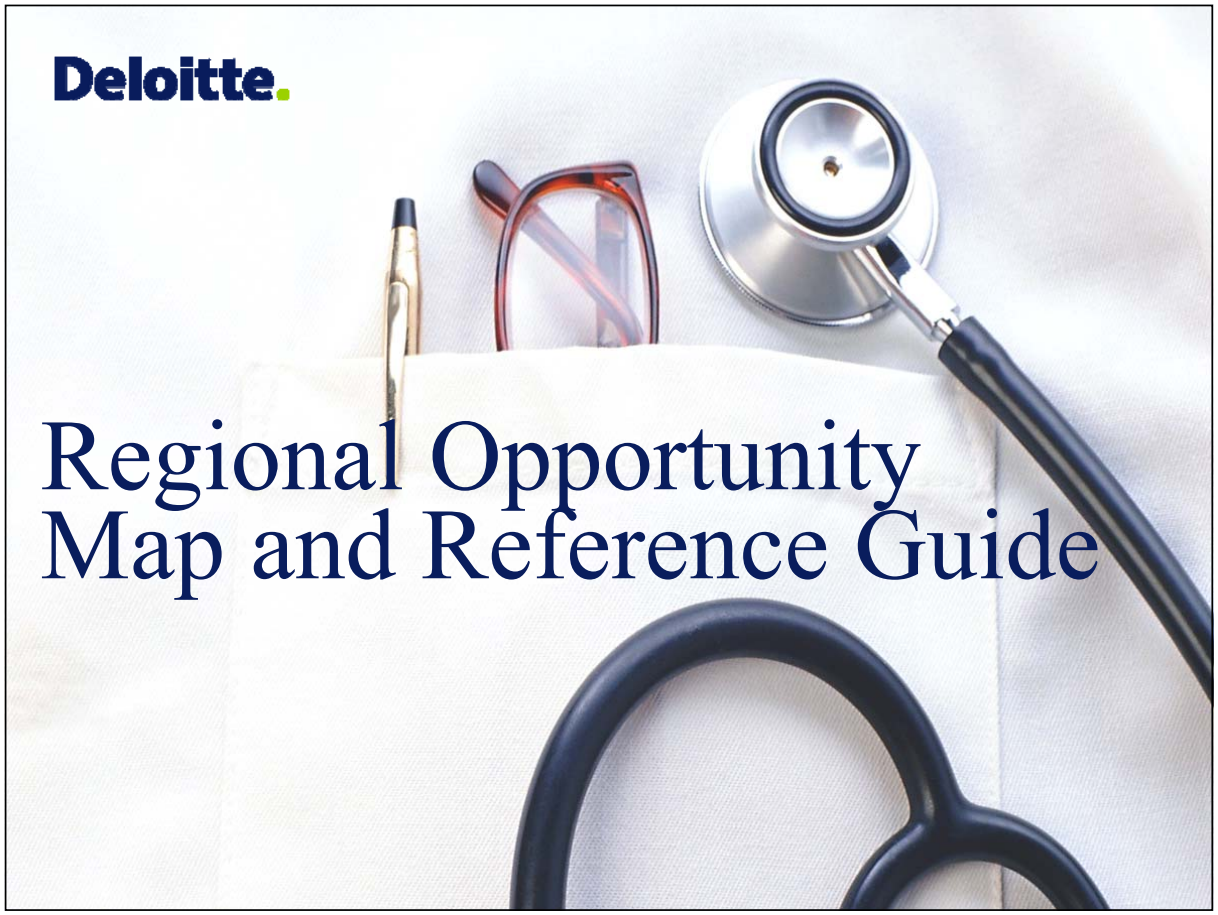
V. Develop a comprehensive Physician Impact Assessment process for physician recruitment related to needs planning and service expansion.

Cluster 1 Opportunities
Risk and Quality Management

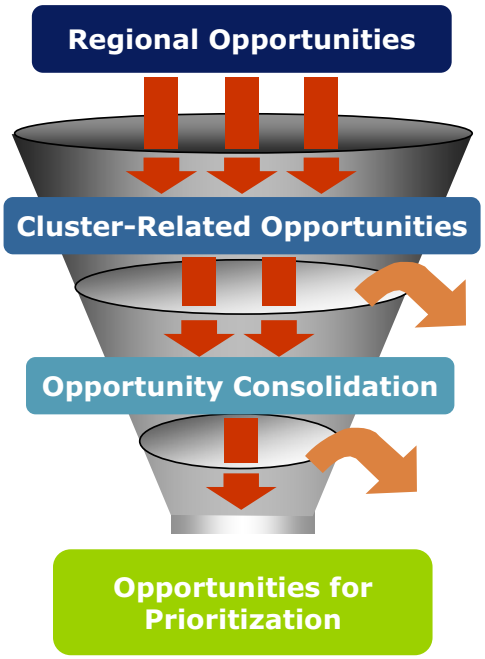
I. Increase awareness, commitment and focus on risk management as a key requirement for operations and decision-making across clinical and non-clinical service areas. Sample areas of focus include:
   - Evaluation/quality/risk/performance management tools for physicians
   - Regular community heath needs assessment
   - Stronger and consistent adoption of CTAS
   - Increased education for Board members

II. Develop a benefits realization approach for RSHIP to ensure investments are aligned to intended outcomes.

III. Increase collaboration and partnership with industry to address increasing environmental health workload and associated risks.



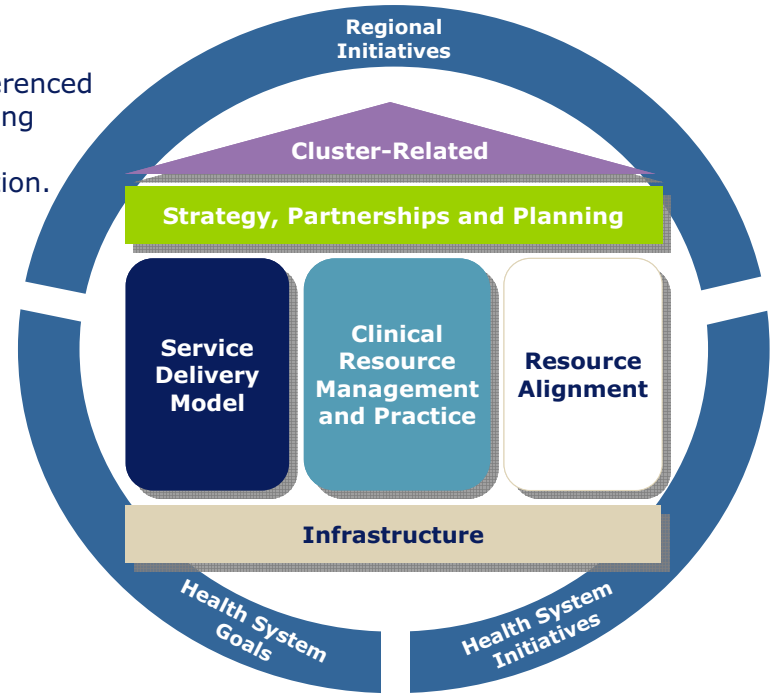
Regional Opportunity Map and Reference Guide
Introduction



- A reference guide has been developed for the opportunities identified in the region's report.
- Opportunities have been filtered to facilitate discussion and planning.
- **Filter 1:** The overlap of cluster and regional opportunities is one filter.
  - Cluster Opportunities will be driven by a separate process through a collaboration of AHW and the Cluster 1 regions, and so have not been prioritized in the region's opportunity map.
  - Where Cluster and regional opportunities overlap, the cluster-related regional opportunities have been identified in this reference guide, but not included in the prioritization and sequencing process.
- **Filter 2:** Like / related opportunities have been consolidated to facilitate planning and action.
  - Opportunity consolidation is based on inter-dependencies and linkages, which are highlighted in the reference guide.

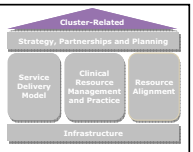
Regional Opportunity Map and Reference Guide
Opportunity Alignment

- To facilitate prioritization, opportunities are aligned across five areas, shown in framework below.
- This framework will be referenced to facilitate an understanding of the different types of opportunities for prioritization.
- Also important will be an understanding of how broader system goals and initiatives, and other regional initiatives impact opportunity prioritization.



Regional Opportunity Map and Reference Guide

Cluster-Related Regional Opportunities

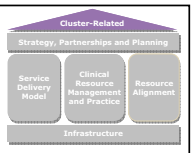


- The following regional opportunities are directly related to cluster opportunities.

Resource Optimization	
Opportunity Name	**Opportunity Description**
Homecare Workload Measurement	Develop and implement workload measurement, and caseload tracking and reporting for home care to enable management decision making.
Continuing Care Staffing Target	Examine staffing allocations across continuing care facilities with respect to recent AHW target of 3.4 HPRD, and in context of continuing care HR plan.
Homecare Caseload Review	Homecare Caseload Review.
HR FTE Investment	Provide additional investment of at least 3 FTE in HR to support stronger centralized roles and strategic focus on recruitment, workforce planning, external partnerships, and developing innovative models at both the staff and physician level.
Procurement Service Consolidation	Where Region adopts stronger regional management model for Food Services and Materials Management, explore Materials Management supporting consolidation of purchase for these areas.

Regional Opportunity Map and Reference Guide

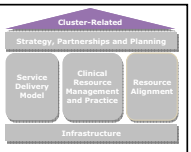
Cluster-Related Regional Opportunities



- The following regional opportunities are directly related to cluster opportunities.

Resource Optimization (continued)	
Opportunity Name	**Opportunity Description**
Telehealth Service Strategy	Engage clinical stakeholders to develop a regional strategy and resource plan to further leverage use of telehealth in clinical service delivery.
	Explore options for increased use of telehealth in service delivery, with impact assessment of the relative costs/benefits to align resources to this service delivery model.
Regional IT Services	Stronger regional interface and collaboration related to IT prioritization and implementation support.
	Investigate the benefit of procuring new remote support tools, including software/patch deployment and network monitoring to increase the efficiency of the help desk.
	Explore the possibilities and options to replace the existing helpdesk phone system.
	Assess the skill level of potential users within the facilities to ensure that each site will respond to training and transition to new systems, thus avoiding a negative impact on service delivery.
Systems Support – Regional Information Management	ARHA should expand collaborative initiatives with other Regions – particularly in North.

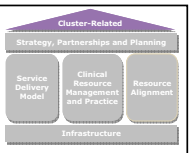
Regional Opportunity Map and Reference Guide
Cluster-Related Regional Opportunities



- The following regional opportunities are directly related to cluster opportunities.

Leadership, Governance, Accountability and Performance Management	
Opportunity Name	**Opportunity Description**
Rural Academic Centres	Explore concept of establishing rural academic centres in Aspen (Cold Lake for East and Hinton for West) with increased relationship with rural training streams (physicians) and nursing schools in the North.
Budget Management Accountability	Shift accountability to management for budget development, thereby enabling Finance to play stronger consultative / advisor / decision support role.

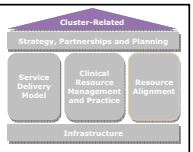
Regional Opportunity Map and Reference Guide
Cluster-Related Regional Opportunities



- The following regional opportunities are directly related to cluster opportunities.

Human Resources Strategy and Management	
Opportunity Name	**Opportunity Description**
Healthy Work Environment	Re-assess the current plan to bring disability management in-house.
	Involve OH&S in broader organizational risk management approach to identify workplace safety risks to patients and staff, and in developing related mitigation strategies.
	Continue effort to assess staff satisfaction with implementation process to act on findings.
	Continued effort to involve front line staff in healthy workplace initiatives.
Increased Recruitment and Retention Support	Increase support and work effort with local communities and physicians to strengthen recruitment and retention.

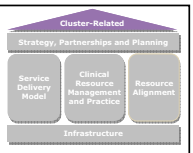
Regional Opportunity Map and Reference Guide
Cluster-Related Regional Opportunities



- The following regional opportunities are directly related to cluster opportunities.

Human Resources Strategy and Management (continued)	
Opportunity Name	**Opportunity Description**
Human Resources Technology	Continue efforts to use HRIS to support management and staff development
	Increased E-learning and online development for staff – particularly for mandatory annual training.
	Online Performance Management processes for staff.
Human Resources Re-focus	Recalibrate Human Resources strategy and programming and lever to become corporate priority. – Shift HR from current decentralized model to stronger centralized, strategic oriented resource. – HR to play stronger role directing its people management

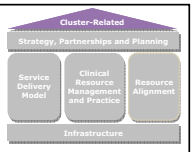
Regional Opportunity Map and Reference Guide
Cluster-Related Regional Opportunities



- The following regional opportunities are directly related to cluster opportunities.

Human Resources Strategy and Management (continued)	
Opportunity Name	**Opportunity Description**
Talent Management	Identify critical workforce elements required to actualize ARHA strategy and developed focused workforce recruitment and development on these roles (physicians, RN's, rehabilitation professionals).
	Assess the Region's current talent quotient, required competencies, and market availability of required talent. Develop internal and external strategy to grow or secure talent.
	Explore concept of establishing rural academic centres in Aspen (two locations Cold Lake for East and Hinton for West) with more formal relationship with rural training streams (physicians) and nursing school in North.
	Ensure that Region is sufficiently resourced to manage people issues at community level and that middle management possess required competencies.
	Increase focus on culture, front-line supervisory skills, workforce communities, and communications to establish a stronger "connectivity" between workforce and Region as a whole.
PCA Recruitment & Retention Plan	Develop a targeted recruitment and retention plan for PCAs, that is integrated into the broader regional HR strategy.
Regional HR Strategy Support	Increase support to enable Human Resources strategy and programming to fulfill its status as a corporate priority.

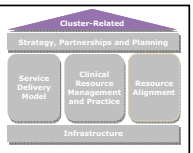
Regional Opportunity Map and Reference Guide
Cluster-Related Regional Opportunities



- The following regional opportunities are directly related to cluster opportunities.

Physician Leadership and Management	
Opportunity Name	**Opportunity Description**
Clinical Program Frameworks and Review	CTAS strategy requirement that considers space configuration, human resources, and training/education needed to ensure region-wide adoption. Triage needs to be fully implemented and supported with properly trained resources. Rural modifiers may need to be considered especially in centres with volumes of less than 15,000 ER visits (not to include booked patients). Space should be configured to accommodate Triage in a standardized and functional manner.
Governance & Leadership	Conduct an externally led review of MAC governance structure/mechanisms with specific attention to by-law adherence/alignment.
	Identify physician leadership requirements and conduct an alignment exercise to determine gaps.
	Create a medical leadership accountability framework – which includes examining current organizational and reporting structures, and current/potential roles and responsibilities for Chiefs in the management and decision making process at a program, site, and regional level.

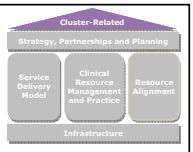
Regional Opportunity Map and Reference Guide
Cluster-Related Regional Opportunities



- The following regional opportunities are directly related to cluster opportunities.

Physician Leadership and Management (continued)	
Opportunity Name	**Opportunity Description**
Physician Human Resources	Continue to develop a regional Physician Human Resource Strategy that links to the HR and regional strategy, and is focused on Physician resource gaps, skills management and education, alignment/realignment of current resources to core service delivery needs, recruitment/retention.
	Continue to explore alternative payment models for physicians in the region, with an objective to improve resourcing, and linkage to care/service delivery model. -As part of this opportunity, explore alternate staffing models in the consideration of physician AFP options – e.g. APN/NP model in ER and community health clinics.
	Continue to develop a regional, comprehensive Physician Impact Assessment process for physician recruitment needs planning, and in assessment when new physicians are being considered and when services are being expanded or developed. This assessment needs to be linked to the region's strategic directions for its clinical programs, and needs to consider broad programming impacts (human resources, infrastructure, funding, etc.) -Physician Impact Assessments should be considered in the context of a regional needs assessment.

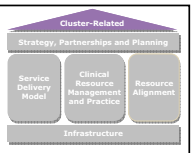
Regional Opportunity Map and Reference Guide
Cluster-Related Regional Opportunities



- The following regional opportunities are directly related to cluster opportunities.

Physician Leadership and Management (continued)	
Opportunity Name	**Opportunity Description**
Quality, Risk, & Performance Management	Create an accountability framework with evaluation and quality/risk/performance management tools for Physicians, which is integrated into the broader regional framework. -Continued and significant education is required at all levels of the organization to promote a quality culture. While the region has undertaken substantial effort in this regard, it must continue its emphasis in this regard.
	Develop a regional approach and support for CME, based on a sustainable business model, and integrated with the physician recruitment and retention strategy and broader regional education function. -Given proximity to academic centre, CME credits should be mandatory to maintain privilege.

Regional Opportunity Map and Reference Guide
Cluster-Related Regional Opportunities

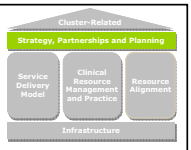


- The following regional opportunities are directly related to cluster opportunities.

Risk and Quality Management	
Opportunity Name	**Opportunity Description**
Technology - Quality and Risk Management	Continue to develop and enhance a quality improvement framework and associated processes, including: -Development of a benefits realization framework that defines the cost, benefits, strategy, policies, and service levels of each IT initiative
	Perform a risk assessment on the impact of the Meditech implementation(s), including a plan for mitigating the identified risks.
Regional CTAS Assessment	Conduct regional assessment of CTAS use in ER Department to determine resources, capital investment, education support, and policies/procedures required to standardize its use as a risk/management tool.

Regional Opportunity Map and Reference Guide

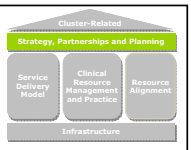
Strategy, Partnerships, and Planning



Opportunity Name	Opportunity Description
VP Medical / Legal / Quality Portfolio Review	Review / restructure Medical / Legal / Quality portfolio to create two roles (1 for Medical and 1 for Performance Management (Quality, Risk, Legal) – Do not replace the current Medical Director vacancy (in light of the above reorganization)
CFB / Cold Lake Physician Relations	Increase senior management dialogue with CFB Cold Lake to create stronger alignment and integration with CFB physician resources.
Equipment Replacement Policy	Deloitte identified the opportunity to 'Reassess bed replacement policy and practice in Region.' The region has identified the preference for review of its broader equipment replacement policy, which is represented by the title of this opportunity.
Implementation Support	Determine most critical areas for investment in change / implementation support throughout the region (based on finding that the Region lacks resources to support and cascade change.)
	Explore opportunity to create a dedicated Change Management group for the ARHA implementation to support end-user change management, communications, and training, which are linked closely to a broader regional education strategy and infrastructure.
Continuing Care Capacity Planning	Support policy development that enables the availability of incremental levels of continuing care for residents living in the community.

Regional Opportunity Map and Reference Guide

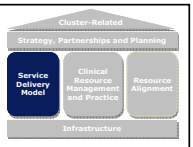
Strategy, Partnerships, and Planning (continued)



Opportunity Name	Opportunity Description
Review Matrix Model	Review matrix model in terms of: – Management roles and responsibilities – Role overlap – Accountability framework for decision-making – Span of control for Director roles (who have site and regional responsibility)
	Re-assess the predominantly decentralized approach to HR management.
	Review span of control across region for both clinical and operating support areas.
	Increase support for regional implementation initiatives that allow change to cascade to the operational level.
	Review need and allocation of practice support roles for Nursing.

Regional Opportunity Map and Reference Guide

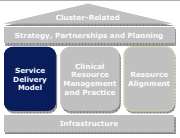
Service Delivery Model



Opportunity Name	Opportunity Description
Clinical Services Role Review	Conduct a clinical service role review to determine the feasibility of the delivery of services by cluster: Conduct a Community Needs Assessment; Assess current programming, hours of operation, capacity, critical mass, and patient safety issues at both the area and regional levels; Identify centres of excellence; and Conduct master and functional planning exercises based outcomes of clinical service role review
	Equipment acquisition plans should align with clinical service role review and regional management models across clinical support departments.
	Swan Hills should undergo a facility role review although the Region reports that this has been done. Region identifies that only significant savings available through closure which is not an acceptable solution given access requirements.
	Any recommendation around investments in this facility needs to be considered in light of the recommendation that the region completed a review of this facility's role.
	Edson staffing investments should be considered with respect to the planned redevelopment of the site.
	Bonnyville staffing investment should be considered should be considered in line with clinical service role review.
	Functional and master plan study required.

Regional Opportunity Map and Reference Guide

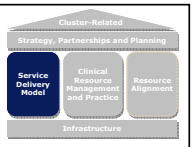
Service Delivery Model (continued)



Opportunity Name	Opportunity Description
Population Health Service Standardization	Assess service standardization across Region, in alignment with a regional community health needs assessment.
Regional Mental Health Program Alignment Review	Refocus Mental Health planning on broader continuum of care.
	Conduct a comprehensive review of regional mental health services to determine the most appropriate alignment of resources across the continuum to meet client needs.
	Reassess value of psychiatry inpatient bed expansion vs. other service models across the region.
	Reassess need for additional inpatient beds vs. outpatient services psychiatry at St. Theresa's (St. Paul).
Regional ER CTAS Utilization	Conduct regional assessment of CTAS used in the ER Department to determine resources, capital investment, education support, and policies/procedures required to standardize its use as a risk/management tool.
Respiratory Therapist Role Review	Ensure consistent range of services supported by Respiratory Therapy available across Region.
Alternative Level Of Care Setting Review	Expand alternative service model like Adult Day Programs and other transitional supports. Assess the required investments to enable success, such as transportation.

Regional Opportunity Map and Reference Guide

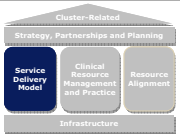
Service Delivery Model (continued)



Opportunity Name	Opportunity Description
Primary Care Model & Access Review	A Community Needs Assessment will assist the region in identifying the challenges in accessing primary care within the region and the resulting impact to ER departments.
	Explore alternative service models to support patient flow and access to care.
	There is a considerable investment staffing opportunity in the acute and ER areas, however this needs to be reviewed in conjunction with primary care physician coverage in the community.
	There is a small efficiency opportunity in the OR/SDC, equivalent to 0.9 FTE, which suggests that there is an opportunity to increase volume capacity in the OR with the current staffing complement.
	Expand functional planning to include alternative service settings and non-acute service delivery.
	Explore alternative service setting for clinic visits seen in the ER.
	Assess feasibility of co-locating community health services in or adjacent to health centres during time of HCC redevelopment.

Regional Opportunity Map and Reference Guide

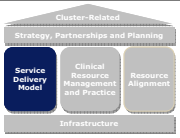
Service Delivery Model (continued)



Opportunity Name	Opportunity Description
Regional DI Alignment Review	Alignment diagnostic along leading practices for Maternal/Child, Orthopedics, and General Surgery services - requirement for alignment with centres of excellence models.
	Review and assess benefit in adopting a regional Diagnostic Imaging management model that plans, organizes and provides DI service by cluster.
	Assess information and equipment needs for enhanced regional management model in high cost and high tech areas like laboratory, Diagnostic Imaging and Pharmacy.
Regional Clinical Nutrition Review	Review and assess benefit in adopting a regional Clinical Nutrition management model that organizes service by cluster: Region should assess the greatest area of need for staffing investment based on the varied staffing levels within Region.
Rehabilitation Review	Conduct a Targeted Rehab Review in Region to determine if current level of investment is desirable and contributes to the desired patient flow and continuum of care needs. – Focus of review should include: required service levels (current and future), model of care, staffing (including mix and potential re-allocation – if appropriate), hours of operation, and professional practice. – Assess staffing requirements in light of further review

Regional Opportunity Map and Reference Guide

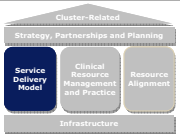
Service Delivery Model (continued)



Opportunity Name	Opportunity Description
Regional Clinical Lab Review	Regional laboratory review: standardized menu, consolidation of resources, LIS, group purchasing, quality monitoring, repatriation.
	Review and assess benefit in adopting a regional laboratory management model that organizes lab service by cluster.
	Develop standardized regional menu.
	Conduct a targeted Lab review in region to support stronger centralization of lab function – Focus of review should include: required service levels, staffing (including CLXT impact and requirements), hours of operation and enabler requirements related to Information Technology and equipment.
	Assess information and equipment needs for enhanced regional management model in high cost and high tech areas like laboratory, Diagnostic Imaging and Pharmacy.
Regional Pharmacy Review	Regional pharmacy review to examine opportunities for formulary standardization, stricter inventory management and control, and PIXIS.
	Review and assess benefit in adopting a regional pharmacy management model that organizes pharmacy service by cluster: Develop standardized formulary; Develop standardized procedures for inventory control
	Assess information and equipment needs for enhanced regional management model in high cost and high tech areas like laboratory, Diagnostic Imaging and Pharmacy.

Regional Opportunity Map and Reference Guide

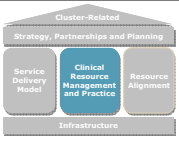
Service Delivery Model (continued)



Opportunity Name	Opportunity Description
Laundry Service Model	Review and assess benefit in adopting a regional laundry management model that organizes laundry service by cluster: -Consider alternative service model for laundry that creates regional laundry centres following cluster / area framework (Athabasca model). -Avoid future capital cost requirements to replace laundry units at each site.
	Assess staffing saving potential through adoption of alternative service model (above).
Plant Operations Service Model	Review and assess benefit in adopting a regional Plant Maintenance and Operations management model that manages by cluster: -Consider alternative service model for staffing, workload planning that incorporate both demand and preventative maintenance.
Food Service Model	Review and assess benefit in adopting a regional food services management model that manages by cluster: Consider alternative service model for food that creates regional food production centres following cluster / area framework; Requires food production changes to include rethermalization; Avoid future capital cost requirements to replace food production capacity at each site.
Housekeeping Service Model	Review and assess benefit in adopting a regional housekeeping management model that focuses on standardization across region.
	Assess span of control across region.

Regional Opportunity Map and Reference Guide

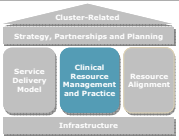
Clinical Resource Management and Practice



Opportunity Name	Opportunity Description
Reallocation of Acute Beds to Continuing Care	Assess feasibility of shifting acute beds to continuing care status where there is low acute occupancy coupled with lengthy placement waits.
	Consider reallocation of acute beds funding to meet longstanding Continuing Care needs in the community.
	Consider reallocation of acute beds to continuing care beds to resolve bed blocking issue.
Regional Discharge Planning Process & Patient Flow	Determine a region wide process and structure to support patient flow and discharge planning.
	Reassess organizational placement and reporting model for dedicated patient flow and discharge support roles.
	Examine regional admission/ discharge process and role creation to support patient flow process.
	Need for stronger discharge planning focus and support in acute care across the region.
	Reassess the planned upward adjustment to Social Work or similar roles (in light of reported investment opportunity) to support patient flow and discharge requirements.
	Strengthen discharge planning and utilization management procedures and improve linkages between the hospital and home care staff.
	Develop standardized discharge and process across region.

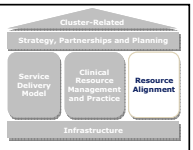
Regional Opportunity Map and Reference Guide

Clinical Resource Management and Practice (continued)



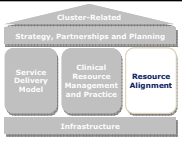
Opportunity Name	Opportunity Description
Coding/Abstracting Enhancements	Improvements to Regional Coding and Abstracting
MD Documentation	Improve MD Documentation in Inpatient Charts
Clinical Protocol Adoption	Develop a clinical adoption strategy for standardized, peer reviewed protocols and care maps for key conditions (e.g. pneumonia, cellulitis, congestive heart failure, and MI management).
Targeted CMG Assessment with CDM Focus	Targeted assessment of CMG's driving beds savable with a focus on CDM to divert admissions related to chronic disease.

Regional Opportunity Map and Reference Guide
Resource Alignment



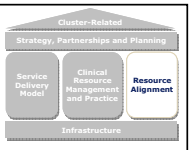
Opportunity Name	Opportunity Description
Mental Health Service HR Planning	Develop a targeted mental health resource strategy to address current and anticipated capacity, staffing, physician and education requirements for expanded service at St. Theresa's.
	Conduct service model and caseload review for current Mental Health Therapists to explore stronger linkage and support to the inpatient service.
Continuing Care HR & Staffing Plan	Identify the total HPRD for all care roles involved in continuing care (PT, OT, Recreation, Social Work) to determine true gap before any potential staffing adjustments are made.
	Develop a targeted HR plan for Continuing Care, as part of the broader regional HR strategy.
	Any staffing investment opportunity needs to be considered in Athabasca, in the context of an adjusted HPPD to reflect the number of patients awaiting placement in the community.
	There is a staffing investment opportunity in St. Theresa in acute care equivalent to 1.9 FTE. This might be offset by the number of patients at St. Theresa's who require an Alternative Level of Care.

Regional Opportunity Map and Reference Guide
Resource Alignment (continued)



Opportunity Name	Opportunity Description
ER / OPD Staffing Plan	There is opportunity for significant investment in the acute and ER/OPD departments at Edson, however this needs to be reviewed in conjunction with primary care physician coverage in the community.
	The potential investment opportunity in Hinton ambulatory needs to be reviewed in conjunction with primary care physician coverage in the community.
	Physician shortage in community drives ER volume and the staffing investment should be seen in the light of many of the ER visits being low acuity clinic visits. (Whitecourt)
	Staffing investment of 9 FTE in acute care and ER/OPD should be considered related to ER/OPD volumes, and in light of proposed facility redevelopment and functional planning. (Barrhead)
	There is a staffing investment equivalent to 1 FTE in ER/OPD that is driven by the increase in volumes, however this needs to be reviewed in conjunction with primary care physician coverage in the community. (Mayerthorpe)
	Consider staffing investment equivalent to 5.0 FTEs to support ER/OPD visits, however this needs to be reviewed in conjunction with primary care physician coverage in the community. (Westlock)
	There is a significant investment in the ER/OPD to address volume and workload. (Cold Lake)

Regional Opportunity Map and Reference Guide
Resource Alignment (continued)



Opportunity Name	Opportunity Description
Westlock Surgical Day Care Capacity	There is an efficiency opportunity in Surgical Day Care that is equivalent to 6 FTE due to potential for additional capacity. This indicates that there is an opportunity to further increase surgical cases within the current staffing complement.
Hinton Perioperative Services Capacity	An efficiency opportunity exists in the combined OR, recovery room and surgical day care. At this time the efficiency target is equivalent to 8 FTE and indicates an opportunity to increase OR/SDC volumes within the current staffing complement.
DI Staffing Plan	Assess future operating savings related to film and staffing with fuller adoption of PACS across Region.
Clinical Lab Staffing Plan	Develop staffing plan based on regional model to address potential staff savings (identified as up to 18 FTEs at the midpoint comparison level).
Clinical Nutrition Staffing Plan	Develop staffing plan based on regional service model.
Pharmacy Staffing Plan	Develop staffing plan based on regional service model.
Corporate Services Staffing Plan	Assess investment required as ARHA adopts stronger Decision Support function.

Regional Opportunity Map and Reference Guide
Infrastructure

Opportunity Name	Opportunity Description
Facility Renewal Plans	Facility renewal plans should be linked to outcomes of clinical service role review for region and be done at the Area Level at a minimum.

Regional Opportunity Prioritization

Regional Opportunity Prioritization
Introduction

- Based on a facilitated working session with the Region's Senior Management Team, the Project Team have developed an Opportunity Sequence Map.

- Opportunity prioritization has focused on sequencing, using four key factors:
  - Opportunity Inter-Dependencies
  - Resource Requirements (Leadership, People, Financial, External Support)
  - Identified Risks
  - Timeline Feasibility
  - Priority Level to the Region

- The opportunity mapping (timeline) has four phases of effort:
  - Phase 1: 0-6 months
  - Phase 2: 6-12 months
  - Phase 3: 12-18 months
  - Phase 4: 18-24 months

Regional Opportunity Prioritization
Introduction (continued)

- During the working session with the region's Senior Management Team, opportunities were reviewed by phase of effort to discuss the appropriateness and feasibility of the preliminary prioritization.
- Throughout the discussion, a "go forward determination" was also assigned to each opportunity to establish if phasing needs to be changed, deferred and / or not pursued:

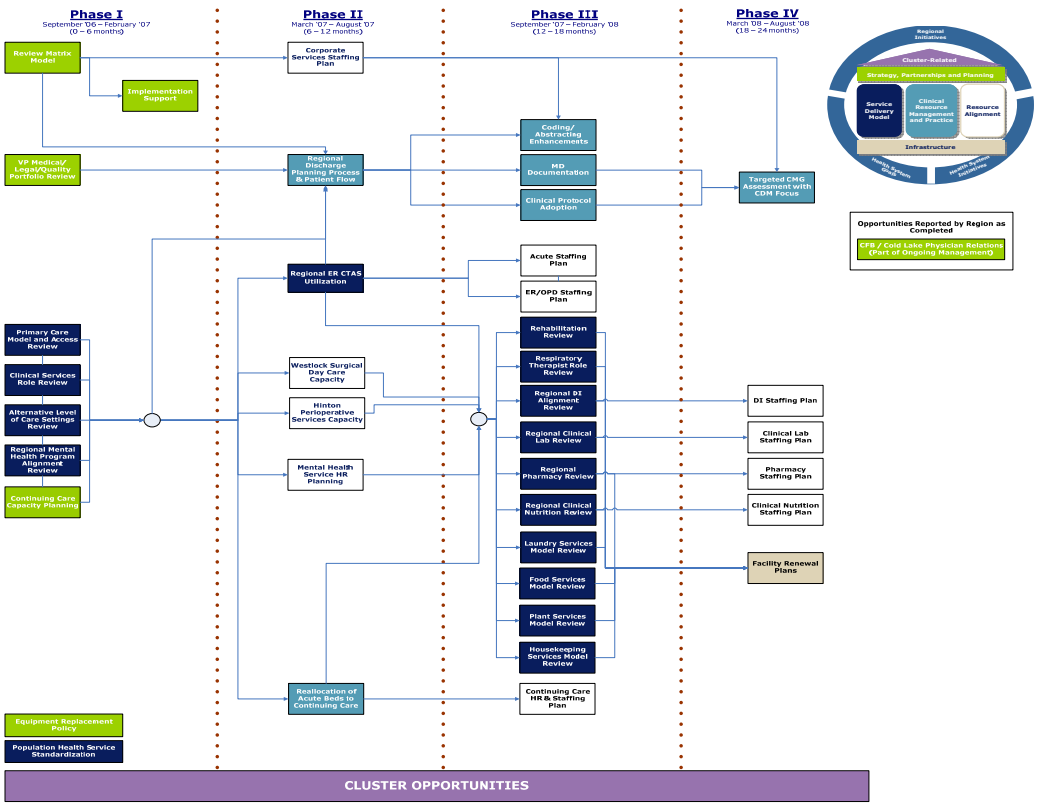
  – ***Priority*** – Opportunities that are considered priorities for achievement by the region over a two year period.

  – ***Deferred*** – Opportunities which must be deferred at this stage, but which will be re-considered for pursuit in the future.

  – ***Not Pursued*** – Opportunities which are not considered as regional priorities, and so will not be pursued.

- The following slide presents the opportunity prioritization map, based on those opportunities identified as priorities by the region.
- Supporting this opportunity map is an overview of the regional lead, required resources, and priority assignment for each regional opportunity.

Regional Opportunity Prioritization Map



Regional Opportunity Prioritization

Phase 1 Senior Leads and Resources

Opportunity Name	Responsible Senior Lead	Project Resources			Prioritization		
		Internal Resources	Additional Financial Support	External Resource Support	Priority	Deferred	Not Pursued
Review Matrix Model	Andrew Will	✓	✓		✓		
Implementation Support	Andrew Will	✓	✓		✓		
VP Medical / Legal / Quality Portfolio Review	Andrew Will / Yolanda Lackie	✓	✓		✓		
Primary Care Model and Access Review	Andrew Will / Yolanda Lackie / Cliff Cottingham	✓	✓	✓	✓		
Clinical Services Role Review	Andrew Will / Cliff Cottingham	✓		✓	✓		
Alternative Level of Care Settings Review	Cliff Cottingham	✓	✓		✓		
Regional Mental Health Program Alignment Review	Cliff Cottingham	✓			✓		
Continuing Care Capacity Planning	Cliff Cottingham	✓			✓		

Regional Opportunity Prioritization

Phase 1 Senior Leads and Resources (continued)

Opportunity Name	Responsible Senior Lead	Project Resources			Prioritization		
		Internal Resources	Additional Financial Support	External Resource Support	Priority	Deferred	Not Pursued
Population Health Service Standardization	Cliff Cottingham	✓			✓		
Equipment Replacement Policy	Shelly Pusch	✓	✓		✓		

Regional Opportunity Prioritization

Phase 2 Senior Leads and Resources

Opportunity Name	Responsible Senior Lead	Project Resources			Prioritization		
		Internal Resources	Additional Financial Support	External Resource Support	Priority	Deferred	Not Pursued
Corporate Services Staffing Plan	Andrew Will / Shelly Pusch	✓	✓		✓		
Regional Discharge Planning Process & Patient Flow	Cliff Cottingham / Yolanda Lackie	✓	✓		✓		
Regional ER CTAS Utilization	Cliff Cottingham / Yolanda Lackie	✓	✓		✓		
Westlock Surgical Day Care Capacity	Cliff Cottingham	✓			✓		
Hinton Perioperative Services Capacity	Cliff Cottingham	✓			✓		
Mental Health Service HR Planning	Cliff Cottingham	✓	✓		✓		
Reallocation of Acute Beds to Continuing Care	Cliff Cottingham	✓			✓		

Regional Opportunity Prioritization

Phase 3 Senior Leads and Resources

Opportunity Name	Responsible Senior Lead	Project Resources			Prioritization		
		Internal Resources	Additional Financial Support	External Resource Support	Priority	Deferred	Not Pursued
Coding/Abstracting Enhancements	Cliff Cottingham / Yolanda Lackie	✓	✓		✓		
MD Documentation	Yolanda Lackie / Cliff Cottingham	✓	✓		✓		
Clinical Protocol Adoption	Yolanda Lackie / Cliff Cottingham	✓	✓		✓		
Acute Staffing Plan	Cliff Cottingham	✓	✓		✓		
ER/OPD Staffing Plan	Cliff Cottingham	✓	✓		✓		
Continuing Care HR & Staffing Plan	Cliff Cottingham	✓			✓		
Rehabilitation Review	Cliff Cottingham	✓		✓	✓		
Regional DI Alignment Review	Cliff Cottingham	✓	✓		✓		
Regional Clinical Lab Review	Cliff Cottingham	✓		✓	✓		

Regional Opportunity Prioritization

Phase 3 Senior Leads and Resources (continued)

Opportunity Name	Responsible Senior Lead	Project Resources			Prioritization		
		Internal Resources	Additional Financial Support	External Resource Support	Priority	Deferred	Not Pursued
Regional Pharmacy Review	Cliff Cottingham	✓	✓		✓		
Regional Clinical Nutrition Review	Cliff Cottingham	✓	✓		✓		
Laundry Services Model Review	Cliff Cottingham / Shelly Pusch	✓			✓		
Food Services Model Review	Cliff Cottingham / Shelly Pusch	✓			✓		
Plant Services Model Review	Cliff Cottingham / Shelly Pusch	✓	✓		✓		
Housekeeping Services Model Review	Cliff Cottingham / Shelly Pusch	✓			✓		

Regional Opportunity Prioritization

Phase 4 Senior Leads and Resources

Opportunity Name	Responsible Senior Lead	Project Resources			Prioritization		
		Internal Resources	Additional Financial Support	External Resource Support	Priority	Deferred	Not Pursued
Targeted CMG Assessment with CDM Focus	Cliff Cottingham / Yolanda Lackie	✓	✓		✓		
DI Staffing Plan	Cliff Cottingham	✓			✓		
Clinical Lab Staffing Plan	Cliff Cottingham	✓			✓		
Pharmacy Staffing Plan	Cliff Cottingham	✓			✓		
Clinical Nutrition Staffing Plan	Cliff Cottingham	✓	✓		✓		
Facility Renewal Plans	Andrew Will	✓	✓	✓	✓		

Deloitte.

AHW RHA Efficiency Review
Aspen Regional Health Authority

Performance Management Overview

Final Report

July 14, 2006

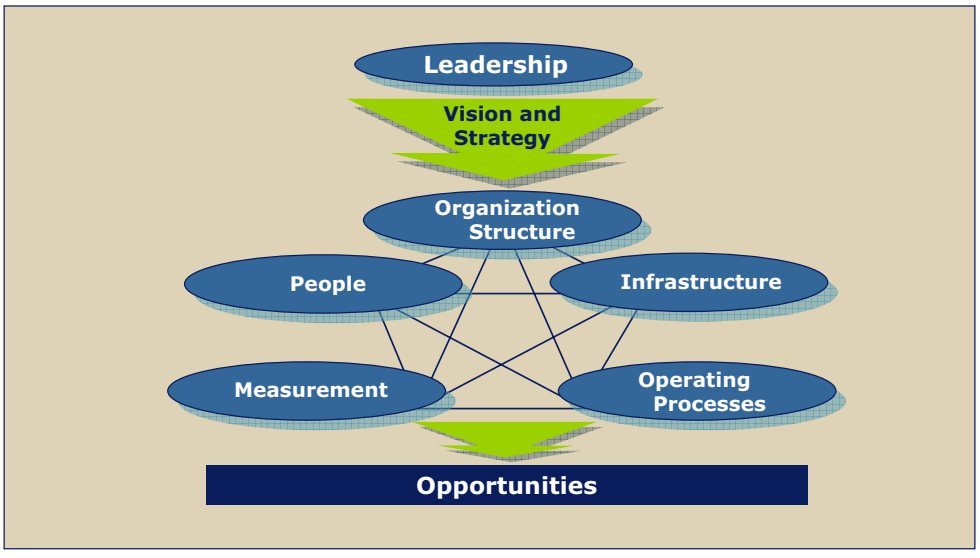
Audit. Tax. Consulting. Financial Advisory.

Property of Alberta Health and Wellness

Performance Management Overview

Key Components of Performance Management

- The framework below is used to assess performance management alignment. There are seven components used in this assessment.



1. Leadership

Leading Practice Attributes	• Visible leadership; vision and strategy focused; Role mentorship and succession planning; Systems thinking and planning; Multi-stakeholder relationships management • Transparent and timely management processes related to decision-making; • Demonstrated commitment to standardization;

Findings	
Documentation Review	**Stakeholder Feedback**
• 3 Year Health Plan; Annual Business Plan; Annual Report • Organization Charts • Accreditation Overview (4 Regions) • Performance Management Profile	• Stakeholders recognize the potential for change at Aspen (new CEO VP East). • Individuals commented on the slow decision-making process through the Issue for Decision requirement. Although the process can be swift for emergent /urgent issues. • Management at various levels identified frustration with limited function and authority related to their roles. • Matrix model and organizational structure deliberately selected to address wide geographical coverage and challenges that traditional program management model would have had with geographical constraints.

Deloitte Observations	• Multiple regional initiatives are in planning mode, however there is limited implementation support. • Need for stronger performance management processes a long standing issue (in early Accreditation recommendations); limited standardization in place. Significant work is underway related to quality reporting at both Board level and within management team. • Many of the leadership roles are overly large and don't allow appropriate time to lead initiatives (Director roles fragmented between site, community, regional responsibilities). • Leadership acknowledges the struggle with balancing consultation, communication and decision-making.

2. Vision and Strategy

Leading Practice Attributes	• Clearly articulated Mission, Vision, and Value Statements (or Guiding Principles) • Current Strategic Plan with supportive structure and processes to cascade to operational level; prioritization process to focus organizational initiatives and decision-making • Performance management processes and structure aligned to support strategy; • Focused on direction • Cross RHA collaboration; integration mindset

Findings	
Documentation Review	**Stakeholder Feedback**
• 3 Year Health Plan; Annual Business Plan; Annual Report, • Performance Management Profile	• RHA continues to undertake substantial planning related to regionalization; a time-consuming process • Relatively young as new regional entity (3 years) • Multiple initiatives and priorities may create limited traction (too fragmented) • Multiple roles responsible for initiative planning; limited roles responsible for implementation

Deloitte Observations	• 3 year plan and annual business plan show alignment; however, many of the strategic initiatives are in planning or early implementation stage. • Limited implementation resources available to cascade change at the operational level is noted. Region does not appear sufficiently resourced in terms of implementation resources to affect strategy and change initiatives.

3. Organization Structure

Leading Practice Attributes	• Organizational structure reflects unique requirements of organization, service delivery; supports changing service and people requirements; • Supports timely decision-making and efficient work flow; role accountability and communication • Minimizes role duplication and confusion • Strategic portfolios instead of service management ones

Findings	
Documentation Review	**Stakeholder Feedback**
• Organization Structure / Charts • Role descriptions (select management roles) • Policy: Issue for Decision • Performance Management Profile	• Multiple roles involved in planning (Regional Coordinators, CHS Managers, Facility Managers, Directors) • Matrix structure (area and regional responsibilities) creates very large role responsibilities – substantive travel – suggested up to 50% • Shift to matrix structure has taken some time for management team to gain comfort level and understanding of required communication • Shift of Recreation Therapy to Facility Manager – endorsed • Mix reaction on rehab staff serving facility reporting to community
Deloitte Observations	• Matrix organization and role structure require substantial role consultation, travel. • Lack of clear role differentiation between number of roles (CHS Managers and Supervisors, Area Director and Facility Managers). • Regional gains appear stronger in community health services side vs. facility. • Variable spans of control across region • Organization may want to consider aligning select functions (such as: education, quality, research, Telehealth, information/privacy) within one senior management portfolio.

4. People

Leading Practice Attributes	• Current Human Resources Strategic Plan; HR planning and management from a regional perspective (move from local to central) • Standardized performance review process with regular application • Identified competencies for roles – particularly at leadership level • Sufficient HR staffing support across organization to support management and staff • Supportive staff development and education program / process in place; career paths / laddering opportunities

Findings	
Documentation Review	**Stakeholder Feedback**
• Role descriptions • HR Strategic Plan • Organization structure	• Most individuals believe HR is under-resourced • Managers identify that performance review compliance is inconsistent • Limited education delivery support available • Recruitment process is decentralized
Deloitte Observations	• Need for comprehensive HR strategy and implementation plan; staff performance management processes appear weak and increased efforts across region related to recruitment. • Limited HR support within recruitment efforts at the area level creates work duplication between areas (all after the same limited number of potential candidates). • Limited education / training support for transition. • Span of control across region requires review. • Senior Management report that significant amount of work and development of HR strategies has occurred as part of overall regional plan and specific to program plans. Middle level management did not comment on this work effort.

5. Infrastructure

Leading Practice Attributes	
	• Current and integrated information management, technology and facility plans • Sufficient and appropriate technology to support efficient and effective operations • Capital replacement plan (current and integrated); Facility development processes and plans to support care requirements and efficient operations • Metrics to assess value of investment (economic and social value, linking service to infrastructure) • Assessment of new business models to enable infrastructure investment

Findings	
Documentation Review	**Stakeholder Feedback**
• IT plan • Capital Redevelopment Submissions	• IT structure reflects organization working through updating and managing legacy systems. • Re-regionalization to Aspen disbanded some legacy systems but left areas without replacement or a better system (for example Environmental Health). Region has committed to align its IT initiatives with RSHIP initiative. • Capital redevelopment in place or planned in numerous sites across region; many work around solutions given poor or inappropriate design. • Where community and facility services are co-located, individuals report good information and work flow.

Deloitte Observations	
	• ER design in most facilities requires review; many facilities suffer cramped space (DI, Lab, Pharmacy). • Region has many individual redevelopment processes underway and would benefit from a consolidated assessment across region, an overall plan at least at the area level, and clearly identified priorities.

6. Measurement

Leading Practice Attributes	
	• Existence of a comprehensive performance management system in place (people, financial, operations, satisfaction, and other key processes) • Development of performance metrics and targets to manage care and service; linkage of measurement to action and communication • Consistent, standardized measures • Performance measurement linked to quality and risk management

Findings	
Documentation Review	**Stakeholder Feedback**
• 3 Year Health Plan; Annual Business Plan; Annual Report, • Accreditation • Annual Reports	• Currently, much work effort devoted to upcoming Accreditation • Continued efforts related to building and implementing quality management across region • Managers appeared without quality or risk management resources to problem solve

Deloitte Observations	
	• Support the continued effort to build and implement performance management processes across region • Potential benefit of region adopting a scorecard for internal management • Indicator development process may require improvement process • Insufficient resources to give related initiatives traction across region • The region has demonstrated a steady work effort in this area, however continued effort is required to cascade processes to operational level.

7. Operational Processes

Leading Practice Attributes	• A formal, organization-wide risk identification and management process is in place; • Established processes in place to support standardization and development of practice • Established processes, initiatives to support standardization of care and service • Established resources to support initiative implementation and monitoring • Assessment of new or different business models to support service delivery and integration • Management processes that support accountability

Findings	
Documentation Review	**Stakeholder Feedback**
• Annual Business Plan • Accreditation Report • Care documentation (charts) • Policy/Procedure	• "New" Aspen still forging its new identity; Managers identify wide variation in practice across sites, staffing and processes across region • Low signing authority, often decisions through Issue For Decision process can be slow, • Matrix responsibilities of area and regional programming is time-consuming and compounds decision-making; although matrix viewed favourably

Deloitte Observations	• Aspen is still a region in formation mode; organization structure should be re-assessed for effectiveness and efficiency in terms of management decision making and the span of control for region-wide roles • Management accountability needs to strengthened at middle management level, and span of control should be reviewed • The region continues to work through the process of regional standardization. Clinical care and management processes are largely site-based.

Summary Remarks

Strengths to build on include…

- **Strong leadership at the corporate level**
- **A defined strategic direction**
- **Matrix organization structure that supports both regional service planning and area-specific delivery**
- **Senior management and staff**
- **RSHIP Initiatives**
- **General awareness about performance measurement and senior leadership commitment**
- **Reported improvements within community health services continuum**

There are, however, some challenges. Aspen needs to:

- **Enable middle management decision-making**
- **Assess the number of priorities it undertakes and ensure there is adequate implementation support**
- **Reassess the feasibility of select roles within its matrix organization model**
- **Focus on a regional approach to HR planning and management, and include support for physicians**
- **More aggressively support regionalized care standards**